HEALTH SCIENCES LIBRARY
UNIVERSITY OF MARYLAND
BALTIMORE

The JOURNAL

of the

INDIANA STATE MEDICAL ASSOCIATION

DEVOTED TO THE INTERESTS OF THE MEDICAL PROFESSION OF INDIANA

EDITOR

FRANK B. RAMSEY, M.D., Indianapolis

ASSOCIATE EDITORS

A. W. CAVINS, M.D., Terre Haute
DAVID A. BICKEL, M.D., South Bend
STEPHEN L. JOHNSON, M.D., Evansville
LALL G. MONTGOMERY, M.D., Muncie

EDITORIAL BOARD

HAROLD D. LYNCH, M.D., Evansville
GEORGE N. LEWIS, M.D., Gary
SAMUEL R. MERCER, M.D., Fort Wayne
GEORGE M. JOHNSON, M.D., Richmond
IRVIN W. WILKENS, M.D., Indianapolis
JENE R. BENNETT, M.D., South Bend

ASSISTANT EDITOR

MRS. SARA M. SNYDER, Indianapolis

BUSINESS MANAGER

JAMES A. WAGGENER, Franklin

Office of Publication: 1019 Hume Mansur Building, Indianapolis 4, Indiana

INDEX TO VOLUME 53

January through December, 1960

January	Pages	1 to 212	July	Pages	1255 to 1424
February	Pages	213 to 392	August	Pages	1425 to 1560
March	Pages	393 to 612	September	Pages	1561 to 1792
April	Pages	613 to 802	October	Pages	1793 to 1962
May	Pages	803 to 1080	November	Pages	1963 to 2144
June	Pages	1081 to 1254	December	Pages	2145 to 2332

HEALTH SCIENCES LIBRARY
UNIVERSITY OF MARYLAND
BALTIMORE

61-1125


PARKE, DAVIS & COMPANY • DETROIT 32, MICHIGAN

The Journal

January 1960

of the INDIANA STATE MEDICAL ASSOCIATION

Office of Publication:
1019 Hume Mansur Building, Indianapolis, Indiana

$1.00 per copy
except Yearbook
$5.00 per year

Contents

SCIENTIFIC

Adrenal Insufficiency Due to Histoplasmosis, A Case Report, Emmett C. Pierce, M.D., Indianapolis 57
Relationship of Benign and Malignant Breast Lesions, M. Shellhouse, M.D., Gary 63
Hepatco-Lenticular Degeneration, A Report of Two Cases, A. Wendell Musser, M.D., Indianapolis 68
Trichophyton Tonsurans Infection of the Scalp in Central Indiana, Howard R. Gray, M.D., John Eric Dalton, M.D., Helene Starcs, M.S., Indianapolis 75
Sensitivity to Elemental Sulfur, A Case Report, L. Edward Gaul, M.D., Evansville 81
Salicylates and the Stomach, J. W. Hurley, M.D., J. H. Ivy, M.D., B. A. McArt, M.D., Elkhart 84
Quinidine Purpura, A Case Report, D. Edmund Storey, M.D., Indianapolis 89

EDITORIALS

Medical Education 92
No Such Thing as an Unloaded Gun 93
Health Information Foundation 94

SPECIAL FEATURES

I. U. School of Medicine Explains New Family Practice Program..... 42
6,860 Students Receive M.D. Degrees in 1958-59 46
Hoosier Winterland, a pictorial feature 98
AMA House of Delegates Acts Favorably on 3 Indiana Resolutions at Texas Meeting 100
Indiana's Psychiatric Care, Treatment and Rehabilitation 110
Forces Affecting the Community's Hospital Bill, Ray E. Brown, Chicago 132

REGULAR FEATURES

Month in Washington 12
Fourth Estate 16
Why Blue Shield Needs and Deserves Your Support, 11th in a series.... 34
Wanted: Locations, Physicians 40
State Board of Health Report 50
President's Page 95
The Woman's Auxiliary Reports to ISMA 96
Journal Medical Essay Contest 97
News Notes 158
Medics and Public Health Officials Organize for Olympic Games.... 158
Diabetes Therapy Film 162
"Exhibits on Film" 164
Pharmaceutical Industry Leads in Basic Research 166
Add 1, by corki 172
Deaths 176
Advertiser's Index 192

BUSINESS

District, County News 176
Association News:
Executive Committee, Nov. 11, 1959..... 178

1959 INDEX

Index for Vol. 53, 1959..... 205

EDITORIAL AND ADVERTISING INFORMATION

All articles must be typewritten, double-spaced with margins of one inch.

Photographs should be printed on glossy paper. Negatives cannot be used.

Illustrations are desirable. Selection of illustrations submitted at discretion of editor and editorial board members. Cost of color illustrations must be shared by the author.

Contributors are responsible for all statements made in their articles. The editors and editorial board members may not be in agreement with all views expressed by authors, but it is desired to give all authors as great latitude as possible. However, the right is reserved to reduce in length or reject any article.

Articles are accepted for publication with the understanding that they are submitted for exclusive publication in THE JOURNAL of the Indiana State Medical Association.

Communications dealing with editorial matter should be sent to Frank B. Ramsey, M.D., Editor, 1802 North Illinois Street, Indianapolis 2, Indiana. All other communications should be sent to THE JOURNAL of the Indiana State Medical Association, 1019 Hume Mansur Building, Indianapolis 4, Indiana.

Advertising rates will be furnished on request. Copy must be received by the 5th of the month preceding month of issue. (Scientific manuscripts must be received at least two weeks earlier if geared for a specific issue.)

Entered as second class matter January 25, 1933, at the Postoffice at Indianapolis, Indiana. Copyright, 1960, by the Indiana State Medical Association. Published monthly at 1019 Hume Mansur Bldg., Indianapolis 4, Indiana.

NOW many more hypertensive patients may have THE FULL BENEFITS OF CORTICOSTEROID THERAPY

Except for one case of mild blood-pressure elevation (150/90) **no hypertension was seen in any of 1500 patients**† as a result of treatment with DECADRON—the new and, on a milligram basis, most potent of all corticosteroids. **Hypertension induced by other steroids diminished or disappeared.**

Thus with DECADRON, hypertension no longer appears to be a contraindication to successful corticosteroid therapy. And the dramatic therapeutic impact of DECADRON was virtually unmarred by diabetogenic or psychic reactions . . . Cushingoid effects were fewer and milder . . . and there were no new or "peculiar" side effects. Moreover, DECADRON helped restore a "natural" sense of well-being.

†Analysis of clinical reports.

Decadron*

DEXAMETHASONE

treats more patients more effectively

*DECADRON is a trademark of Merck & Co., Inc. ©1959 Merck & Co., Inc.

MERCK SHARP & DOHME
DIVISION OF MERCK & CO., INC., PHILADELPHIA 1, PA.

THE INDIANA STATE MEDICAL ASSOCIATION

1021 Hume Mansur Building, Indianapolis 4 — Telephone MElrose 6-3406

ANNUAL CONVENTION — OCT. 3-5, 1960, FRENCH LICK

OFFICERS FOR 1959-60

President—Earl W. Mericle, M.D., 1633 N. Capitol Ave., Indianapolis 2.

President-elect—Guy A. Owsley, M.D., 214 N. High St., Hartford City.

Treasurer—Okla W. Sicks, M.D., 606 Hume Mansur Building, Indianapolis 4.

Executive Secretary—Mr. James A. Waggener, 1021 Hume Mansur Building, Indianapolis. (Home Telephone: Franklin, Indiana, REdfield 6-6392.)

Assistant to the Executive Secretary—Miss Lucille Kribs, 1021 Hume Mansur Building, Indianapolis.

Field Secretary—Mr. Robert J. Amick, Oak Hill, R.R. 3, Scottsburg.

Field Secretary—Mr. Howard Grindstaff, 1021 Hume Mansur Building, Indianapolis.

Legal Counselor—Mr. Robert Hollowell, 2939 N. Meridian, Indianapolis.

Editor, The JOURNAL—Frank B. Ramsey, M.D., 1802 N. Illinois St., Indianapolis 2.

Assistant Editor—Miss Corki Wilson, 1019 Hume Mansur Bldg., Indianapolis 4.

COUNCILORS

District	Councilor	Term Expires
1	William B. Challman, Mt. Vernon	Oct. 1962
2	J. H. Crowder, Sullivan	Oct. 1960
3	John M. Paris, New Albany	Oct. 1961
4	Joseph M. Black, Seymour	Oct. 1962
5	Robert K. Webster, Brazil	Oct. 1960
6	Harry P. Ross, Richmond	Oct. 1961
7	Ralph V. Everly, Indianapolis	Oct. 1962
8	Guy A. Owsley, Hartford City	Oct. 1960
9	K. O. Neumann, Lafayette	Oct. 1961
10	J. P. Vye, Gary	Oct. 1962
11	Max R. Adams, Flora	Oct. 1960
12	Maurice E. Glock, (Chairman) Fort Wayne	Oct. 1961
13	Burton Kintner, Elkhart	Oct. 1962

DELEGATES TO THE A.M.A.

Terms expire December 31, 1960:

Delegates	Alternates
Harold C. Ochsner, M.D. Indianapolis	James H. Gosman, M.D. Indianapolis
E. S. Jones, M.D. Hammond	Robert M. Brown, M.D. Marion
Francis L. Land, M.D. Fort Wayne	George W. Willison, M.D. Evansville

Terms expire December 31, 1961:

Delegates	Alternates
Gordon B. Wilder, M.D., Anderson	Walter L. Portteus, M.D., Franklin
Wendell C. Stover, M.D., Boonville	John M. Paris, M.D., New Albany

SECTION OFFICERS 1959-60

Section on Surgery:
Chairman, Ted L. Grisell, M.D., Indianapolis
Vice-chairman, Pierre C. Talbert, M.D., Bluffton
Secretary, Richard Davis, M.D., Marion.

Section on Medicine:
Chairman, V. Brown Scott, M.D., Shelbyville
Vice-chairman, Stephen L. Johnson, M.D., Evansville.
Secretary, Charles Jackson, M.D., Bluffton.

Section on Ophthalmology and Otolaryngology:
Chairman, Marvin P. Cuthbert, M.D., Indianapolis
Vice-chairman, John R. Swan, M.D., Indianapolis
Secretary, M. Richard Harding, M.D., Indianapolis

Section on Anesthesiology:
Chairman, Paul Littlefield, M.D., Indianapolis
Vice-chairman, Joseph H. Stamper, Anderson
Secretary, M. L. Hicks, Indianapolis

Section on General Practice:
Chairman, Edward C. Voges, M.D., Terre Haute
Vice-chairman, Burton E. Kintner, M.D., Elkhart.
Secretary, Joseph M. Black, M.D., Seymour

Section on Obstetrics and Gynecology:
Chairman, Mahlon F. Miller, M.D., Fort Wayne.
Vice-chairman, John E. Mackey, M.D., Indianapolis.
Secretary, John F. Spahr Jr., M.D., Indianapolis.

Section on Public Health and Preventive Medicine:
Chairman, Henry G. Nester, M.D., Indianapolis.
Vice-chairman, Paul H. Martin, M.D., Elkhart.
Secretary, Albert L. Marshall Jr., M.D., Indianapolis.

Section on Radiology:
Chairman, John R. Lionberger, M.D., South Bend.
Vice-chairman, Chester A. Stayton Jr., M.D., Indianapolis.
Secretary, David Wheeler, M.D., Indianapolis

1959-1960 DISTRICT MEDICAL SOCIETY OFFICERS

District	President	Secretary	Place and date of meeting
1.	Noel Neifert, M.D., Tell City	Gilbert Wilhelmus, M.D., Evansville	1960
2.	Herbert O. Chattin, M.D., Vincennes	J. S. Brown, M.D., Carlisle	1960
3.	P. T. Hodgin, M.D., Orleans	(to be appointed)	French Lick, May 18, (tentative), 1960
4.	Robert M. Reid, M.D., Columbus	David L. Adler, M.D., Columbus	Columbus, May 11, 1960
5.	Gilbert Rhea, M.D., Greencastle	James B. Johnson, M.D., Greencastle	Greencastle, 1960
6.	Kenneth G. Hill, M.D., Newcastle	John A. Davis, M.D., Flat Rock	Shelbyville, May 11, 1960
7.	Arthur Records, M.D., Franklin	Herbert L. Egbert, M.D., Indianapolis	1960
8.	Richard C. Swan, M.D., Anderson		Anderson, June 8, 1960
9.	Harry E. Klepinger, M.D., Lafayette	Forrest J. Babb, M.D., Stockwell	Lafayette, May 18, 1960
10.	Martin O'Neill, M.D., Valparaiso	John R. Frank, M.D., Valpariso	Whiting, May 11, (tentative), 1960
11.	George Jewell, M.D., Kokomo	C. L. Wise, M.D., Camden	Wabash, 1960
12.	Harold F. Zwick, M.D., Decatur	Stephen C. Michaelis, M.D.	Fort Wayne, May 3, 1960
13.	Thomas A. Elliott, M.D., Elkhart	James M. Wilson, M.D., South Bend	1960



now...

after 5 years of research and 41,000 patient days of clinical testing

Mead Johnson *announces*

a new infant formula

Enfamil*

Infant formula

nearest to mother's milk[1] in nutritional breadth and balance

In a well controlled institutional study, Enfamil was compared with three widely used infant formula products. The investigators[2] report:

This formula produced:

weight gains greater than average,
stool firmness between firm and soft . . . and
lower stool frequency.

NEAREST. . . to mother's milk in its pattern of protein, fat and carbohydrate by caloric distribution

NEAREST. . . to mother's milk in its pattern of vitamins and minerals (more vitamin D in accordance with NRC recommendations)

NEAREST. . . to mother's milk in its fat composition (not butterfat; no sour regurgitation)

NEAREST. . . to mother's milk in its ratio of saturated to unsaturated fatty acids

NEAREST. . . to mother's milk in its low renal solute load

1. Macy, I. G.; Kelly, H. J., and Sloan, R. E.; with the Consultation of the Committee on Maternal and Child Feeding of the Food and Nutrition Board, National Research Council: The Composition of Milks, National Academy of Sciences, National Research Council, Publication 254, Revised 1953. 2. Research Laboratories, Mead Johnson & Company.

ENFAMIL LIQUID—cans of 13 fluid ounces.
1 part Enfamil Liquid to 1 part water for 20 cal. per fl. oz.
ENFAMIL POWDER—cans of 1 lb. with measure.
1 level measure of Enfamil Powder to 2 ounces of water for 20 cal. per fl. oz.

MEAD JOHNSON & COMPANY, EVANSVILLE 21, INDIANA

*Trade Mark

Mead Johnson
Symbol of service in medicine

I.S.M.A. Committees and Commissions for 1959-60

COMMITTEES

Executive

Don E. Wood, Indianapolis, chairman; Wendell E. Covalt, Muncie; Earl W. Mericle, Indianapolis, president; Guy A. Owsley, Hartford City, president-elect; Maurice E. Glock, Fort Wayne, chairman of the Council; Okla W. Sicks, Indianapolis, treasurer.

Grievance

Philip B. Reed, Indianapolis, chairman; Raymond E. Nelson, South Bend; George L. Derhammer, Brookston; William H. Garner, New Albany; Lloyd C. Marshall, Mt. Summit; M. C. Topping, Terre Haute; Paul L. Stier, Fort Wayne; Russell J. Spivey, Indianapolis; Elton R. Clarke, Kokomo; Cleon A. Nafe, Indianapolis.

Student Loan

Earl W. Mericle, Indianapolis, president; Okla W. Sicks, Indianapolis, sec.-treas.; John D. Van Nuys, Indianapolis, dean, I.U. School of Medicine; Robert Hollowell, Indinapolis, attorney; Harry P. Ross, Richmond; James O. Ritchey, Indianapolis; Lester D. Bibler, Indianapolis.

Medical-Legal Review

E. Rogers Smith, Indianapolis, chairman; Keith E. Selby, South Bend; Lall G. Montgomery, Muncie.

COMMISSIONS

Convention Arrangements

Ray H. Burnikel, Evansville, chairman; Jack G. Weinbaum, Terre Haute, vice-chairman; Howard E. Hill, Muncie, secretary; Irvin H. Scott, Sullivan; Jesse Benz, Marengo; Robert Zink, Madison; John Mader, Richmond; James M. Leffel, Indianapolis; Robert Harris, Noblesville; Michael Shellhouse, Gary; Max Long, Marion; Donald G. Mason, Angola; Bernard E. Edwards, South Bend; Ray Tharpe, Indianapolis; Edward B. Smith, Indianapolis.

Constitution and ByLaws

Charles A. Jones, Franklin, chairman; Lowell J. Hillis, Logansport, vice-chairman; John B. Cleveland, Michigan City, secretary; William B. Challman, Mt. Vernon; Dillon Geiger, Bloomington; Richard H. Woolery, Bedford; Gordon S. Fessler, Rising Sun; A. W. Cavins, Terre Haute; Howard E. Sweet, Richmond; Irwin S. Hostetter, Muncie; William M. Sholty, Lafayette; Philip J. Rosenbloom, Gary; Truman E. Caylor, Bluffton; G. O. Larson, LaPorte; Robert M. Hansell, Indianapolis.

Legislation

Don E. Wood, Indianapolis, co-chairman; Walter L. Portteus, Franklin, co-chairman; Eugene F. Senseny, Fort Wayne, secretary; P. J. V. Corcoran, Evansville; Robert O. Bethea, Farmersburg; Don Kerr, Bedford; Joe M. Black, Seymour; Joseph G. S. Weber, Terre Haute; Paul R. Tindall, Shelbyville; John W. Hendricks, Indianapolis; Paul T. Lamey, Anderson; Lee J. Maris, Attica; J. P. Vye, Gary; Donald K. Winter, Logansport; Otis R. Bowen, Bremen.

Public Information

William G. Bannon, Terre Haute, chairman; James M. Kirtley, Crawfordsville, vice-chairman; Seth W. Ellis, Anderson, secretary; R. L. Kleindorfer, Evansville; Mordecai M. McDowell, Vincennes; B. E. Sugarman, French Lick; Harry R. Baxter, Seymour; William R. Tindall, Shelbyville; Harry G. Becker, Indianapolis; Franklin F. Premuda, Hammond; R. M. Hummel, Marion; Naf H. Gladstone, Fort Wayne; Richard W. Holdeman, South Bend; T. D. Armstrong, Michigan City; Albert A. Fischer, Indianapolis.

Governmental Medical Services

Charles R. Alvey, Muncie, chairman; T. J. Bruegge, Kokomo, vice-chairman; George Willison, Evansville, secretary; Jack McKittrick, Washington; Irvin E. Huckleberry, Salem; William A. Johnson, North Vernon; V. Earle Wiseman, Greencastle; Glen Ward Lee, Richmond; Arvine Popplewell, Indianapolis; Robert E. Williams, Lafayette; Harry R. Stimson, Gary; Howard A. Stellner, Fort Wayne; James M. Wilson, South Bend; Jean V. Carter, Tipton; Stanley W. Burwell, Muncie.

Public Health

Emmett B. Lamb, Indianapolis, chairman; Richard C. Swan, Anderson, vice-chairman; Howard T. Hammel, Bedford, secretary; Daniel Hare, Evansville; Ralph O. Smith, Vincennes; Joseph E. Dudding, Hope; Robert K. Webster, Brazil; John A. Davis, Flat Rock; Allan K. Harcourt, Indianapolis; John R. Stanley, Muncie; Forrest J. Babb, Stockwell; E. S. Jones, Hammond; E. S. Rifner, Van Buren; Robert M. Lohman, Fort Wayne; John C. Richter, Laporte.

Voluntary Health Agencies

Kenneth H. Brown, New Albany, chairman; Norman R. Boeher, Indianapolis, vice-chairman; Karl R. Schlademan, Fort Wayne, secretary; R. Case Hammond, Evansville; Herbert O. Chattin, Vincennes; Robert M. Reid, Columbus; Anne S. Nichols, Greencastle; Wilson L. Dalton, Shelbyville; James L. Doenges, Anderson; Charles E. Rutherford, Otterbein; H. Glenn Gardiner, East Chicago; Wendell Ayres, Marion; Louis C. Bixler, South Bend; James Gosman, Indianapolis; Wendell A. Shullenberger, Indianapolis.

Medical Economics and Insurance

John Langohr, Columbia City, chairman; Edward T. Edwards, Vincennes, vice-chairman; Lowell I. Thomas, Indianapolis, secretary; Wendell C. Stover, Boonville; William H. Garner, Jr., New Albany; William Scharbrough, Medora; Hubert T. Goodman, Terre Haute; Morris D. Wertenberger, Richmond; Albert T. Jones, Anderson; Murray E. Harden, Lafayette; Robert N. Bill, Gary; Richard P. Good, Kokomo; George E. Paine, Elkhart; J. L. Arbogast, Indianapolis; John W. Beeler, Indianapolis.

Inter-Professional Relations

Frank H. Green, Rushville, chairman; Robert H. Rang, Washington, vice-chairman; Robert D. Howell, Indianapolis, secretary; Joseph D. McDonald, Evansville; William Paynter, Pekin; Kenneth Schneider, Nashville; Paul Humphrey, Terre Haute; Floyd A. Boyer, Indianapolis; C. V. Rozelle, Anderson; Kenneth O. Neumann, Lafayette; Milton B. Gevirtz, Hammond; Joseph B. Davis, Marion; Jack L. Eisaman, Bluffton; F. R. Nicholas Carter, South Bend; Neal E. Baxter, Bloomington.

Medical Education and Licensure

Francis L. Land, Fort Wayne, chairman; Harry Klepinger, Lafayette, vice-chairman; Kenneth G. Kohlstaedt, Indianapolis, secretary; Dallas Fickas, Evansville; William C. Reed, Bloomington; Robert W. Harris, New Albany; Jack E. Shields, Brownstown; Basil M. Merrell, Rockville; Norman F. Richard, Shelbyville; William N. Wishard, Jr., Indianapolis; Kemper N. Venis, Muncie; Robert A. Hedgecock, Frankfort; Ralph C. Eades, Valparaiso; Elton R. Clarke, Kokomo; Louis E. How, South Bend.

Special Activities

Malcolm O. Scamahorn, Pittsboro, chairman; Guy B. Ingwell, Knox, vice-chairman; Ralph M. Steffy, Portland, secretary; Joseph E. Coleman, Evansville; C. P. Fox, Washington; Eli Goodman, Charlestown; George A. May, Madison; Norman M. Silverman, Terre Haute; H. N. Smith, Brookville; Robert M. Butterfield, Muncie; Robert H. Wiseheart, Lebanon; Forrest R. LaFollette, Hammond; Earl W. Bailey, Logansport; David C. Gastineau, Fort Wayne; E. M. Sirlin, Mishawaka.



in sinusitis

. . . into a mixed culture of the four organisms commonly involved in sinusitis . . . *Str. hemolyticus, D. pneumoniae, H. influenzae* and *Staph. aureus* (in this case a resistant strain) . . . we introduce the five most frequently used antibiotics.

Twenty-four hours later (in this greatly enlarged photograph), note that only *one* of the five leading antibiotics has stopped *all* the organisms, including the resistant staph! This is Panalba.

In your next patient with sinusitis . . . in *all* your patients with potentially-serious infections . . . provide this extra protection with your prescription:

Dosage—1 or 2 capsules 3 or 4 times a day.
Supplied—Capsules containing Panmycin phosphate equivalent to 250 mg. tetracycline hydrochloride, and 125 mg. Albamycin as novobiocin sodium, in bottles of 16 and 100.
Now available: **new Panalba Half-Strength Capsules in bottles of 16 and 100.**

Panalba*

(Panmycin* Phosphate plus Albamycin*)

The broad-spectrum antibiotic of *first* resort



Upjohn The Upjohn Company Kalamazoo, Michigan

*TRADEMARK, REG. U. S. PAT. OFF.

COUNTY MEDICAL SOCIETY DIRECTORY

COUNTY	PRESIDENT	SECRETARY
Adams	J. B. Terveer, Decatur	William Freeby, 226 S. Second St., Decatur
Allen	William R. Clark, Fort Wayne	D. S. Painter, 222 Medical Center Bldg., Ft. Wayne 2
		David L. Wise, Fort Wayne, Ex. Secy. 716 Medical Center Bldg.,
Bartholomew-Brown	Alvin L. Henry, Columbus	Slater Knotts, County Hospital, Columbus
Benton	Dan Tucker Miller, Fowler	Robert H. Leak, Boswell
Boone	Paul R. Honan, Lebanon	Margaret A. Bassett, 218 E. Main, Thorntown
Carroll	Charles L. Wise, Camden	Max R. Adams, Flora
Cass	W. K. Newcomb, Royal Center	Jay M. King, 201 S. Third St., Logansport
Clark	Samuel Adair, Jeffersonville	David Jones, Charlestown
Clay	J. F. Mauer, M.D., Brazil	R. K. Webster, M.D., 28 N. Franklin St., Brazil
Clinton	Frederick W. Flora, Frankfort	Charles Bush, Jr., Kirklin
Daviess-Martin	Marshall H. Seat, Washington	C. Philip Fox, 305 People's Bank, Washington
Dearborn-Ohio	Charles F. Fletcher, Sunman	F. A. Streck, 326 Walnut St., Lawrenceburg
Decatur	James C. Miller, Greensburg	William R. Shaffer, 214 N. Franklin, Greensburg
DeKalb	John Hines, M.D., Auburn	Charles A. Novy, M.D., Garrett
Delaware-Blackford	Howard E. Hill, Muncie	Leland Brown, 412 White River Blvd., Muncie
Dubois	Elton Heaton, Huntingburg	Allen Scales, 409 Van Buren, Huntingburg
Elkhart	Irving Mishkin, Elkhart	Page E. Spray, 316 Fourth St., Elkhart
Fayette-Franklin	Arlington M. Hudson, Connersville	J. L. Steinem, 812 Grand Ave., Connersville
Floyd	John R. Higgins, New Albany	Daniel Cannon, 1201 E. Spring, New Albany
Fountain-Warren	Peter R. Petrich, M.D., Attica	Edward M. Humphrey, M.D., 1005 Orchard Dr., Covington
Fulton	Virgil C. Miller, Akron	Charles L. Richardson, 121 W. Eighth St., Rochester
Gibson	R. G. Geick, M.D., Ft. Branch	R. E. Weitzel, M.D., 114 S. Hart St., Princeton
Grant	Russel Hummel, Marion	E. S. Rifner, Van Buren
Greene	Robert Moses, M.D., Worthington	Harry Rotman, M.D., Jasonville
Hamilton	C. M. Donahue, Carmel	John G. Haywood, 120 No. 11th, Noblesville
Hancock	Bronie A. Vingis, Greenfield	Donn R. Hunter, 10 W. Boyd Ave., Greenfield
Harison-Crawford	W. J. Brockman, Corydon	David J. Dukes, 439 Chestnut, Corydon
Hendricks	Robert W. Kirtley, Danville	Lloyd S. Terry, 138 W. Marion, Danville
Henry	W. K. Saint, New Castle	W. C. Heilman, Jr., New Castle
Howard	Robert Phares, Kokomo	M. E. Artis, 107½ S. Union, Kokomo
Huntington	Richard Wagner, Huntington	B. Trent Cooper, Roanoke
Jackson	C. A. Wiethoff, Seymour	Harold E. Miller, Vehslage Bldg., Seymour
Jasper-Newton	E. R. Beaver, Rensselaer	Ralph I. Hartsough, Remington
Jay	R. E. Schenck	J. S. Fitzpatrick, 603 Arch, Portland
Jefferson-Switzerland	Ralph M. Pratt, Jr., Madison	W. E. Childs, 412 E. Main St., Madison
Jennings	William A. Johnson, North Vernon	John H. Green, North Vernon
Johnson	George Tiley, Greenwood	George E. Bullington, 251 E. Jefferson St., Franklin
Knox	Nathaniel D. Ewing, Vincennes	Charles E. Hendrix, 603 Busseron, Vincennes
Kosciusko	Wymond B. Wilson, M.D., Mentone	Carl E. Schrader, 600 E. Winona Ave., Warsaw
LaGrange	C. D. Benedict, LaGrange	P. E. Yunker, Howe
Lake	R. N. Bills, Gary	L. J. Armalavage, Gary
		Mr. John B. Twyman, Ex. Secy., 4640 W. 5th Ave., Gary
LaPorte	C. E. Muhleman, LaPorte	Fred S. Carter, LaPorte
		Ernest P. Messner, Ex. Secy., 117 W. 8th St., Michigan City
Lawrence	Edgar Bridwell, Bedford	Guy Waldo, P.O. Box 286, Bedford
Madison	Richard C. Swan, Anderson	D. P. Bixler, 1931 Brown St., Anderson
Marion	Irvin W. Wilkens, Indianapolis	Ray Tharpe, 3202 N. Meridian, Indianapolis
		Mr. Arthur G. Loftin, Exec. Secy. 418 Hume Mansur Bldg., Indianapolis
Marshall	James F. Rimel, Plymouth	James O. Coursey, Jr., 109 N. Walnut St., Plymouth
Miami	L. L. Hill, Denver	P. W. Snyder, 25 Court St., Peru
Montgomery	Richard Eggers, Crawfordsville	W. E. Shannon, 901 Cottage Ave., Crawfordsville
Morgan	Loren F. Taylor, Martinsville	William P. Winter, 60½ E. Morgan St., Martinsville
Noble	Carl Stallman, Kendallville	Frank W. Messer, Kendallville
Orange	W. E. Schoolfield, Orleans	C. S. Manship, Paoli
Owen-Monroe	Eldred F. Hardtke, M.D., Bloomington	Anthony Pizzo, M.D., Bloomington Hospital, Bloomington
Parke-Vermillion	Fred Evans, Clinton	Casper Harstad, 216 W. High St., Rockville
Perry	E. R. Snyder, Troy	Noel L. Neifert, 515 Main St., Tell City
Pike	M. H. Omstead, Petersburg	M. H. Omstead
Porter	F. J. Kleinman, Valparaiso	Ralph C. Eades, 6 Napoleon St., Valparaiso
Posey	John R. Crist, Mount Vernon	Herman Hirsch, 126 W. 5th St., Mt. Vernon
Pulaski	John D. Karns, Winamac	E. L. Hollenberg, 105 N. Franklin, Winamac
Putnam	L. W. Veach, M.D., Bainbridge	Anne Nichols, M.D., 707 E. Seminary St., Greencastle
Randolph	C. R. Slick, M.D., Winchester	M. E. McClure, Union City
Ripley	Charles Lippoldt, Batesville	A. W. Aldred, Milan
Rush	Marvin G. Norris, Rushville	Charles E. Sheets, Manilla
St. Joseph	George E. Gates, South Bend	Herbert Frank, South Bend
		Mr. Harry Davis, Exec. Secy. 106 W. Monroe
Scott	Marvin L. McClain, Scottsburg	F. S. Napper, Scottsburg
Shelby	James H. Tower Jr., M.D., Shelbyville	W. L. Dalton, M.D., 117 W. Washington, Shelbyville
Spencer	John C. Glackman Jr., Rockport	Michael O. Monar, Rockport
Starke	J. R. Matthew, North Judson	Earl R. Leinbach, Hamlet
Steuben	Robert Barton, Angola	M. M. Crum, Angola
Sullivan	Joe E. Dukes, M.D., Dugger	J. S. Brown, M.D., Carlisle
Tippecanoe	L. R. Johnson, Lafayette	Harley H. Frey, Jr., 405 Lafayette Life Bldg., Lafayette
Tipton	George L. Compton, Tipton	W. A. Kurtz, 202 S. West, Tipton
Vanderburgh	William T. Barnhart, Evansville	Mr. Arthur P. Tiernan, Evansville 109½ S. E. 3rd Street
Vigo	James O. Conklin, Terre Haute	Hubert T. Goodman, 410 Rose Dispensary Bldg., Terre Haute
Wabash	Robert A. Rauh, Wabash	Robert M. LaSalle, Jr., 55 W. Market St., Wabash
Warrick	Arthur R. Rogers, Newburgh	Robert H. Terry, 117 S. Second St., Boonville
Washington	I. E. Huckleberry, Salem	H. G. Coleman, Salem
Wayne-Union	Harold D. Hill, Cambridge City	Morris Wertenberger, Reid Memorial Hospital, Richmond
Wells	Robert G. Cook, Bluffton	Charles E. Jackson, Bluffton
White	Stanley E. McClure, Monon	David C. Beck, Monticello
Whitley	L. J. Minick, Churubusco	D. B. Reid, Columbia City

reaches all nasal and paranasal membranes *systemically*[1]



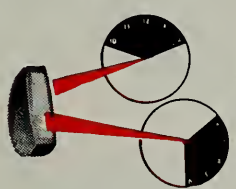
Pharmacologically balanced formula for prompt symptomatic relief

- in nasal and paranasal congestion
- in sinusitis and postnasal drip
- in allergic reactions of the upper respiratory tract

Triaminic*[2,3] *is safer and more effective than topical medication

- transported systemically to *all* respiratory membranes
- provides longer-lasting relief
- presents no problem of rebound congestion
- avoids "nose drop addiction"

Relief is prompt and prolonged because of this special timed-release action:



first— the outer layer dissolves within minutes to produce 3 to 4 hours of relief

then— the core disintegrates to give 3 to 4 *more* hours of relief

Each Triaminic timed-release Tablet provides:
Phenylpropanolamine HCl.....50 mg.
Pheniramine maleate.....25 mg.
Pyrilamine maleate.....25 mg.

Dosage: 1 tablet in the morning, midafternoon and at bedtime. In postnasal drip, 1 tablet at bedtime is usually sufficient.

Each timed-release Triaminic Juvelet® provides: ½ the formulation of the Triaminic Tablet.

Dosage: 1 Juvelet in the morning, midafternoon and at bedtime.

Each tsp. (5 ml.) of Triaminic Syrup provides: ¼ the formulation of the Triaminic Tablet.

Dosage (to be administered every 3 or 4 hours): *Adults* — 1 or 2 tsp.; *Children 6 to 12* — 1 tsp.; *Children 1 to 6* — ½ tsp.; *Children under 1* — ¼ tsp.

1. Fabricant, N. D.: E.E.N.T. Monthly *37*:460 (July) 1958.
2. Lhotka, F. M.: Illinois M. J.: *112*:259 (Dec.) 1957.
3. Farmer, D. F.: Clin. Med. *5*:1183 (Sept.) 1958.

the leading oral nasal decongestant...

Triaminic®

timed-release tablets and juvelets
also non-alcoholic, fruit-flavored syrup

SMITH-DORSEY • a division of The Wander Company • Lincoln, Nebraska

the states provide assistance to persons over age 50 judged to be totally and permanently disabled. An influential lawmaker, Rep. Burr Harrison (D., Va.), disclosed that he would introduce legislation to remove the age 50 limitation to allow all persons regardless of age to participate. He estimated this would not require any hiking of the taxes. Rep. Harrison is chairman of a House Ways and Means Subcommittee that held recess hearings on administration of the disability program.

Meanwhile, Chairman Wilbur Mills (D.,Ark.) of the full Ways and Means Committee cleared the way for full-scale hearings this Congressional session on the entire issue of Social Security. In listing specific phases to be considered, however, the lawmaker did not mention the Forand proposal.

"CLEAN IT'S OWN HOUSE"

A spokesman for the American Medical Association told the Federal Communications Commission that the AMA believes the best solution to objectionable advertising and programs on television and radio is for the industry "to clean its own house."

Dr. Eugene F. Hoffman, co-chairman of the AMA's Physician's Advisory Committee on Television, Radio and Motion Pictures, declared "the medical profession . . . stands ready to assist the networks and individual stations in determining accuracy and good taste of broadcast material involving health or medicine--either commercial or public service." ◄



"But, Doctor, I just can't swallow a lot of tablets"

"Little mother, just

ONE

BONADOXIN®

tablet stops morning sickness (you take it at bedtime)"



The formula tells why BONADOXIN quickly stops nausea and vomiting of pregnancy in 9 out of 10 cases.* Each tiny BONADOXIN tablet contains:
Meclizine HCl (25 mg.) for antinauseant action / Pyridoxine HCl (50 mg.) for metabolic replacement

More than 60,000,000 tablets prescribed and taken. Toxicity low, tolerance excellent. In bottles of 25 and 100. Usual dose: one tablet at bedtime; severe cases may require another on arising. See PDR, p. 779.

BONADOXIN also effectively relieves nausea and vomiting associated with: anesthesia, radiation sickness, Meniere's syndrome, labyrinthitis, cerebral arteriosclerosis and motion sickness.

After Baby Comes

For infant colic, try antispasmodic BONADOXIN Drops... stop colic in 7 out of 8 cases.*

Each cc. contains:
Meclizine 8.33 mg. / Pyridoxine 16.67 mg.

See PDR, p. 779.

*Bibliography available on request.

New York 17, New York • Division, Chas. Pfizer & Co., Inc. • Science for the World's Well-Being

The Fourth Estate Looks at Medicine

Hoosier Headlines

Perhaps it's about time, but the doctors themselves are suddenly becoming concerned about the few among them who are too cold and calculating in their dealings with sick and frightened patients.

Gone is the bedside manner, replaced too frequently with a scientific robot in white uniform who in chilly, impersonal tone recites the clinical diagnosis.

And who hasn't been shocked at least once by the seemingly bored indifference of some hospital attachés.

The problem was recognized at the recent annual meeting of the Indiana State Medical Association. And, in a national magazine article, Warren R. Young, put his finger on the pulse of the problem:

"Of all human acts, few can match the quiet splendor of the moment when the pale and tremulous fingers of a sick person are grasped in the firm reassuring hands of a compassionate physician."

Dr. John Van Nuys, dean of the Indiana University Medical School, admitted: "We've become a little over-scientific (in dealing with patients)."

American patients are so sophisticated and informed, Dr. Van Nuys pointed out, that doctors sometimes make the mistake of talking scientifically to them. He explained that the I.U. medical school was trying to meet the problem by stressing the importance of looking at the whole patient.

Of course, while some doctors lack sympathy because they have "lost touch," it also is true that some have so many patients it is a constant fight for them to treat each one as a human being. A few have forgotten that with their special privileges, high status and good incomes, go special responsibilities.

Then again, there are many miserable and irritating patients.

It is undoubtedly true that some of the best bedside manner physicians couldn't carry the stethoscope of a good doctor. There are many, though, with great ability and considerable compassion.

Yet I can't help but believe a little more sympthetic treatment from the majority of our doctors could perhaps help them regain some of their lost prestige with the public.

From column by *IRVING LEIBOWITZ*
Indianapolis Times
Oct. 14, 1959

Doctors and Politics

Red Tape for a Divided Profession

From Sir WALTER FERGUSSON HANNAY

Sir—The Minister of Health proclaims with modest pride that the National Health Service cost the nation £626m. last year, some £200m. more than in 1949-50. Surely the command of so great a sum of public money, regardless of any visible evidence of the Service's increased efficiency or any noticeable improvement in the nation's health, must indubitably be rewarded by Cabinet rank.

A heedless public wearily accepts a steadily declining standard which the munificent and much-vaunted Health Service provides. But the doctors, impounded by the politicians regardless of their wishes, stir uneasily in this costly cauldron.

Patients patiently queue in the doctor's waitingroom for their medicines, treatment and certificates, and, when seriously ill, wait endlessly for admission to a hospital bed. Yet the Ministry make no endeavour to lighten the doctor's surgery and, since 1948, have not built one new hospital. The accomodation and sanitation of many of our hospitals is little changed from the time of Florence Nightingale.

The medical profession itself has been disrupted and weakened by that age-old political manoeuvre, entirely foreign to its character, of division. We now have two classes of doctor, the consultant and the general practitioner, each in a bureaucratic-tight compartment from which there is no escape. Gone for ever are the days when a Jenner or a Sir James Mackenzie could

Continued on page 20

■ Exhibits unusual analgesic properties, different from those of any other drug ■ Specific and superior in relief of SOMAtic pain ■ Modifies central perception of pain without abolishing natural defense reflexes ■ Relaxes abnormal tension of skeletal muscle

SOMA™

N-isopropyl-2-methyl-2-propyl-1, 3-propanediol dicarbamate

■ More specific than salicylates ■ Less drastic than steroids

■ More effective than muscle relaxants

SOMA has an unique analgesic action. It apparently modifies central pain perception without abolishing peripheral pain reflexes. SOMA is particularly effective in relieving joint pain. Patients say that they feel better and sleep better with SOMA than with previously used analgesic, sedative or relaxant drugs.
SOMA also relaxes muscle hypertonia, with its stresses on related joints, ligaments and skeletal structures.

ACTS FAST. Pain-relieving and relaxant effects start in 30 minutes and last 6 hours.

NOTABLY SAFE. Toxicity of SOMA is extremely low. No effects on liver, endocrine system, blood pressure, blood picture or urine have been reported. Some patients may become sleepy, particularly on high dosage.

EASY TO USE. Usual adult dose is one 350 mg. tablet 3 times daily and at bedtime.

SUPPLIED: Bottles of 50 white coated 350 mg. tablets.
Literature and samples on request.

WALLACE LABORATORIES, NEW BRUNSWICK, N. J.

Fourth Estate

Continued from page 16

enter the profession as a general practitioner to become a distinguished consultant and a benefactor to mankind.

Yet despite this calamitous state of affairs an apparent listlessness appears to have descended on all concerned. The politicians would seem to be hypnotised by a vast army of civil servants.

The Royal Colleges ostensibly seem smugly satisfied with their role in directing the nation's medical future. Receiving annually some £2,500,000 distributed as secret merit awards for outstanding scientific work, of which neither the public nor the profession is apprised, and paid anonymously to their consultant members, the Royal Colleges are assured of financial stability.

But there are no merit awards for the general practitioner. He enjoys one privilege denied to his colleague the consultant, the "Star Chamber." For the Ministry has devised a secret court in which the general practitioner is judged, and fined out-of-hand, by his new masters. Moreover, the general public needs of necessity hold him in scant regard when it considers the machinations of the British Medical Association, with its threats of strike action and its annual demands for wage increases, such a feature of the trade union movement.

Holding the future of medicine in this country in their hands, the politicians impassively reject appeals for legislation to avert the approaching disintegration of our Health Service. That distinguished legal luminary the Minister of Health, having broken every pledge given by the Conservative party to the electorate to amend the National Health Service Act of 1948, directs his talents to further enslaving the profession with forensic red tape and tying up the loose ends left behind by that misguided architect of our nationalized Health Service, the Wizard from Wales.

With its splendid record of denationalisation and its encouragement to private enterprise, the Conservative Government has established an era of material and financial prosperity. While encouraging each citizen to work, without let or hindrance, at employment best suited to his gifts, it should accord a similar freedom to the medical profession, which under the voluntary hospital system gave ample proof of its dedicated right to conserve the nation's health.

Yours faithfully,
W. FERGUSSON HANNAY.
Harley Street, W.I.

(The above clipping was sent to Dr. Hugh S. Ramsey, Bloomington, Ind. by Hon. Richard Hare, slavonic studies professor, University of London, England, visiting professor, Indiana University, spring semester, 1959.

Hon. Richard Hare is author of a new book, *Portraits of Russian Personalities,* Oxford University Press.

This book depicts the character, personality and influence of each of a number of famous Russian radicals and conservatives, predecessors to the Russian Revolution.

The radicals are not eulogized but shown up for what they really were! This is not a pro-communist book.

Mrs. Hare is the internationally famous sculptress, Dora Gordine, of Russian-Scottish ancestry whose work is depicted in December, 1958 issue of *The Connoisseur.*

Part of Hare's letter reads: "I am sending you a cutting from the *Daily Telegraph* with a letter from a prominent English doctor expressing sensible opinions about the English, so-called National Health Service. (Aug. 18, 1959 issue.)

"What a pity the English doctors cannot organize *themselves* to secede *completely* from this ghastly state bureaucracy.")

Helping the Handicapped

One-third of a million handicapped persons apply each year for jobs at public employment offices. In Kokomo, the Indiana Employment Security Division currently has job applications from 52 individuals with physical disabilities of one kind or another.

In 1958, according to Otis O. Cassida, division manager, the office received 5,462 work applications of which 2% were handicapped to some degree. Jobs were found for 113 handicapped persons during this period.

No physically handicapped job seeker is ever referred to a job for which he is not well qualified or where his disability would be a hazard to himself or others, Cassida says. "In fact all of our referrals are on that basis—we compare qualifications of job applicants to requirements of job openings listed by employers," he explains.

He added that fewer and fewer employers demand full physical perfection when hiring. Company after company has set up more reasonable standards adapted to the realistic demands of

Continued on page 24



RELA—a new myogesic for better relaxant *and* analgesic therapy—more adept management of spasm and pain in strains, sprains and low back pains.

RELA—though a single drug—is a true myogesic and works rapidly to achieve three desired effects...

Rela relaxes acute muscle spasm
Relief of muscle spasm (96% excellent to good effectiveness)[1]

Rela provides a unique quality of persistent pain relief through its relaxant and analgesic actions
"Relief from pain was usually rapid and sometimes dramatic"[1]

Rela, through relaxation and analgesia, assures daytime ease and nighttime rest
"... A number of patients reported freedom from insomnia which they attributed to freedom from pain."[1]

indications: RELA is most beneficial in those conditions of the musculoskeletal system manifesting pain, stiffness and spasm.

safety: Studies of more than 1400 patients indicate that the toxicity of RELA is exceptionally low. In human subjects, respiratory, blood pressure or blood chemistry changes and/or renal, hepatic or endocrine dysfunction have not been reported.

dosage: The usual adult dosage of RELA is one tablet 3 times daily and at bedtime. RELA has a rapid onset of action, with relief usually apparent within 30 minutes, and persisting for at least 6 hours.

supply: RELA is available as 350 mg., pink, coated tablets in bottles of 30.

1. Kuge, T.: To be published.

H-227

MYOGESIC
muscle—analgesic relaxant

Schering

Fourth Estate

Continued from page 20

their jobs. This modern approach, he points out, is helping provide physically handicapped workers equal job opportunity with the able-bodied and is giving employers hundreds of steady, efficient and productive workers.

It is good to know, during this first week of October when "Hire the Handicapped" Week is being observed, that people with physical disabilities are not being forgotten.

Kokomo Tribune
Oct. 5, 1959

A Warning and a Spur

Since the two drug firms have played important parts in the life of this community, Indianapolis should be gratified at the dismissal of a federal antitrust suit against them. Eli Lilly & Co. and Pitman-Moore were among five major drug manufacturers which the government accused of fixing prices on Salk vaccine.

Federal Judge Phillip Forman of Trenton, N. J., agreed with the defense that the government had not made a case. The trial had begun on Oct. 13, and the defendant firms were not even asked by the court to present their side of the case.

This court action confirms the local belief in the business integrity of these major concerns.

The judge pointed out that the government could not find the five businesses guilty through "suspicion and conjecture." In addition, the government had not been able to build a bridge of facts between what it thought the drug firms might have done, and what they actually did. In short, the two local drug manufacturers were haled into court on nothing more than a poor case of suspicion.

Harassment through legal action is not unknown, but it is dirty pool. The drug firms had the money and time to fight the case successfully. Yet, any business must consider how it might be able to defend itself against the resources of an entire nation should some federal official want to take action.

This is another good example of how big government can abuse its power and strain the intent of the law. The facts which have been admitted are that the drug firms have the same sales price for Salk vaccine even though their production costs are not identical. The market and competition fixes the price, actually.

The same general statement can be made about nails, to pick a random but common example.

Yet, the government took the five drug firms to come to find out what officials of these companies had contended all along—that the charge is complete nonsense. Surely there are legal brains in government employment keen enough to discern the difference between fact and suspicion. Distinguishing between the two is basic to any legal action.

The outcome of this case should be a warning to those public functionaries who have an inflated sense of their position and importance. Government must work to serve the people.

At the same time, Americans should heed the implied threat to their activities which government harrassment and interference can bring. This should be another spur to halt the movement toward bigger government.

Indianapolis Star
Dec. 7, 1959

Toxic Killer of Mothers, Babies Believed Found

Indianapolis, Ind. (AP)—Two young faculty members at the Indiana University medical school have discovered a substance that may be responsible for the death of 1,500 mothers and 30,000 babies each year.

The substance, named "hysterotonin" by Drs. Charles A. Hunter and William F. Howard, appears to be the cause of hypertension in toxemia, a major pregnancy hazard to both mother and child. Toxemia is known popularly as blood poisoning and hypertension as high blood pressure in the arteries.

The researchers believe hysterotonin is a product of unbalanced body chemistry and probably due to a defective enzyme, a substance that speeds a chemical reaction without actually taking part in it.

The compound was found in the fluid-filled sac that protects the unborn child and also in the lining of the uterus.

Eight to 10% of all pregnant women are affected by toxemia and a resulting condition called eclampsia. The doctors said the discovery of hysterotonin gives hope of improved treatment and possible prevention of toxemia.

Evansville Courier
Oct. 13, 1959

Continued on page 28

tocort®

Triamcinolone LEDERLE

At anti-inflammatory and antiallergic levels ARISTOCORT means:

- **freedom from salt and water retention**
- **virtual freedom from potassium depletion**
- **negligible calcium depletion**
- **euphoria and depression rare**
- **no voracious appetite—no excessive weight gain**
- **low incidence of peptic ulcer**
- **low incidence of osteoporosis with compression fracture**

Indications: rheumatoid arthritis; arthritis; respiratory allergies; allergic and inflammatory dermatoses; disseminated lupus erythematosus; nephrotic syndrome; lymphomas and leukemias. *Precautions:* With ARISTOCORT all traditional precautions to corticosteroid therapy should be observed. Dosage should always be carefully adjusted to the smallest amount which will suppress symptoms. After patients have been on steroids for prolonged periods, discontinuance must be carried out gradually.
Supplied: Scored tablets of 1 mg. (yellow); 2 mg. (pink); 4 mg. (white); 16 mg. (white). Diacetate Parenteral (for intra-articular and intrasynovial injection). Vials of 5 cc. (25 mg./cc.).

References: 1. Feinberg, S.M., Feinberg, A.R., and Fisherman, E.W.: *J.A.M.A.* 167:58 (May 3) 1958. 2. Epstein, J.I. and Sherwood, H.: *Connecticut Med.* 22:822 (Dec.) 1958. 3. Friedlaender, S. and Friedlaender, A.S.: *Antibiotic Med. & Clin. Ther.* 5:31 (May) 1958. 4. Segal, M.S. and Duvenci, J.: *Bull. Tufts North East M. Center* 4:71 (April-June) 1958. 5. Segal, M.S.: Report to the A.M.A. Council on Drugs, *J.A.M.A.* 169:1063 (March 7) 1958. 6. Sherwood, H. and Cooke, R.A.: *J. Allergy* 28:97 (Mar.) 1958. 7. Duke, C.J. and Oviedo, R.: *Antibiotic Med. & Clin. Ther.* 5:71 (Dec.) 1958. 8. McGavack, T.H.: *Clin. Med.* (June) 1958. 9. Freyberg, R.H.; Berntsen, C.A., and Hellman, L.: *Arthritis and Rheumatism* 1:215 (June) 1958. 10. Hartung, E.F.: *J.A.M.A.* 167:97 (June 21) 1958. 11. Hartung, E.F.: *J. Florida Acad. Gen. Pract* 8:18, 1958. 12. Zuckner, J.; Ramsey, R.H.; Caciolo, C., and Gantner, G.E.: *Ann. Rheum. Dis.* 17:398 (Dec.) 1958. 13. Appel, B. Tye, M.J., and Leibsohn, E.: *Antibiotic Med. & Clin. Ther.* 5:71 (Dec.) 1958. 14. Kalz, F.: *Canad. M.A.J.* 79:400 (Sept.) 1958 15. Mullins, J.F., and Wilson, C.J.: *Texas State J. Med.* 54:64 (Sept.) 1958. 16. Shelley, W.B.; Harun, J.S., and Pillsbury, D.M. *J.A.M.A.* 167:959 (June 21) 1958. 17. DuBois, E.F.: *J.A.M.A* 167:1590 (July 26) 1958. 18. McGavack, T.H.; Kao, K.T.; Leake D.A.; Bauer, H.G., and Berger, H.E.: *Am. J. Med. Sc.* 236:72 (Dec.) 1958. 19. Council on Drugs: *J.A.M.A.* 169:257 (Jan. 17 1959. 20. Rein, C.R.; Fleischmajer, R., and Rosenthal, A.R. *J.A.M.A.* 165:1821 (Dec. 7) 1957.

Lederle LEDERLE LABORATORIES, A Division of AMERICAN CYANAMID COMPANY, Pearl River, New York

Fourth Estate

Continued from page 24

Memo to Doctors

Back in 1956-57 when government agencies, schools and parents bought an estimated $125,000,000 of polio vaccine to immunize school children against infantile paralysis, the emphasis was on producing and distributing sufficient quantities of the vaccine.

After the initial immunization campaigns, the federal government, which allocated about $54,000,000 to the states to help purchase the vaccine, decided that some of the major drug companies had used the situation to fix prices and eliminate competition. It brought charges resulting in the indictment of five firms.

The trial of the five drug firms covers one aspect of the polio immunization campaign. There were others—the administration's initial refusal to support a nationwide program with government funds; the lack of a comprehensive program for use of the vaccine; the refusal of physicians in many areas to join in community immunization programs on a non-profit basis.

Today these same groups are again united in their opposition to a program of health care for social security beneficiaries.

Americans will not tolerate much longer the high and artificial cost of medical care and health programs. Price gouging by drug firms and opposition to social security programs by organized medicine are part of a pattern of giving dollars a higher priority than the people's health.

Terre Haute Advocate
Nov. 6, 1959

The Road Back

Argentina has been having a tough, tough time getting its economy back on the highroad of prosperity. The other day, *U.S. News & World Report* asked Argentine Minister of Economy Alvaro Alsogaray how things were coming. He said that light was ahead, and the inflation turn was due.

"Next month, November, will be a real turning point," he said. "Prices will start going down for the first time in 15 years . . . People realize—after many years of inflation, mishandling of our affairs and mistakes—that it was necessary to do something drastic to get the country back on its feet."

And what is this drastic thing the Argentines are attempting? What is the goal?

"It is the philosophy of free enterprise, to develop a way of living more or less like yours in the United States. We are removing all controls. We have taken price ceiling off everything. We have cut out many subsidies. Everything is free of controls—prices are the market prices." This is like the United States? It is like it used to be.

Argentina is proving that the way out of inflation is to remove the government from the price making and price sustaining business—in fact from business of any kind.

"Many of our troubles come from government businesses," declared Mr. Alsogaray. He said the cost of running the federal administration was 87 billion pesos and the cost of running the businesses which the government had taken over was 120 billion pesos.

"We are going to sell as many of these state enterprises to private interests as we can," he said. "The important thing is to put these companies under a competitive system."

Here is an example of a government which

OVER 80 YEARS' SPECIALIZED EXPERIENCE IN THE RESTORATIVE TREATMENT OF

"THE PROBLEM DRINKER"

At The Keeley Institute your patients are assured of receiving:

- the most modern, coordinated, comprehensive, rehabilitative regimen
- in addition to medical, nutritional and physiotherapeutic treatment, we also offer psychiatric diagnosis and psychotherapy
- full cooperation throughout with the referring physician
- in addition to the care of the alcoholic we also treat narcotic and drug addiction
- surprisingly low cost—to cover all medical care, medicines, laboratory work, room and excellent cuisine

You can obtain more detailed information by writing us direct.

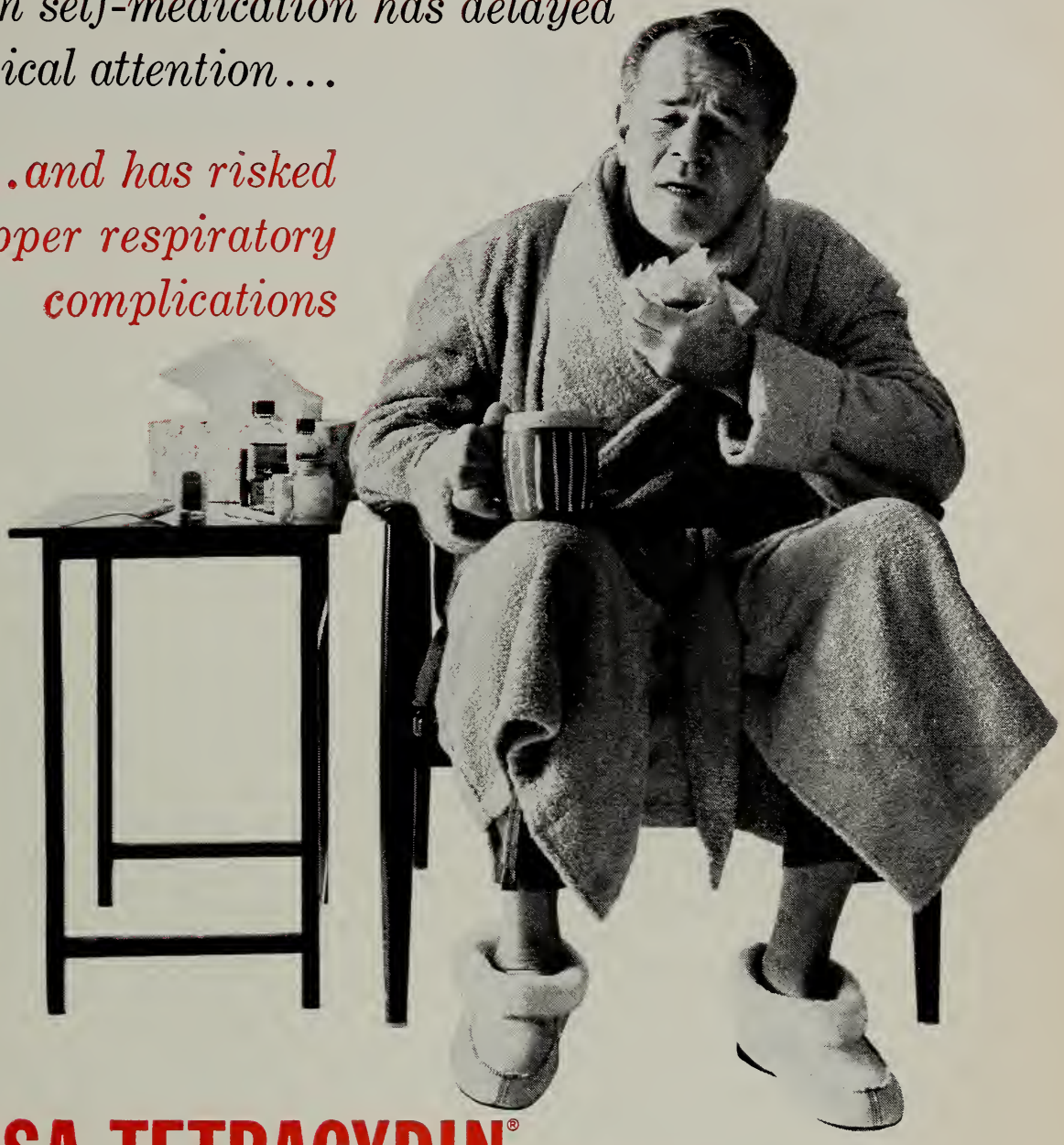
WE WELCOME YOUR REFERRALS...

THE KEELEY INSTITUTE
DWIGHT, ILLINOIS

Member American Hospital Association, Member Illinois Hospital Association. Licensed by the Department of Public Health, State of Illinois.

in the **"COMMON COLD"**
when self-medication has delayed medical attention...

...and has risked upper respiratory complications



COSA-TETRACYDIN® CAPSULES

Cosa-Tetracyn® — analgesic — antihistamine compound

act quickly to

- *control secondary infection*
- *alleviate cold symptoms*

each capsule contains:

Cosa-Tetracyn	125 mg.
phenacetin	120 mg.
caffeine	30 mg.
salicylamide	150 mg.
buclizine HCl	15 mg.

average adult dose: 2 capsules q. i. d.

Pfizer *Science for the world's well-being*

PFIZER LABORATORIES, *Division, Chas. Pfizer & Co., Inc., Brooklyn 6, N.Y.*

Fourth Estate

Continued

has discovered the hard way that free enterprise is the best system. It has discovered that when government interferes with the economy by trying to control it artificially—either by price controls, subsidies or state ownership—it fouls up the works and the result is creeping economic paralysis that erupts in violent economic disorder.

Here in the United States of America, the liberals have been and are forcing upon this country these same things which Argentina has found necessary to repudiate in order to save its economic life. The same things have ruined Chile and hurt Uruguay desperately. England compounded its woes with such practices. France had similar miseries. How, with all of these flagrantly bad examples laid out for all to see, can anyone insist that such practices are the true and sound economic way? How? . . . Unless they seek to force the nation into socialism.

America must take heed and reverse the socialist trend before too long, else it is due for a period of violent economic disorder that could bring to an end the life you know today.

Indianapolis Star
Oct. 31, 1959

Lower Insurance Costs for Drivers

The principle of basing motor car insurance premiums on the driving record of the policyholder makes sense. The accident-free motorist should pay less. The accident-prone bender of fenders should pay more. This is the plan to be offered in Missouri by companies affiliated with the National Bureau of Casualty Underwriters and the National Automobile Underwriters Assn. The Travelers Insurance Co., now an independent, has announced a similar plan of its own.

The bureau-association plan will work this way: A household that has gone three years without a chargable accident and without a conviction for a moving traffic violation can get a 20% discount on the basic policy rate. If there is only one moving violation on the record, a 10% discount would be allowed. A chargeable accident or two moving violations would continue the regular rate.

A bad record—several accidents, moving violations, or a serious conviction such as for drunk driving—moves the percentages to the other side of the ledger. Based on a point system, the careless driver would pay from 20 to 100% above the basic rate. The Travelers plan would allow discounts up to 30% based on a 5-year record.

Some independent insurance companies have comparatively low rates already because they can be more selective in their choice of policyholders. Some mutuals operate in that manner and others are considering a comprehensive system similar to the plans adopted by the bureau companies and Travelers.

We can't predict the effect on revenue but the method offers an added incentive for careful driving. The cost of insurance is based on the average of accident experience. But the carelessness of some drivers contributes heavily to the generally high rates that all must pay. Individual schedules of rates that reward the good driver and penalize the careless could contribute to safety. Certainly the public can see the fairness of the plan.

Kansas City Star
Reprinted in *Kokomo Tribune*
Oct. 5, 1959



PROTECTION AGAINST LOSS OF INCOME FROM ACCIDENT & SICKNESS AS WELL AS HOSPITAL EXPENSE BENEFITS FOR YOU AND ALL YOUR ELIGIBLE DEPENDENTS

ALL PREMIUMS COME FROM

PHYSICIANS SURGEONS DENTISTS

ALL BENEFITS GO TO

PHYSICIANS CASUALTY & HEALTH ASSOCIATIONS
OMAHA 31, NEBRASKA
Since 1902
Handsome Professional Appointment Book Sent to you FREE upon request.

Abraham Flexner

One of the truly great men of our era—Abraham Flexner—died on Monday at the age of 92. To him more than to any other man in his lifetime we owe the great advances that have been made in medical education.

Dr. Flexner's famous report on medical schools was published in 1910. He wasn't by any means the first American to recognize that the training of doctors—or rather the lack of it—in many of the schools in this country was a major scandal. In 1901, seven years before Dr. Flexner undertook his study, the American Medical Association had taken up the question and in 1905 its newly organized council on medical education had classified 82 of the 160 medical schools in the country as class A and 78 others as inferior.

The Flexner report reached much the same conclusion but its contribution lay more particularly in the details that it provided, based upon personal visits to the schools. Names were named. Some schools, including a dozen in Chicago, were described as "disgraceful" and others as "shameful."

The institutions so exposed never recovered. In a few years they all had disappeared and today the 80 surviving medical schools in the country are all listed as Class A. This does not mean that they are all equally good; it does mean that a graduate of any of them can claim to have had at least a fair chance to prepare himself for his professional career.

Dr. Flexner did more. He not only destroyed the poor schools but persuaded men of wealth to subsidize the good ones. It is said that half a billion dollars of support given medical education and research in this country since the 1910 report can be traced directly to his influence.

Truly, Abraham Flexner was one of the movers and shakers of his era. The world is a different and a better one, thanks to his influence.

Chicago Tribune
Sept. 23, 1959

A lawyer and a surgeon rented a suite of offices and hired a receptionist to serve them both. One day a woman came in, approached the receptionist's desk and said, "I've got a little wart on my neck I want to have removed."

The receptionist thought for a moment, then asked, "Is that wart corporal or corporeal?"—*Back Bay Breeze.*



prescribe

NIPHYLLINE

the unique specific

This exclusive development is a ***definite chemical,*** neutral in action, and ***specific in prophylaxis and treatment of angina pectoris.*** It is effective orally in about thirty minutes, for periods of 7 to 8 hours . . . and, even when given routinely, does not cause nausea or gastric upset. Niphylline is an efficient vasodilator and diuretic combining the effectiveness of Neothylline (soluble, neutral, stable derivative of theophylline) and pentaerythritol tetranitrate, substantially more effective than mannitol hexanitrate. Thus, the patient receives the benefits of both drugs without any annoying side effects.

Niphylline is safe, and well tolerated . . . exerts strengthening effect on heart muscles, and acts synergistically, remarkably reducing severity and frequency of cardiac attacks.

Indications: Relief and control of angina pectoris, cardiovascular symptoms, asthenia, coronary spasm with myocardial pain, prophylaxis and treatment of left ventricular insufficiency, cardiac dyspnea and oliguresis.

Dosage: One or two tablets, 3 or 4 times daily, or as directed by physician.

Supplied: Bottles of 100 and 1000 tablets.

PM **PAUL MANEY**
LABORATORIES, INC.
Cedar Rapids, Iowa

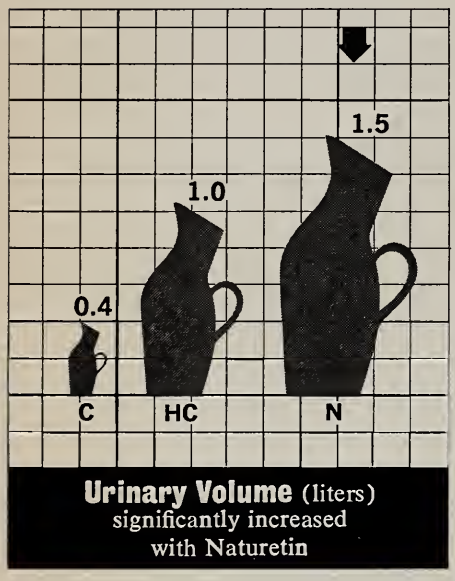
more closely approaches the ideal diuretic

Naturētin

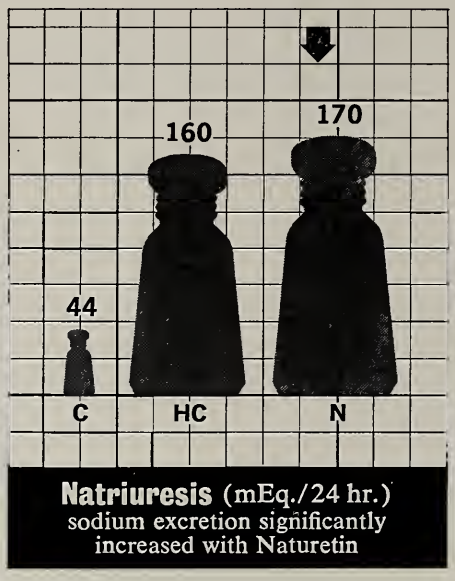
Squibb Benzydroflumethiazide

"When compared to other members of this heterocyclic group of compounds, this drug [NATURETIN] shows a significantly increased natriuresis and decreased loss of potassium and bicarbonate. In this respect it more closely approaches a natural or 'ideal diuretic.' It is effective upon continuous administration and causes no significant serum biochemical changes. It is effective in a wide variety of edematous and hypertensive states and represents a significant advance in diuretic therapy." *Ford, R.V.: Pharmacological observations on a more potent benzothiadiazine diuretic; accepted for publication by the American Heart Journal.*

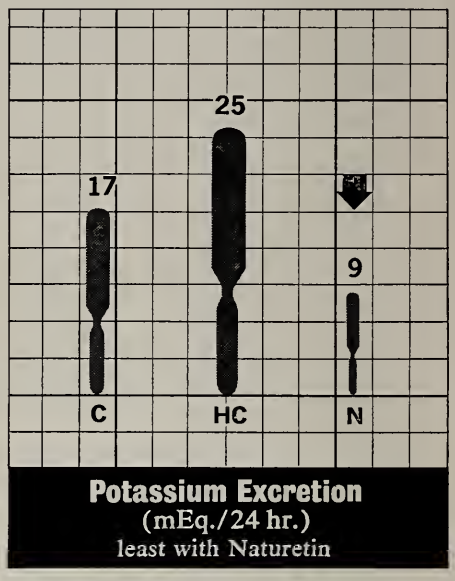
Comparison of electrolyte excretion pattern for the 24 hours following typical doses of chlorothiazide, hydrochlorothiazide, and Naturetin[1]



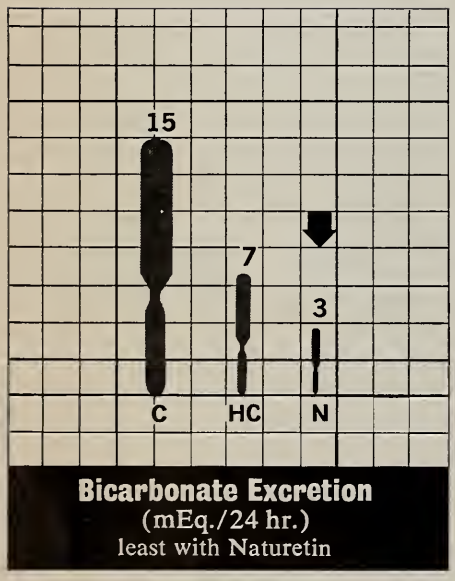
Urinary Volume (liters)
significantly increased
with Naturetin



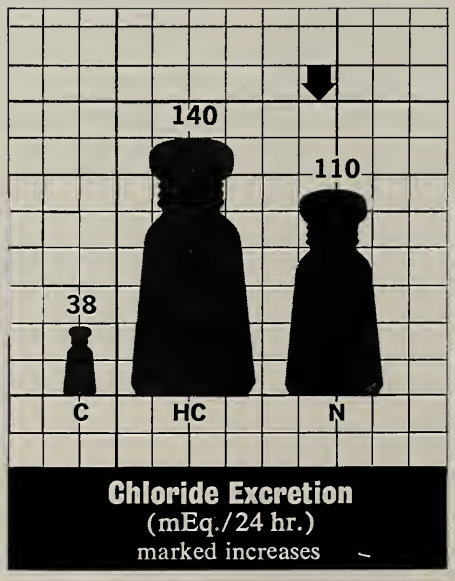
Natriuresis (mEq./24 hr.)
sodium excretion significantly
increased with Naturetin



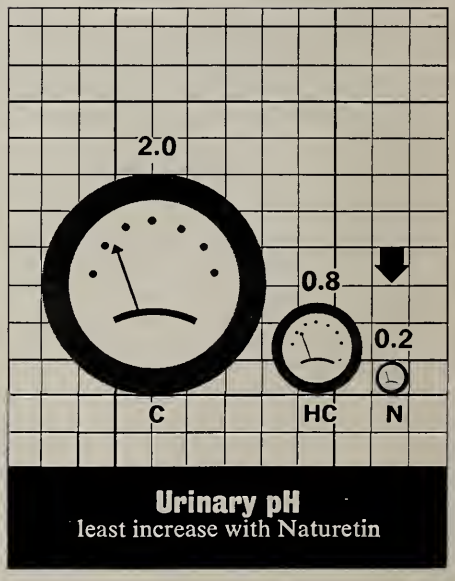
Potassium Excretion
(mEq./24 hr.)
least with Naturetin



Bicarbonate Excretion
(mEq./24 hr.)
least with Naturetin



Chloride Excretion
(mEq./24 hr.)
marked increases



Urinary pH
least increase with Naturetin

Typical Doses: Chlorothiazide—1,000 mg.; Hydrochlorothiazide—50 mg.; Naturetin (Benzydroflumethiazide)—5 mg.

1. Adapted from: Ford, R. V., Squibb Clin. Res. Notes 2:1 (Dec.) 1959.

proven successful[1] in almost every case of

skin itch



and dryness

Used in the bath SARDO releases millions of microfine water-dispersible globules* to provide a soothing, softening suspension which enhances your other therapy. SARDO baths . . .

1 **rehydrate the dry, itchy, scaly skin**

2 **add comfort to the therapeutic care**

3 **act to measurably increase natural emollient skin oil**

4 **minimize loss of natural oil and excessive moisture with a fine non-occlusive film**

Patients will appreciate pleasant, convenient, easy to use, pine-scented SARDO. Non-sensitizing. Most economical. Bottles of 4, 8 and 16 oz.

1. Spoor, H. J.: N. Y. State J. Med. Oct. 15, 1958

Sardo®
in the bath

for atopic dermatitis
eczematoid dermatitis
senile pruritus
contact dermatitis
soap dermatitis



Samples and literature yours for the asking.

Sardeau, Inc. 75 East 55th Street New York 22, N. Y.

© 1959 *Patent Pending, T.M.*

I. U. School of Medicine Explains New Family Practice Program

(A more detailed description of I. U. School of Medicine's new two-year "family practice program" as announced in the Journal last month has been released, as follows, by the center's news bureau.)

The two-year family practice program is intended to provide the medical school graduate with a basic education adequate for family practice. It is planned to accomodate six trainees at first, three in each year of the program.

I. The first nine months will be spent in a rotation which includes:

a) Three months on an Emergency Service. This will be under the direct supervision of the Department of Surgery. The service will consist of an initial period of indoctrination in the basic surgical principles and technics which are applicable to emergency work, and of a subsequent assignment at the Marion County General Hospital, where experience will be obtained in the management of simple fractures and other injuries and in the diagnosis of acute illness of various kinds, and where the trainee can observe and participate in the management of major medical and surgical emergencies.

b) Three months in the Carter Hospital, where appropriate basic instruction and experience in psychiatry will be provided. This will include special attention to the area of family care and to the emergency management, hospitalization, discharge and out-patient follow-up of patients with common psychiatric disorders. It will also be designed to assist the trainee in the diagnosis and management of the emotional disturbances which he will encounter during his later work on the medical and pediatric services, and will enable him to request psychiatric consultation intelligently and use it effectively at that time.

c) Three months of orientation to the policies and practices of the medical, Ob-Gyn, and pediatric services of Long Hospital; consisting of one month on each service respectively. During this time the trainee will function substantially as a rotating intern. The purpose of this period is to familiarize the trainee with the functioning of those services in which he is later to work in a progressively more responsible capacity, and to begin to develop in him some poise and facility in the management of a wide variety of medical situations.

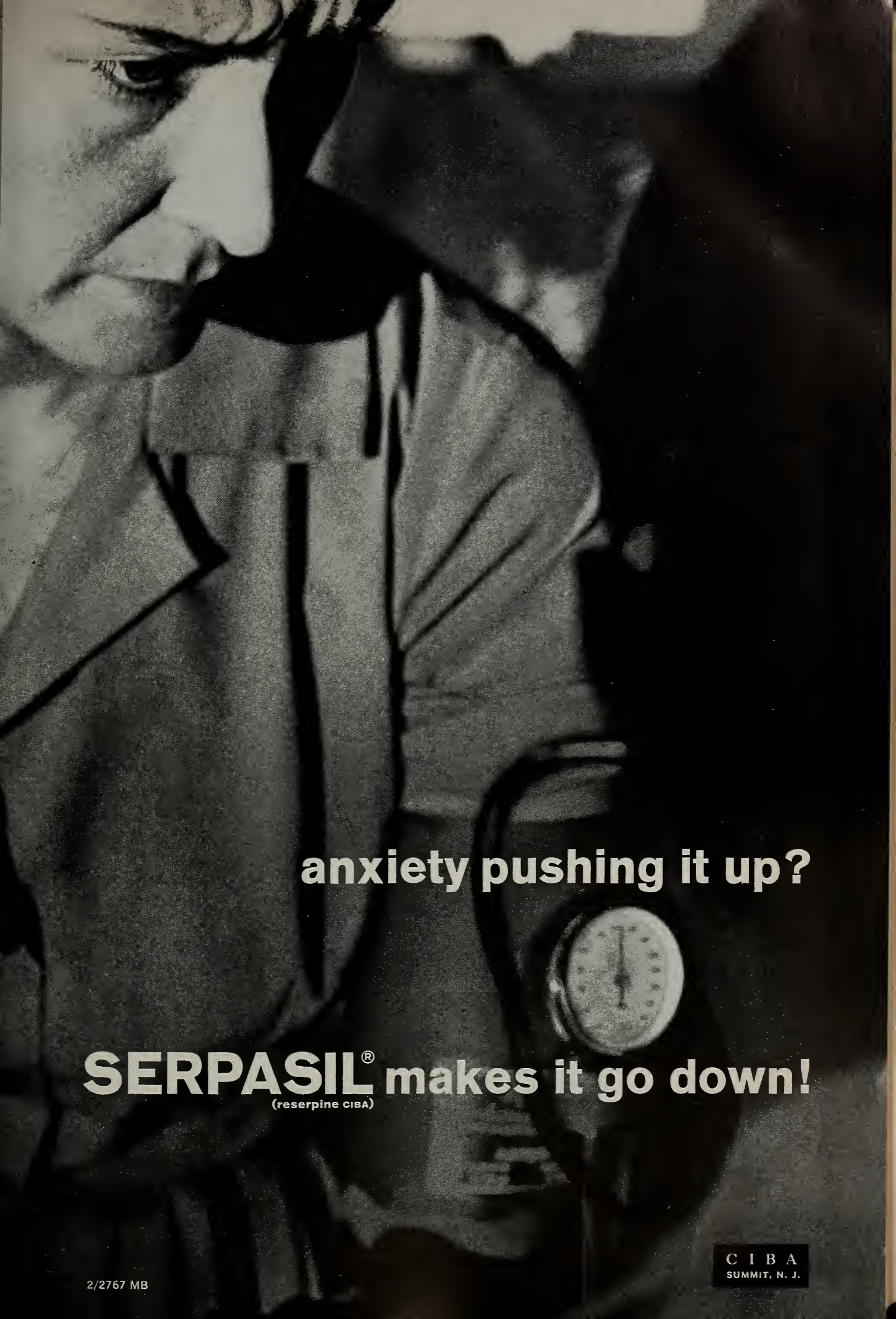
II. The remaining 15 months will be divided into seven months of medicine, five of pediatrics and three of elective work, which is expected to consist usually of obstetrics and gynecology, but which might occasionally be devoted to additional work in medicine, pediatrics, psychiatry or the emergency clinic. Work on these services will be arranged as follows:

a) During the seven months on medicine, the trainee will be based in the out-patient department and will be under the primary supervision of the medical chief of the out-patient department. Here he will practice out-patient medicine. The medical chief of the clinic will see to it that suitable patients are directed to him, emphasizing patients in whom follow-up care will be feasible and patients whose illness is associated with or complicated by social and economic problems.

Psychiatric consultation will be freely available, and it is expected that the trainee, with this help, can assume responsibility for the management of emotional disorders similar to those he will encounter in practice. The trainee will also be permitted to admit from his out-patient practice a limited number of patients to his own service on the medical wards.

In the beginning of his medical training his ward work will be closely supervised by the assistant residents in charge of the wards where his patients are located, but with increasing experience he will take on progressively more responsibility. Wherever possible he will continue to follow these patients in the clinic after their discharge from the medical service.

When a trainee's patients are transferred from the medical service to other in-house services, the trainee is expected to follow them and to provide whatever assistance he can, such as the


anxiety pushing it up?
SERPASIL®
(reserpine CIBA)
makes it go down!
CIBA
SUMMIT, N. J.
2/2767 MB

I. U. School of Medicine

Continued

regulation of diabetes in a diabetic patient who is subjected to surgery. When any patient whom the trainee has acquired in the medical out-patient clinic is to be seen in another specialty clinic or admitted to a service other than the medical service, the trainee will be urged to accompany the patient and participate in the out-patient or in-patient procedures as far as possible.

With any hospital admission of one of his patients, the trainee will be expected to take the role of a family physician in such matters as explaining to the patient and the family the nature of the illness and the need for hospital treatment, acting as a liasion agent between the family and the administrative personnel of the hospital, counseling where possible in financial and insurance matters under the supervision of the appropriate hospital authorities, and exploring with the help of social service the community resources which can be marshalled to assist with the problems of his patient.

During the period on medicine, a special effort will be made to have the trainee evaluate initially and follow in a responsible role patients who come with acute illness to the Emergency Room of the Long Hospital. This will include, for example, patients with gastro-intestinal hemorrhage who might be followed during an emergency barium study or other emergency diagnostic procedures and then during their subsequent hospitalization on the medical or surgical service. This will supplement, at a more mature stage in the trainee' development, the experience which he has had in the Emergency Clinic of the Marion County General Hospital.

Provision will be made during the medical rotation for experience on special clinics such as dermatology and otorhinolaryngology clinics.

b) The five months on pediatrics will include a period of three months as a resident on one of the in-patient services. This is a position of considerable responsibility and it will aid in maturing the trainee as a responsible physician in addition to its specific educational value in the field of pediatrics.

Two months will be spent in the out-patient department under the direction of the chief of the pediatric out-patient service. During this time some special experience will be provided in management of the problems of the newly born.

c) The obstetrics and gynecology service will be especially designed to provide training in the fields of office gynecology and non-operative obstetrics.

III. Some special education opportunities will be provided for the trainees in this program as a group, both for their intrinsic educational value and for their value in promoting group esprit. This will include participation in a special journal club with faculty advisors.

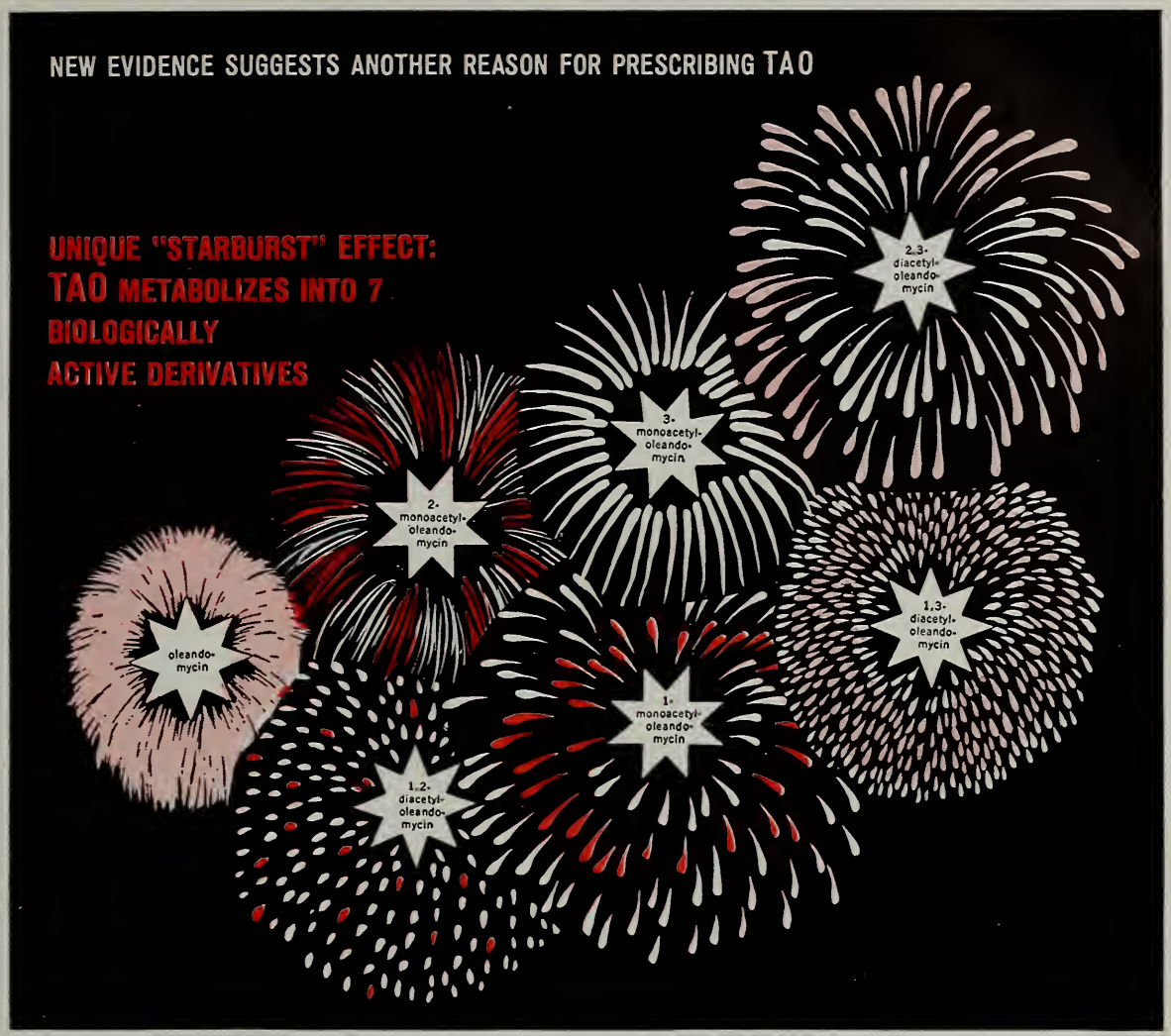
Particular attention will be paid to pertinent articles in the fields of medicine, pediatrics, psychiatry, and obstetrics and gynecology. Lectures and conferences on medical economics, medical ethics, health insurance and other fields related to practice will be presented by guest speakers and by practitioners presently on the part-time faculty of the medical school.

The program and the performance of the participants will be subjected to review every six months by a committee consisting of representatives of the departments of medicine, psychiatry, pediatrics, surgery, and obstetrics and gynecology.

If the performance of a trainee is not adequate to make it advisable to continue him in the program, he will be dropped, but in all cases arrangements will be made to provide at least an experience roughly equivalent to a one-year general rotating internship. The basic responsibility for administering the training aspects of the program will fall on the department of medicine. ◄



From Quote



The impression that TAO is an unusually active antibiotic has steadily gained recognition by impressive clinical performance. Now come reports of in **vivo** and in **vitro** biological and biochemical evaluations that show TAO to be indeed unique.[1,2]

TAO differs from other antibiotics in that it is metabolized to multiple active compounds which **remain** active throughout their presence in the body. These 7 derivatives (in addition to TAO) show activity against common Gram-positive pathogens, including resistant strains of **Staph. aureus.**

In light of these findings, take another look at TAO performance: • 92% success in published cases of Gram-positive respiratory, skin, soft tissue and genitourinary infection • Effective against 78% of 64 "antibiotic-resistant" epidemic staphylococci. (In the same study, chloramphenicol was active against 52%; erythromycin against only 25%)[3] • No side effects in 94%; infrequent reactions mild and easily reversed • Quickly absorbed • Highly palatable.

Sound reasons to: Start with TAO to end 9 out of 10 common Gram-positive infections.

Supplied: TAO Capsules—250 mg., and 125 mg., bottles of 60. **TAO for Oral Suspension**—125 mg. per tsp. (5 cc.) when reconstituted; unusually palatable cherry flavor; 60 cc. bottle. Prescription only.

Other TAO forms available: TAO Pediatric Drops: flavorful, easy to administer. **TAO®-AC:** TAO analgesic, antihistaminic compound. **TAOMID®:** TAO with triple sulfas. **Intramuscular or Intravenous:** in clinical emergencies. Prescription only.

1. English, A. R., and McBride, T. J.: Proc. Soc. Exper. Biol. & Med. 100:880 (Apr.) 1959. 2. Celmer, W. D.: Antibiotics Annual 1958-1959, New York, Medical Encyclopedia, Inc., 1959, p. 277. 3. English, A. R., and Fink, F. C.: Antibiotics & Chemother. 8:420 (Aug.) 1958.

designed for superior control of common Gram-positive infections

TAO®

(triacetyloleandomycin)

Capsules/Oral Suspension



Rx PFIZER

New York 17, N. Y.
Division, Chas. Pfizer & Co., Inc.
Science for the World's Well-Being

6,860 Students Receive M.D. Degrees in 1958-59

AMA Headquarters, Chicago—In its annual compresensive report on all aspects of medical education, the Council on Medical Eduation and Hospitals of the American Medical Association announced that the 1958-59 graduating class receiving the M.D. degree numbered 6,860, only one less than in 1957-58.

These two classes were the largest except for the 1954-55 year when the class was 6,977. The increase in that term was occasioned by including as graduates the 50 students completing the intern year then required by Stanford University.

According to the council's report, which appeared in the November 14 issue of the Journal of the American Medical Association, 43 medical schools had decreases in the number graduated while 34 schools experienced increases.

Women comprised 5.4% of the graduating class and comprised 5.9% of the Canadian 1958-59 graduating class.

Much of the council's report dealt with educational opportunities for the number of medical students considered adequate to satisfy medical service needs in a vastly growing population.

"To accomplish this task and at the same time maintain high standards of medical education represents a challenge at least as important as any problem facing medicine today," the AMA report said.

The council indicated a need for 10,000 graduates a year from medical schools in the United States by 1975.

"The fundamental issue," the report said, "does not involve the question of which of various studies have resulted in the most accurate estimate of the need for increased numbers of medical school graduates. The basic and urgent concern is that all estimates indicate a need for expansion of educational facilities in medicine in a brief period which far exceeds any expansion of such facilities that has occurred in a similar period during modern times."

The council offered several methods which could be used to meet the need for expanded educational facilities in medicine, including increased capacity of existing medical schools, but then added:

"Care must be exercised that medical schools not be induced to expand beyond their capacity to maintain the proportionately increased teaching staff necessary to preserve high standards of education and research."

The council estimated that even though existing schools are expanded, "it appears likely that at least 10 new schools with an average graduating class of 100 students will be required" to meet the health care needs of an exploding population.

On the subject of medical students of the future, the council said that "medicine is finding increased competition for the pool of top-ranking students because it no longer occupies the unique position as a profession which it held in the past and shared largely only with law and

COOK COUNTY
GRADUATE SCHOOL OF MEDICINE

INTENSIVE POSTGRADUATE COURSES
STARTING DATES — WINTER-SPRING, 1960

SURGERY—
Surgical Technic, Two Weeks, February 1 and February 22
Femoral Arteriography, Four Days, January 5
Proctoscopy & Sigmoidoscopy, One Week February 1
Head, Neck & Plastic Surgery, One Week, March 7
Colon Surgery, One Week, March 7
Blood Vessel Surgery, One Week, March 14
Fractures & Traumatic Surgery, Two Weeks, March 21

GYNECOLOGY & OBSTETRICS—
Vaginal Approach to Pelvic Surgery, One Week, February 1
General & Surgical Obstetrics, Two Weeks, February 8
Office & Operative Gynecology, Two Weeks, February 22

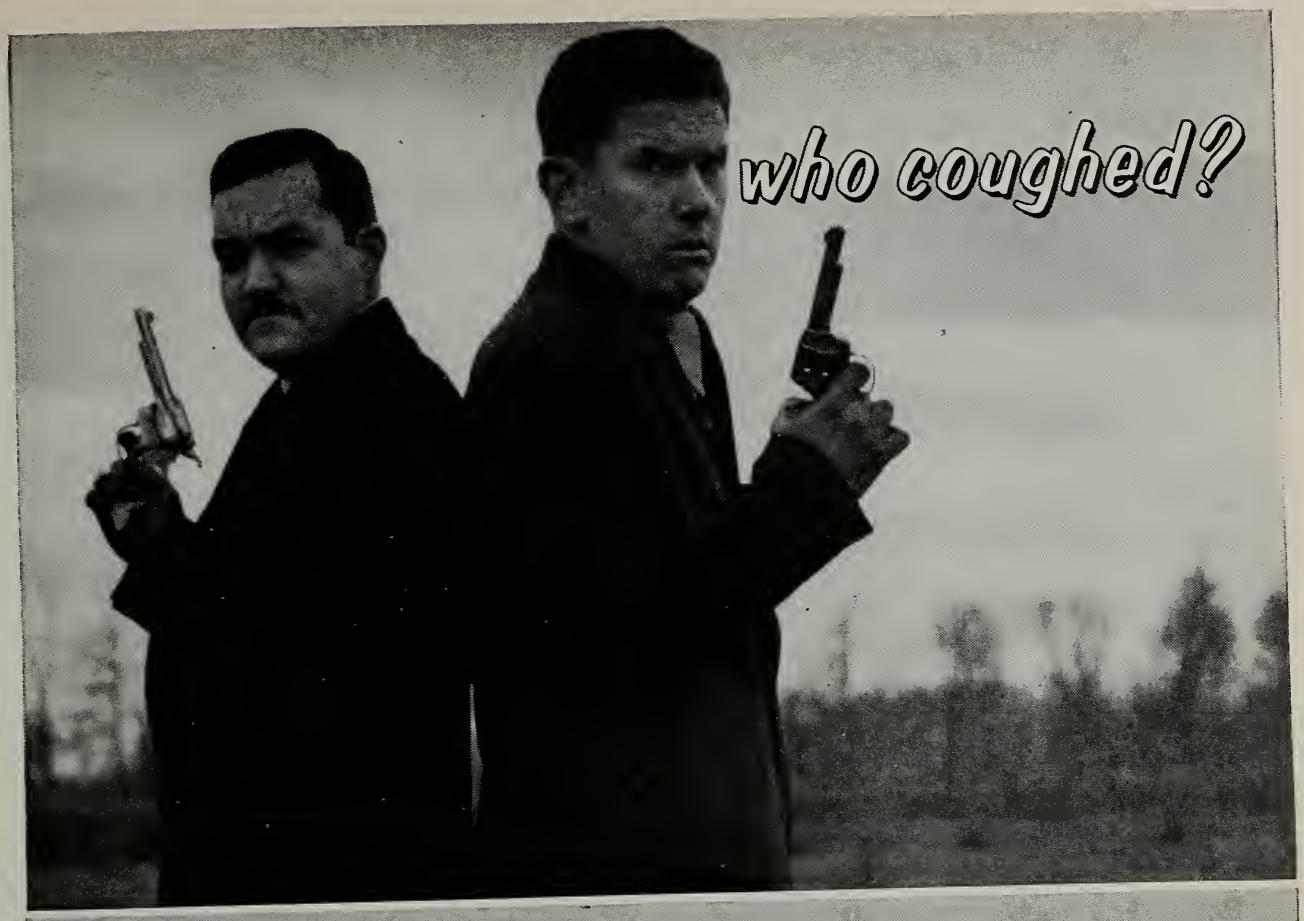
MEDICINE—
Gastroscopy & Gastroenterology, Two Weeks, April 18
Advancements in Internal Medicine, One Week, March 28
Two-Week Intensive Course, May 2
Basic Electrocardiography, Two Weeks, May 16

UROLOGY
Two-Week Intensive Course, April 4
Cystoscopy, Two Weeks, by appointment

RADIOLOGY—
Clinical Uses of Radioisotopes, Two Weeks, March 21

TEACHING FACULTY—ATTENDING STAFF OF COOK COUNTY HOSPITAL

Address:
REGISTRAR, 707 South Wood Street, Chicago 12, Illinois



WHENEVER COUGH THERAPY IS INDICATED

Hycomine®
SYRUP

THE *complete* Rx FOR COUGH CONTROL

cough sedative / antihistamine / expectorant

- relieves cough and associated symptoms in 15-20 minutes
- effective for 6 hours or longer
- promotes expectoration
- rarely constipates
- agreeably cherry-flavored

NOW MORE EFFECTIVE THAN EVER WITH THE NASAL DECONGESTANT PHENYLEPHRINE

Each teaspoonful (5 cc.) of HYCOMINE* contains:

Hycodan®		
Dihydrocodeinone Bitartrate (Warning: May be habit-forming)	5 mg.	6.5 mg.
Homatropine Methylbromide	1.5 mg.	
Pyrilamine Maleate		12.5 mg.
Phenylephrine Hydrochloride		10 mg.
Ammonium Chloride		60 mg.
Sodium Citrate		85 mg.

Supplied: As a pleasant-to-take syrup. May be habit-forming. Federal law permits oral prescription.

Endo®

Literature on request

ENDO LABORATORIES Richmond Hill 18, New York

* U.S. Pat. 2,630,400

Students Receive

Continued

the ministry. The professions open to the college graduate are now much broader, and they provide the prestige, intellectual satisfaction and financial rewards comparable to those offered by medicine."

The council cautioned that "medicine must make active efforts to inform young people of the breadth of interests and challenges it offers or surely it will suffer a serious loss of the best young talent."

Other salient points in the council's report are:

—During 1958-59, 56 institutions in the U. S. and five in Canada initiated, completed or have funds committed for construction and equipment of new facilities.

—Major projects planned for initiation in 1959-60, with funds already committed, is estimated at approximately 49 million dollars for construction and five million dollars for equipment. Such construction is being planned by 31 schools.

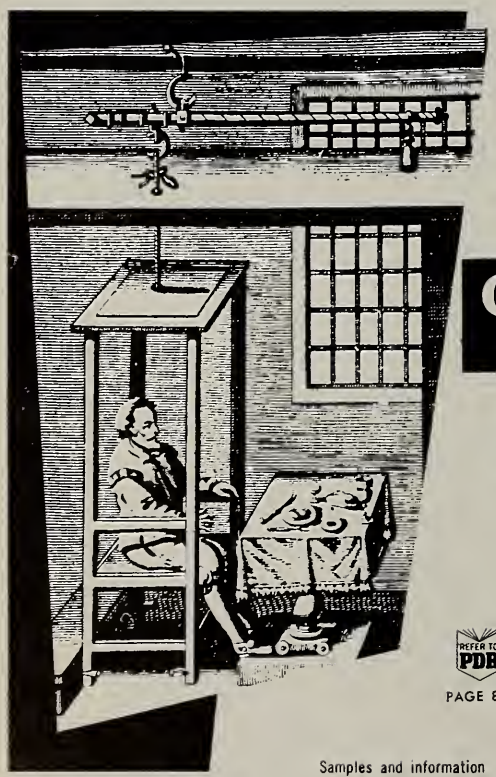
—The total enrollment in first year medical school classes for the 1958-59 academic year was 8,128, the largest to date in the United States. Entering class sizes increased in 35 schools, were unchanged in 24, and decreased in 26.

—In 1958-59, a total of 59,102 applications were filed by 15,170 persons or an average of 3.9 applications made by each prospective medical student.

—Of all first-year medical students, more than one-third, 37%, came from five states—New York, Pennsylvania, California, Ohio and Illinois.

—There were fewer than 20 first-year medical students from each of seven states—Alaska, Delaware, Maine, Nevada, New Mexico, Vermont and Wyoming, and fewer than 30 from two other states—New Hampshire and Rhode Island. Of these nine states, only New Hampshire and Vermont have medical schools.

—At least two-thirds of the entering classes comprise "B" average students. About one-sixth had college grade averages of "A" and about one-sixth to one-seventh had "C" averages. ◄



Sanctorius on his steelyard chair in the act of weighing himself for a metabolism experiment

in obesity

bring the . . . MOOD UP

. . . WEIGHT DOWN

keep BLOOD PRESSURE LEVEL

with

QUADAMINE

GRANUCAP ®

Quadamine GRANUCAPS® provide uniform and sustained therapeutic response. No excitation or sedation. Elevates the mood, protects against nutritional deficiencies, promotes activity and depresses the urge to eat.

Each GRANUCAP® (Sustained release) capsule contains:

Dextro Amphetamine Sulfate	15 mg.	Vitamin C	30.0 mg.
Amobarbital	45 mg.	Ferrous Sulfate	20.0 mg.
Vitamin A	6,600 Units	Cobalt Sulfate	0.49 mg.
Vitamin D	400 Units	Copper Sulfate	2.8 mg.
Vitamin B-1	1.6 mg.	Sodium Molybdate	0.45 mg.
Vitamin B-2	2.5 mg.	Zinc Sulfate	3.9 mg.
Niacinamide	15.5 mg.	Potassium Iodide	0.13 mg.

REFER TO PDR

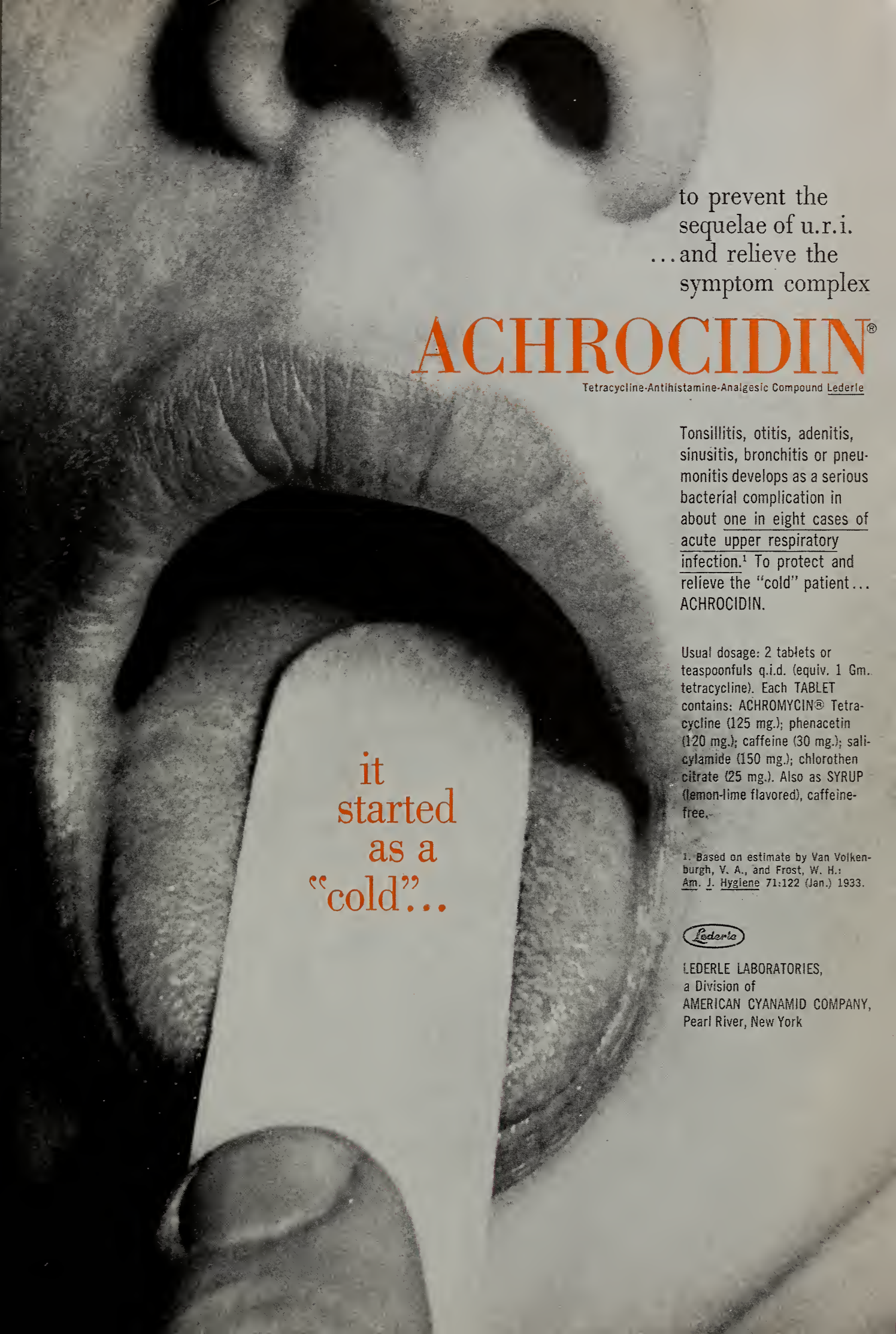
PAGE 826

Samples and information on request. Write or ask your TUTAG representative

TUTAG

S. J. TUTAG & COMPANY

DETROIT 34, MICHIGAN



to prevent the sequelae of u.r.i. ...and relieve the symptom complex

ACHROCIDIN®

Tetracycline-Antihistamine-Analgesic Compound Lederle

Tonsillitis, otitis, adenitis, sinusitis, bronchitis or pneumonitis develops as a serious bacterial complication in about one in eight cases of acute upper respiratory infection.[1] To protect and relieve the "cold" patient... ACHROCIDIN.

Usual dosage: 2 tablets or teaspoonfuls q.i.d. (equiv. 1 Gm. tetracycline). Each TABLET contains: ACHROMYCIN® Tetracycline (125 mg.); phenacetin (120 mg.); caffeine (30 mg.); salicylamide (150 mg.); chlorothen citrate (25 mg.). Also as SYRUP (lemon-lime flavored), caffeine-free.

1. Based on estimate by Van Volkenburgh, V. A., and Frost, W. H.: Am. J. Hygiene 71:122 (Jan.) 1933.

Lederle

LEDERLE LABORATORIES,
a Division of
AMERICAN CYANAMID COMPANY,
Pearl River, New York

Indiana State Board of Health

DIVISION OF COMMUNICABLE DISEASE CONTROL

MONTHLY REPORT - November, 1959

Disease	Nov. 1959	Oct. 1959	Sept. 1959	Nov. 1958	Nov. 1957
Animal Bites	239	435	601	326	205
Chickenpox	180	40	36	360	327
Conjunctivitis	24	38	91	40	30
Diphtheria	0	0	1	1	5
Dysentery, Unspecified	23	16	14	11	113
Impetigo	72	112	302	61	41
Infectious Hepatitis	39	18	12	11	18
Infectious Mononucleosis	10	12	5	7	1
Influenza	583	411	375	706	9186
Measles (Rubeola-Rubella)	95	35	79	270	48
Meningitis, Meningococcal	2	1	1	0	9
Meningitis, Other	17	23	49	13	11
Mumps	89	41	40	147	357
Pertussis	29	40	81	91	35
Pneumonia	98	76	112	148	199
Poliomyelitis	13	20	55	22	14
Streptococcal Infections	229	135	182	232	159
Tinea Capitis	5	7	21	72	26

Tested . . . and proved . . .

ORAL therapy in diaper rash!



Convenient . . . simply open a capsule and add the contents to the baby's daily formula, or to fruit juice or water. No lotions . . . no rinses . . . no ointments . . . just oral therapy.

Send for samples and literature.

S. F. DURST & CO., INC.
Philadelphia 20, Pa.

Effective therapy! Thousands of pediatricians and general practitioners prescribe Pedameth for ammonia dermatitis—and they continue to prescribe it. Clinical tests have proved its effectiveness. Pedameth is safe because it contains only dl-methionine (0.2 Gm.) one of the essential amino acids. When Pedameth is administered, the pH of the urine is lowered and an as-yet-unknown antibacterial agent appears in the urine. Pedameth works . . . it's the safe, effective, convenient answer to ammoniacal diaper rash.

Prescribe

PEDAMETH®

(dl-methionine DURST)

The Journal of the INDIANA STATE MEDICAL ASSOCIATION

Supervised by THE COUNCIL

Volume 53 — January 1960 — Number 1

Non-tuberculous systemic fungous infections are being recognized as a common cause of Addison's disease.

A Case Report:

Adrenal Insufficiency Due to Histoplasmosis

*EMMETT C. PIERCE, M.D.**

Indianapolis

PRIOR TO 1935, tuberculosis was given as the cause of Addison's disease in 80 to 90% of the cases. More recently, in only approximately 50% of the patients can adrenal tuberculosis be demonstrated.[1] With a reduction in the number of cases of Addisons disease due to tuberculosis, the systemic fungus infections must be considered as etiologic agents in adrenal insufficiency.[2] Adrenal involvement is more frequent in histoplasmosis than in the other systemic mycoses,[3] and the possibilty of histoplasmosis should be considered especially in persons who live or have lived in the Central Mississippi Valley where the disease is prevalent.[4]

The adrenal glands are among the most frequently involved organs in histoplasmosis,[5] but relatively few cases of adrenal insufficiency associated with this fungus disease have been reported. Rawson *et al*[6] reported a case in 1948 and in a review of the literature found eight other cases. Crispell *et al*[2] reported four such cases and in a review of the literature found that prior to 1956 there was a total of 15 cases of histoplasmosis associated with clinical symptoms suggestive of adrenal insufficiency. In 1958, Reid *et al* reported three cases of histoplasmosis in New Zealand, and one of these patients had adrenal insufficiency.

This past year a patient was seen at Marion County General Hospital who was diagnosed as having adrenal insufficiency. This was based on the history of postural hypotension, particularly

* From the Department of Pathology, Marion County General Hospital, and the Department of Pathology, Indiana University School of Medicine.

on arising in the morning; increasing fatigue; and a decrease in the urinary 17-ketosteroids.

Case Report

A 57-year-old machinist, who had been treated for hypertension for three years, began to notice excessive fatigue in January, 1958. During the following three months the fatigue became more severe. He had been on a weight reduction diet, but now developed anorexia and during this three months he lost approximately 45 pounds. Intermittent episodes of chills and fever, and a sharp left anterior chest pain occurred. There was dyspnea on slight exertion and near syncopal spells on arising in the mornings.

On April 14, 1958, he was brought home from work in a state of near collapse with profound weakness and shortness of breath. He was treated by his family physician and was told to confine himself to bed for a week. There was only slight improvement in his symptomatology. He was then admitted to the Memorial Clinic of Indianapolis.

Physical examination revealed an acutely and chronically ill white male who was dyspneic on minimal exertion. The blood pressure was 130/80 mm Hg. The eyes, ears, nose and throat were essentially negative. The heart revealed a tachycardia, and P-2 was greater than A-2. A few scattered rhonchi were present throughout the lung fields. The liver margin was five finger breadths below the right costal margin, and was slightly tender and irregular. Genital and rectal examinations were essentially negative. Neurological examinations were also within normal limits.

Laboratory examinations revealed the hemoglobin to be 13.8 gm per 100 ml of blood and the hematocrit to be 41%. The white blood count was 6400 per cu mm, with a normal differential. Urinalysis revealed a specific gravity of 1.026, 6-8 white blood cells and 0-1 red blood cells per high power field, 2 + albumin, negative for sugar and an alkaline reaction. The blood sugar was 94 mg per 100 ml of blood and the blood urea nitrogen was 13.8 mg per 100 ml of blood. The serologic test for syphilis was negative. Cephalin flocculation was negative at 24-hours and 2 + at 48-hours. Thymol turbidity was 1 mg per 100 ml blood. The bilirubin was 0.93 mg per 100 ml serum, and the alkaline phosphatase was 12 Bodanski units.

A chest x-ray on April 21, 1958, was interpreted as follows: "The heart size was on the upper limits of normal without significant contour. There was intensification of the perivascular shadows with more reaction on the left than on the right. Costophrenic angles were clear. The infiltrative process was revealed as a diffuse haziness in both lung fields. Atypical pneumonia or chronic granulomatous disease should be considered."

On April 28, 1958, a smear revealed rare acid fast bacilli. A report on May 29, 1958, stated that on culture there was no growth of fungi, and on June 6, 1958, no growth of acid fast bacilli on culture was reported. The patient was started on isoniazid and para-aminosalicylic acid on receiving the report of acid fast bacilli being present on smear. He was transferred to Sunnyside Sanatorium on May 5, 1958.

Chest x-rays on admission showed a very scattered disease process over both lung fields, which consisted of considerably increased vascular markings. It was the clinical impression that this patient had far advanced pulmonary tuberculosis. INH and PAS therapy was continued. Six sputum smears done between May 6, 1958, and June 3, 1958, were all negative for acid fast bacilli. A smear and culture on July 1, 1958, was also negative. A tuberculin skin test on June 19, 1958, was negative to intermediate strength, and was 1 + to second strength .005 PPD. Histoplasmin, blastomycin, and coccidiodin skin tests were all negative. The sedimentation rate increased from 19 mm per hour on May 5, 1958, to 23 mm per hour on July 14, 1958. The Mazzini test was non-reactive.

A sputum examination sent to the Indiana State Board of Health Laboratories was reported as showing an occasional gram-positive yeast-like organism. Complement fixation antibody tests for fungus disease, including the whole yeast and histoplasmin antigen, and the blastomycin antigen were done and the whole yeast phase of histoplasmin was reactive 1:64, the histoplasmin antigen 1:16 and the blastomycin antigen 1:32. Three sputum smears were sent to the Kansas City Field Station, U. S. Public Health Service on June 12, 1958. Two of these were reported as positive for histoplasma capsulatum. During this hospitalization the patient was febrile with normal temperatures present in the morning, then an afternoon rise to 100° or 101°. Oc-

casionally the temperature rose to 103°. On July 17, 1958 the patient left the hospital against medical advice, signing his own release.

The patient remained at home with profound weakness being the most prominent manifestation of his illness. On August 25, 1958 he was admitted to Marion County General Hospital. The blood pressure was 100/70 mm of Hg and the pulse rate was 78 per minute, weakly palpable but regular. He appeared to be in a state of exhaustion and fatigue. A scaly, erythematous skin lesion was present on the face and it had a butterfly distribution. The chest had an increased A-P diameter and there was considerable loss of adipose tissue in the supraclavicular, and infraclavicular areas bilaterally. A few coarse, sticky rales were heard in the right lower chest posteriorly and laterally. The heart had a regular sinus rhythm and no murmurs were heard. The liver was palpable 3 cm below the right costal margin, and the liver margin was firm and rounded. There was tenderness present in the right costo-vertebral angle. There was profound demonstrable weakness of all muscle groups in a symmetrical distribution. There was some limited motion of his right upper extremity and he complained of an intermittent cramping pain in the joints of his right hand, wrist and elbow.

On 8-26-58 the urine had a specific gravity of 1.010 and was negative for albumin and sugar. The V.D.R.L. and Kolmer were negative. The histoplasmin skin test was read as negative, and the intermediate strength PPD skin test was read as negative. On 8-27-58 the hemoglobin was 14.1 gm. The white blood cells were 5,100 mm,^{3} with a differential of 48% neutrophiles, 51% lymphocytes, 1% eosinophiles. The sedimentation rate was 38 mm hr. The serum bilirubin was 1.0 mgm per 100 ml blood with a direct of 0.53 mgm and an indirect of 0.47 mgm per 100 ml blood. The total protein was 6.7 gm per 100 ml of blood, with the albumin being 3.57 gm and the globulin 3.13 gm. Repeated sputum examinations were negative for acid fast bacilli or fungi. On 8-29-58 the 17-ketosteroids of the urine were reported as 3.6 mg for 24 hours. The urine creatinine for this period of time was 920 mgm. Roentgenograms of the chest on 8-27-58 showed the right diaphragm somewhat higher than the left. The cardiac shadow was within normal limits. There was some increase in the linear markings throughout the lung fields which suggested interstitial fibrosis. There was no radiographic evidence of active pulmonary disease.

On 8-27-58 blood was sent to the Indiana State Board of Health Laboratories for complement fixation test for fungi. On 9-5-58 these were reported as:

Histoplasmosis.	
Whole yeast phase antigen	Reactive 1:256
Histoplasmin antigen	Reactive 1:128
Blastomycosis	
Yeast phase antigen	Reactive 1:32
Coccidoidomycosis	
Coccidioidin antigen	Non-reactive

The patient was placed on nasal oxygen and INH. His temperature on admission was 100°. This returned to normal the next day and he remained afebrile throughout the remaining hospital course. He became progressively weaker and he expired on 9-5-58.

Autopsy

The body was that of a white male with evidence of recent weight loss, whose body length was 66 inches and the estimated weight was 140 pounds. There was a scaly rash on the face which had a butterfly distribution.

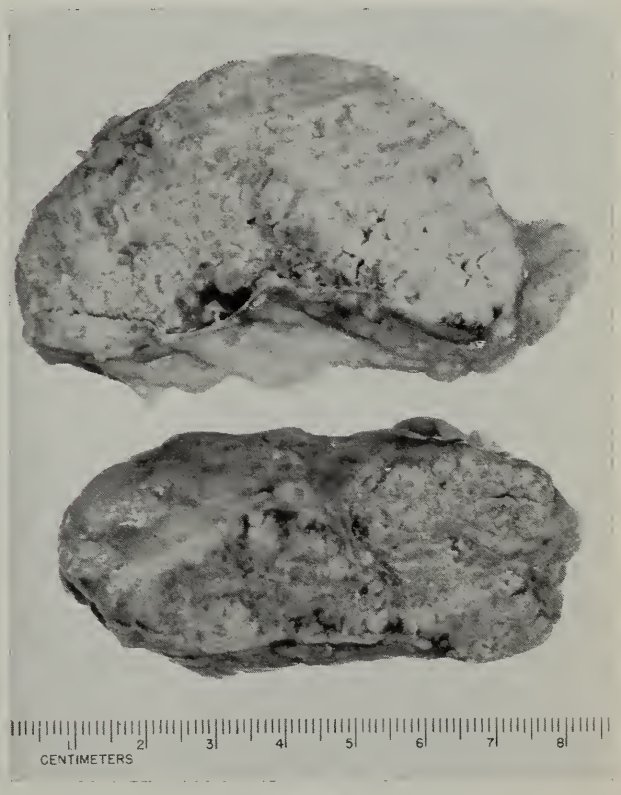


FIGURE 1

GROSS APPEARANCE of the adrenal glands. The normal architecture is completely destroyed and the adrenals are markedly enlarged.



FIGURE 2

A REPRESENTATIVE section of the liver. There is a diffuse and focal infiltrate of polymorphonuclear leukocytes. (H and E X 100)

The coronary vessels showed marked sclerosis, but no definite point of occlusion was found. The right lung weighed 740 gm, the left 750 gm. The upper lobes were red-brown, firm, and in a few areas were granular on palpation. On sectioning, the parenchyma of the lower lobes was moist. The spleen was quite enlarged, weighing 785 gm. There were numerous small granular areas on the surface. The liver weighed 1595 gm and showed no gross abnormalities. The left adrenal weighed 80 gm and the right adrenal weighed 60 gm. The normal architecture was completely replaced by caseation necrosis. (Figure 1)

Microscopically, areas suggestive of granulomas were present in the heart and lungs. An occasional granuloma was seen in the liver and focal and diffuse infiltrates of polymorphonuclear leukocytes were present. (Figure 2) The adrenals showed much caseation necrosis. Many granulomas were seen, and these consisted of Langhans type giant cells, concentric layers of epithelioid cells and a surrounding infiltrate of lymphocytes. (Figure 3)

Gridley stains (Figure 4) and periodic acid-Schiff stains done on the adrenals revealed the presence of small oval organisms which were typical of H. capsulatum. No organisms were found in the other organs and acid-fast stains were negative. Although no organisms were demonstrated it was felt that the hepatitis was probably due to the histoplasmosis.

At the time of autopsy, sections of lung and spleen were taken for culture, and these failed to produce the organism.

Discussion

Histoplasmosis is quite similar to tuberculosis in its clinical manifestations including a primary complex.[8,9] Histologically the lesions of these two diseases may be similar and the differentiation made only by special stains such as acid-fast stains and Gridley stain, or by culture. Due to the similarity in the pathologic picture it may be that some cases of adrenal insufficiency due to histoplasmosis have been erroneously diagnosed as tuberculosis.[10]

Skin tests and serologic complement fixation tests may help to establish the clinical diagnosis

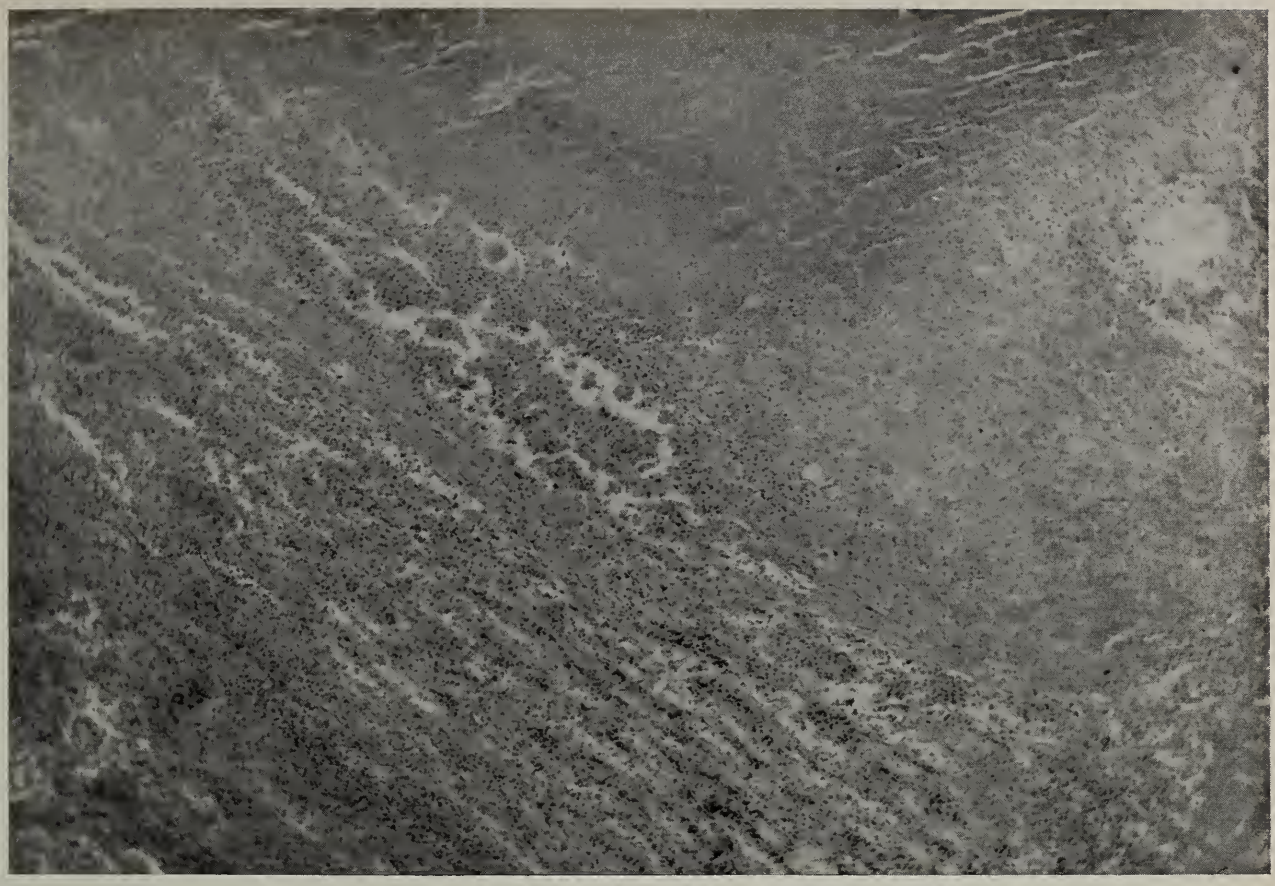


FIGURE 3

A SECTION of the adrenal showing large areas of caseation necrosis and the presence of granulomas. (H and E X 100)

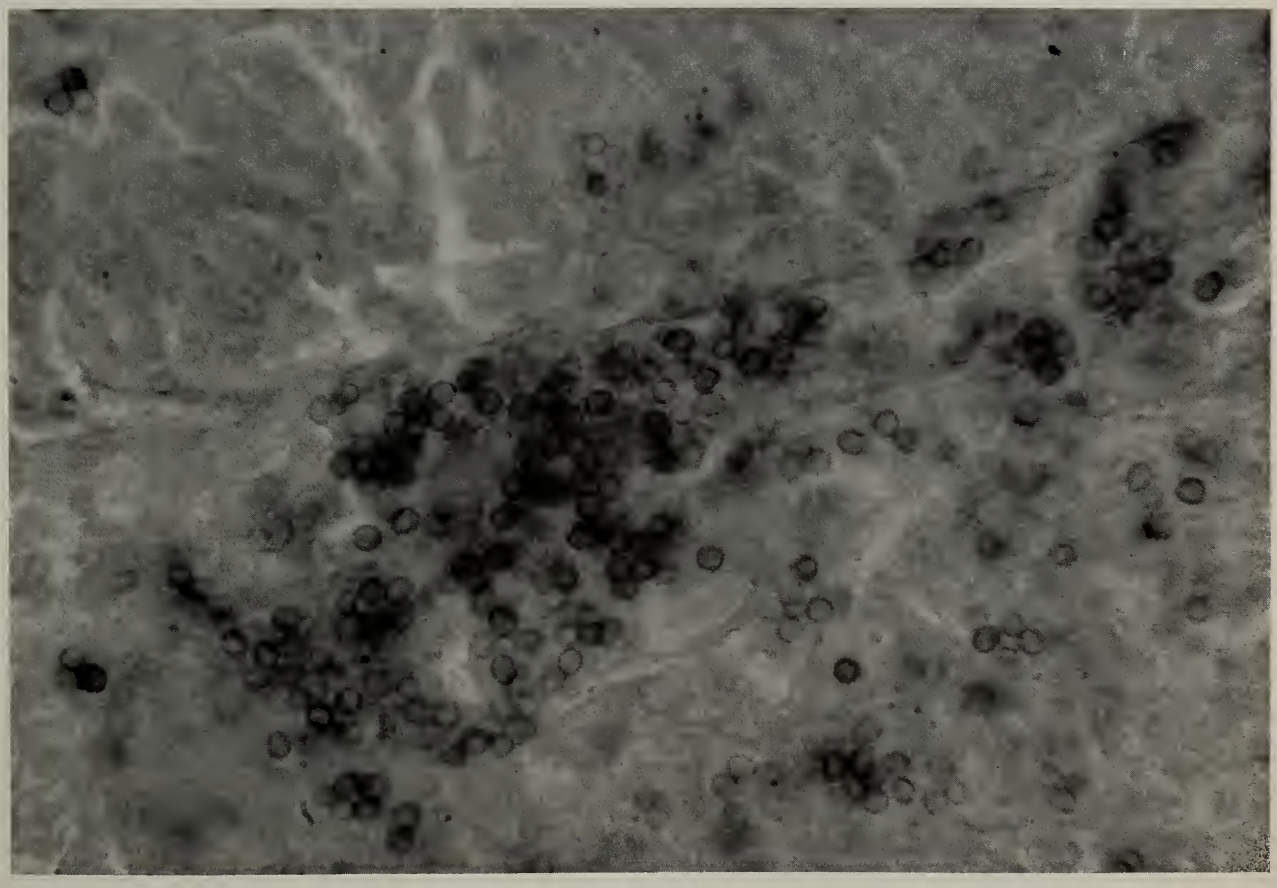


FIGURE 4

H. CAPSULATUM organisms in the adrenal gland. (Gridley stain X 900)

of histoplasmosis. In one series, however, 50% of the cases of disseminated histoplasmosis did not have a positive skin test.[3] The complement fixation reaction may be of diagnostic as well as prognostic significance. This is an acute-phase reaction and the antibodies fade out after a few weeks or months as the infection becomes asymptomatic or inactive.[3] Cross reactions may occur with the fungus antigens, but usually such reactions are in lower titer than the reaction to the antigen of the infecting organism. Titers of 1:160 to 1:2560 are found only in active infections with H. capsulatum.[11]

Positive cultures from autopsy material were not obtained in this case; however, the finding of the organism in the adrenals, and the positive complement fixation test, reactive to the titer of 1:256 with the whole yeast phase antigen, and to 1:128 with the histoplasmin antigen, are considered confirmatory of the diagnosis of histoplasmosis.

Although a typical skin pigmentation, characteristic of Addison's disease was not present, the hypotension and the diminished urinary 17-ketosteroids are suggestive of adrenal insufficiency. At autopsy the adrenals were completely destroyed by caseation necrosis and this certainly is good evidence for adrenal insufficiency.

In the past there has been no specific therapy for histoplasmosis but recently Amphotericin B has shown promise in the treatment of this disease.[12] The possibility of disseminating a primary infection which would of itself be self-limited is a hazard of steroid therapy,[3] but if there is adrenal insufficiency, steroid replacement would be necessary. In their four cases of adrenal insufficiency due to histoplasmosis, Crispell, *et al*[2] successfully used steroid replacement therapy. Three of their patients were alive 5 years, 3 years, and 3 months after the diagnosis of the two diseases had been established.

Summary

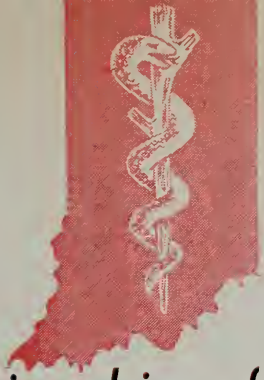
With the decline of tuberculosis as a cause of adrenal insufficiency, histoplasmosis must be considered as a possibility, especially in the endemic area of the Central Mississippi Valley. This is a case report of a patient with adrenal insufficiency due to histoplasmosis. Due to clinical manifestations that are similar, tuberculosis and histoplasmosis are often difficult to differentiate. Sputum cultures, skin tests, and fungus complement fixation tests are of value in establishing the clinical diagnosis of histoplasmosis.

ACKNOWLEDGEMENT

The author gratefully acknowledges the assistance of R. Flanders, M.D. of the Memorial Clinic of Indianapolis, John D. Miller, M.D., superintendent and medical director, Sunnyside Sanatorium, and Mr. Robert Albright, photographer, Marion County General Hospital.

REFERENCES

1. Williams, R. H.: *Textbook of Endocrinology,* W. B. Saunders Company, 1956.
2. Crispell, K. R., Parson, W., Hamlin, J., and Hollifield, G.: Addison's Disease Associated with Histoplasmosis. *Amer. J. Med.* 20:23-28, Jan. 1956.
3. Christie, A.: The Disease Spectrum of Human Histoplasmosis. *Ann. Int. Med.* 49:544-554, Sept. 1958.
4. Boyd, W.: *Pathology for the Physician,* 6th ed., Lea and Febiger, 1958.
5. Schulz, D. M.: Histoplasmosis: A Statistical Morphologic Study. *Am. J. Clin. Path.* 24:11-24, Jan. 1954.
6. Rawson, A. J., Collins, L. H., and Grant, J. L.: Histoplasmosis and Torulosis as Causes of Adrenal Insufficiency. *Am. J. Med. Sc.* 215:363-370, Apr. 1948.
7. Reid, J. D., Cable, J. V., and Laurenson, G. R.: Histoplasmosis: A Report of Cases in New Zealand. *N. Zeal. Med. J.* 57:325-327, Aug. 1958.
8. Schulz, D. M.: A Partially Healed Primary Lesion in a Case of Generalized Histoplasmosis. *Arch. Path.* 50:457-463, Oct. 1950.
9. Straub, M., and Schwarz, J.: The Healed Primary Complex in Histoplasmosis. *Am. J. Clin. Path.* 25:727-740, July, 1955.
10. Vivian, D. N., Weed, L. A., McDonald, J. R., Clagett, O. T., and Hodgson, C. H.: Histoplasmosis: Clinical and Pathological Study of 20 cases. *S. G. O.* 99:53-62, July, 1954.
11. Campbell, C. C., and Binkley, G. E.: Serologic Diagnosis with Respect to Histoplasmosis, Coccidioidomycosis, and Blastomycosis and the Problem of Cross Reaction. *J. Lab. Clin. Med.* 42:896-906, Dec. 1953.
12. Baum, G. L., Schwarz, J., and Wang, C. J. K.: Treatment of Experimental Histoplasmosis with Amphotercin-B. *Arch. Int. Med.* 101:84-86, Jan. 1958. ◄



There are many varieties of breast malignancy. There is only one benign breast nodule: the one in the laboratory bottle!

Relationship of Benign And Malignant Breast Lesions

M. SHELLHOUSE, M.D.

Gary

THE PURPOSE of this paper is to stress the importance of examining breasts periodically and routinely and to make a differential diagnosis by biopsy. If proper advice and therapy is instituted immediately, the outcome is more beneficial and happier to both the patient and the doctor.

From 1954 through 1957, there were 800 breast cases admitted to Methodist and St. Mary's Mercy Hospitals in Gary, Ind. These records were carefully checked for statistical purposes. The data obtained are used in presentation of this paper. Other sources of information are listed in the bibliography.

The importance of any tumor, be it on the skin or hidden in some other organ, is whether or not malignancy is present. In the breast, too often a benign lesion is coexisting with malignant tissue or one having malignant tendencies. The only positive way to determine this is by a wide excisional biopsy by frozen section, preferably using general anesthesia. If more extensive surgery has to be done, the patient is ready. With the use of local anesthesia, there is danger of disseminating malignant cells.

Of the 800 breast cases, 186 were malignant—over 23%. Malignant tumors were associated with one or more benign breast conditions in 64 cases, showing about 33% prevalence. The majority of benign diseases fall in the category of chronic cystic and fibrocystic disease, adenofibromas, intraductal papillomas, sclerosing adenosis and hyperplasias. To break these down into separate entities would necessitate considerable reduplication and unnecessary mathematical figures which could not be remembered. Suffice it to say, we had 39 malignant breast lesions associated with cystic mastitis and 25 malignancies with the remainder of combinations of benign conditions.

"Early" diagnosis is a term which is difficult to interpret. Does it mean the size of tumor? Or does it refer to subjective or objective symptoms of the host? The answer is probably neither. Often times, the operator is surprised when along with a "benign" tumor, the pathologist will encounter pre-malignant or malignant cells as will be discussed later. A small tumor may show axillary nodal metastasis and still be asymptomatic.

From the clinician's point of view, earlier differential diagnosis must be made to diagnose breast cancer. Every lump, abnormal nipple, bloody discharge from nipple, and history of previous benign biopsy in recurrent tumors should be considered malignant until proven otherwise. A wide surgical excisional biopsy is essential. It is wishful thinking to say, "Oh, this is only a fibroadenoma—it is freely movable," or "This one is only chronic cystic mastitis—I wouldn't worry." These utterances are made too frequently because the clinician after so many years of "experience" fools himself into believing that his fingers will make the diagnosis.

Not By Skill Alone

Dr. A. P. Stout admonished,[1] "Do not attempt by skill in clinical diagnosis, to differentiate a cyst or a benign tumor from a cancer. You can never live long enough to become so experienced that you can tell them *all* apart."

True enough, many of these benign lesions will be diagnosed correctly by procrastination. But what about the unfortunate ones who may

harbor co-existent malignancy? It is the latter group that makes up our statistical data which we are not not to be proud of in spite of super-radical surgery.

Notwithstanding the fact that there is considerable information disseminated to the lay public regarding "early signs of cancer," there is a large group of people hesitant to obtain examination because of fear of truth, and because "It can't happen to me" attitude, or because of skepticism. There is a group of medical people in the same category.

If these two groups would succumb to cancerphobia and submit to repeated examinations and immediate biopsies, if abnormalities were found, it is quite feasible that more early malignancies, or precancerous lesions preferably would be detected. The figure for survival rate would be changed numerically in favor of the host and reputation of the doctor.

Benign Lesions Encountered

Benign lesions which are encountered in breasts as to frequency in our series include:

FIBROCYSTIC DISEASE was diagnosed microscopically in 189 individuals in combination with other benign conditions, including 11 malignancies, almost 6%. The youngest patient was 18 years old and the oldest was 67. The average age was 35.5 years. The majority of fibrocystic disease was found in the 25 to 40 years group. However, older individuals may have fibrocystic disease with carcinoma as in the following individual:

Case Report

A lady age 67, was readmitted to Mercy Hospital in August of 1957. History showed that she had a right radical mastectomy in 1952. Her admission in 1957 was for "probable carcinoma of left breast." Frozen section followed by left radical mastectomy showed carcinoma and fibrocystic disease. She expired Aug. 13, 1957 of pulmonary embolism. There were no distant metastases other than in left axillary region.

It is impossible to state definitely whether or not carcinoma of the left breast had its origin from the right breast in view of the fact that no other metastases were found—it could well be another primary tumor in the left breast. If so, a simple mastectomy in 1952 might have prevented this unfortunate sequela.

CHRONIC CYSTIC MASTITIS — a very frequent benign finding. The breast may be tender, feels nodular or lumpy; there may be grey to green nipple discharge. It is usually the nipple discharge that the patient is somewhat concerned about because "it doesn't look nice." The average age group in this series of 163 patients haboring chronic cystic mastitis was 40.5 years—the age in which considerable cancer is found. In this group there were 28 patients who had unsuspected cancer clinically, over 17%. This is a high percentage of malignancy to be ignored in what appears to be a benign breast.

To quote Brunschwig[2] "More is being learned about benign lesions and their potentialities for possible future malignant changes, which in turn leads to greater efficiency in their management with the view to prophylaxis of cancer."

At the present time, in Lewison's book on Breast Cancer,[3] there is sufficient evidence to show that there is a positive relationship between benign breast disease and cancer.

The following two cases (two of 19 malignancies in this group) are quite typical of the above relationship:

Two Case Reports

A woman, age 43, was seen by her doctor May 1, 1955, because of a lump, the size of a walnut, present in her right breast about three months. Biopsy within one week showed a carcinoma with invasion. Pathological report after radical procedure showed lymph node metastasis and chronic cystic mastitis.

It is quite obvious that this patient had chronic cystic mastitis before a large lump was noted. Would a simple mastectomy a few years before have prevented carcinoma if this patient had been examined periodically and an abnormal breast was found? This appears like a radical approach for a benign lesion, and yet 17% is no trifle. We are not dealing with inanimate objects. Each one of these 28 women is a mother, wife, sister or aunt to someone and is in the age group of 40 to 50 years—middle age cancer group whose life expectancy now is very closely numbered.

It is a group whose life expectancy may be much greater, not for all probably, but with good risk if simple mastectomies were done more often, particularly in ages 40 and over. Each individual case must be judged upon its own findings as to age, extent, duration and recurrence of benign lesions. The problem should be

discussed frankly with the patient before simple mastectomy is done. The cosmetic effect, use of prosthesis, dress-wear and emotional aspects which may confront the patient should be frankly discussed with the husband also.

The following is my most recent and somewhat lengthy report on a patient whose breast biopsy dates to 1952.

The patient was seen by me Nov. 3, 1952 complaining of "lumps in breasts." She was 31 years old at this time. She had a freely movable lump at 5 o'clock position in her right breast and "shotty" breast laterally. The left breast showed a similar lump at 3 o'clock position near the areola, plus "shotty" breast laterally.

On Nov. 20, 1952 she had wide excisional biopsies of both breasts. Pathological diagnoses were: "Chronic cystic mastitis, fibrocystic disease, and scattered small dome cysts." This report was identical for both breasts. She returned in June of 1953 complaining of "lumps" in both breasts again. Examination showed more "shotty" breast tissue on medial side of left breast and more prominent on lateral surface of right breast. I said casually, "It is probably the same trouble." But as an afterthought I said, "It would be better to remove the right breast."

After two years she returned and informed me that her breasts were all right because she visited a good clinic out of state and was told to quit worrying. She was happy! However, in April of 1957 she again came to my office complaining that "lumps were getting larger." After examination I advised surgery to both breasts. She finally returned in February of 1959 ready for surgery. A hard tumor, the size of a hazel-nut, was found in the right breast on the lateral surface among the "shotty" mass. The left breast showed a resilient tumor on the medial surface, the size of a golf-ball. After very wide excisional biopsies (partial mastectomies) diagnoses were: carcinoma right breast and cystic disease; left breast showed a large dome cyst and cystic disease. After right radical mastectomy and axillary dissection, pathological report showed axillary metastases. She is now 38 years old. This case fulfills in my mind the admonishment of Drs. Stout,[1] Brunschwig[2] and Lewison[3] in previous paragraphs.

Fibroadenoma

FIBROADENOMA is a firm, freely movable tumor, variable in size and found in younger ages. It is more frequent in negro females. This tumor must be distinguished at times from lumpiness in functional mastopathy present in the second half of menstrual cycle which, after menses, reverts back to near normal.

The importance of a fibroadenoma is to differentiate it from cancer. A wide excisional biopsy must be done. If in doubt, a frozen section should be done with anticipation of radical breast surgery. During pregnancy or lactation a lump, though freely movable, must be excised. Carcinoma is very unfavorably influenced during pregnancy.

Fibroadenoma, though benign, may undergo malignant changes.[4] If sarcomatous change occurs, amputation of the breast including pectoral fascia and without axillary nodal dissection will suffice. However, in squamous cell metaplasia of fibroadenoma, a radical surgical removal is necessary.

In our 4-year series, fibroadenoma was pathologically diagnosed 141 times as an entity or in combination with other conditions. There were nine patients having associated carcinoma. Average age in our series was 30.5 years.

Two Case Reports

Following is a very brief resume of one of these benign fibroadenoma patients. The patient, age 27 years, was operated upon Nov. 3, 1954, for a freely movable tumor in the left breast which was known to have been present for five months. No axillary nodes were palpable. A frozen section proved this to be fibroadenoma and suspicious of malignancy. Microscopical interpretation was a duct-cell carcinoma with infiltration and fibroadenoma. No axillary nodal metastasis was found.

Another patient, age 39 years, saw her doctor for a painful right breast. She stated that for two months she had felt a lump. Tenderness started about two weeks before admission to the hospital. On the 23rd of December, 1954, a frozen section showed a malignancy. Radical breast surgery showed axillary nodal involvement. Incidental finding showed, also, a fibroadenoma in close proximity.

To try to analyze these two cases is purely theoretical. Did the fibroadenoma develop first? If so, how long had it been present? If these benign tumors had been detected earlier and excised widely, would cancer have developed in these breasts? These questions should invoke

considerable discussion pro and con. In my own mind, cancer would probably have been delayed, if not totally prevented in this breast.

Intraductal Papilloma

Bloody discharge from nipple is a frequent sign and complaint; the grey or brown discharge may also be present. About 14% of carcinoma in breast will produce sanguineous discharge[5] and only 4% is evident as early carcinoma. Intraductal papillomas should be considered as premalignant. Diagnosis is made microscopically. In our series this was encountered 55 times. Twelve patients or 22% were associated with cancer.

Two Case Reports

Following are two brief cases: A negro girl, age 27, was seen by her physician on Oct. 9, 1955, complaining of slight bloody discharge from nipple of the left breast. The discharge was intermittent for about one year. A biopsy performed Oct. 13, 1955, showed intraductal papillomatosis and carcinoma with early invasion.

Another patient, age 42 years, was biopsied in August, 1950. Diagnosis then was intraductal papilloma. In June, 1954, because of recurrent lumpy breast with occasional bloody discharge of several months duration, biopsy was repeated. Biopsy report showed chronic cystic mastitis, sclerosing adenosis, intraductal papillomatosis and last, but not least, invasive carcinoma. In July, 1954, a radical breast operation was done. Microscopic report at this time, showed numerous cysts, intraductal papillomas, sclerosing adenosis and axillary nodal metastasis.

Gynecomastia

GYNECOMASTIA is a diffuse hypertrophic enlargement present more often in young individuals and will sometimes spontaneously subside at or near puberty. Testosterone therapy, at times, is indicated. In adult male patients, simple mastectomy should be performed because gynecomastia increases susceptibility to carcinoma.[6]

Simple mastectomy was performed as a bilateral procedure five times and 22 times as a unilateral mastectomy for gynecomastia and other conditions in our series.

According to Lewison, simple mastectomy appears to be justifiable as a prophylatic measure in multiple or diffuse benign breast tumors, particularly with premalignant tendencies. It is justifiable in intracystic or intraductal papillomatosis, chronic cystic mastitis with hyperplasias and recurring conditions such as fibroadenoma, gynecomastia in adults and in cystosarcoma phyllodes. Other indications are in certain inoperable carcinomas for palliation and extensive suppurative conditions which do not respond to antibiotic or conservative treatment.

In regard to 186 malignancies encountered in our series, there was no attempt made to classify them into grades. Of importance was the fact that 64 cases were unsuspected and were clinically diagnosed as benign tumors. As to the age incidence in the total number of cancers, the youngest was 23 years, the oldest was 86 years. The average age was 48.7 years. In the 40-50 age group, there were 70 patients; 43 in the 50-60 years of age group; and 55 patients in the 60 to 86 year group. In the 23 to 40 age group, there were 18 cases.

Benign and malignant lesions were more frequent in the left breast—344 and 104 respectively. The right breast showed 270 benign and 82 malignant.

Surgical Treatment

Treatment of malignant breast tumors is predominantly surgical. Breast cancers with or without axillary involvement require radical surgery and axillary nodal dissection *en bloc,* providing there are no metastases to lungs or other distant organs. If the internal mammary chain is involved, as it is quite often in lesions of the medial side of breast, then more radical surgery is probably indicated. Castration, in pre-menopausal age, increases the salvage rate by about 12 to 15%.

X-ray therapy is used after radical surgery if nodes are positive. It is used also in those cases of inoperable carcinoma, which have or have not had simple mastectomy for palliation.

Adrenalectomy and hypophysectomy in younger individuals shows some improvement. Following adrenalectomy, cortisone is used daily in doses as required.

Hormone therapy is useful for certain metastatic cases. Androgens are used in females below age 60 and estrogens in age above 60 years as a palliative measure, in conjunction with x-ray therapy in metastatic bone and soft tissue lesions. Chemotherapy is also advised.

Radical Surgery

Future radical surgery, now in progress in some institutions, consists of the Urban technic and other more radical approaches. What the salvage rate will be following these extreme radical approaches is not yet known. However, if the internal mammary nodes are inolved (this is determined by biopsy of 2nd and 3rd interspace), then it is best not to do super-radical surgery.

It appears that the radical approach will always be necessary for those patients who are inadequately examined and inadequately treated or who fail to be examined. It likewise appears that those who are examined periodically may be spared radical surgery by early and adequate wide excisional biopsy. In some cases a simple mastectomy is done as a prophylactic measure.

Discussion

It appears that treatment of carcinoma of breast must be anticipated before nipple retraction is seen, before "pig-skin" phenomenon is noted, and before tumor masses are so large that assymetry of breast can be detected by a young child.

A concerted effort must be made to prevent the classical findings from even being present. It is not unusual to do a complete colectomy for diseases of the colon. It is not unusual to do hip disarticulation for a malignancy or disease of the foot or leg. A frontal lobotomy is not infrequent now. Adrenalectomies, hypophysectomies, oophorectomies and pelvic exenterations are done to improve salvage rate. Very few doctors will question the efficacy of these procedures as these are done in an attempt to prolong life. But, if a simple mastectomy should be done contra lateral to radical mastectomy, or a simple mastectomy should be done for benign conditions such as cystic disease or intraductal papillomatosis, etc., there would be many doctors who would condemn such a procedure but would do extensive radical operations several months or years later.

Conclusions

1. The purpose of this paper is to stress early diagnosis of breast tumors.
2. Two Gary Hospitals in 1954 through 1957, had 800 patients with breast lesions. In this group there were 186 malignancies or 23%. Malignant tumors coexisted with benign lesions, particularly with chronic and fibrocystic disease in 39 cases.
3. Differential diagnosis is made by wide surgical excisional biopsy by frozen section, preferably under general anesthesia.
4. Several cases are briefly presented to show the association of benign and malignant conditions in cases which clinically appeared benign.
5. Complacency in lay groups and procrastination in the medical profession results in a poor salvage rate.
6. Predominant "benign" breast lesions in this series are fibrocystic disease, chronic cystic mastitis, fibroadenoma, intraductal papillomas, adenosis, gynecomastias and miscellaneous infections, respectively.
7. The left breast was involved 344 times, the right 270 in benign conditions. The left breast was involved 104 times, whereas the right 82 times, for malignancies.
8. Simple mastectomy appears justifiable in multiple or diffuse benign breast tumors, particularly with premalignant tendencies, in chronic cystic mastitis and other recurrent benign lesions and gynecomastia, particularly in adults. In these conditions, it is a prophylactic measure. Simple mastectomy is also indicated in certain inoperable carcinomas as a palliative measure.
9. Treatment of carcinoma is predominantly surgical. X-ray therapy, castration in premenopausal age increases the salvage rate. Adrenolectomy and hypophysectomy in selected cases is of some benefit. Hormonal therapy is for palliation, particularly in distant metastasis.
10. Super-radical breast surgery using Urban technic and more radical modifications are used in selected cases.

3811 Washington St.,
Gary

BIBLIOGRAPHY

1. Stout, A. P.: Lesions of the Breast, *Postgraduate Medicine* 5:101-106, (February) 1949.
2. Brunschwig, Alex: Symposium on Surgery of carcinoma, *Surgical Clinics of N. A.,* Philadelphia, W. B. Saunders 311, April, 1953.
3. Lewison, Edward F.: *Textbook of Breast Cancer,* Baltimore, The Williams and Wilkins Company, 1955, pp. 125-137.
4, 5, 6. Copeland, M. M. and Geshickter, C. F.: Diagnosis and Treatment of Premalignant Lesions of the Breast, *Surgical Clinics of N. A.*, Philadelphia, W. B. Saunders 1717-1739, Decmeber, 1950. ◄

Heavy metal poisoning should be considered in diagnosing of obscure illnesses.

A Report of Two Cases

Hepato-Lenticular Degeneration

*A. WENDELL MUSSER, M.D.**

Indianapolis

A REPORT of two cases of hepato-lenticular degeneration with complete autopsies is of importance in this day when so much emphasis has been placed upon heavy metals and their association with neurological, neoplastic and hematological disorders. Little can be added to the gross pathology and possibly the microscopic pathology as elucidated in Wilson's original exhaustive monograph of 1911. We feel, however, that the reporting of two more cases of this disease may add something to our knowledge of this disease and, in turn, to the possible importance of metallic ions in the pathogenesis and pathologic physiology of many disease states.

Material

Case I

The first patient was a 22-year-old white male who was admitted to the Indiana University Medical Center after having been confined in a local mental hospital for a period of six months. The patient apparently had been well until approximately two years before his death, at which time he developed weakness and headaches, soon followed by tremors of the upper extremities. During the next one and one-half years the patient was seen by several physicians and in several institutions, but no definite diagnosis was made nor therapy attempted.

The patient was admitted to the LaRue D. Carter Hospital for Mental Diseases approximately six months before his death. Upon admission the diagnosis of schizophrenia with Parkinsons syndrome was made, and the patient subsequently received psychiatric therapy consisting of electro-shock therapy, subcoma insulin treatment and supportive psychotherapy.

Three months before his death the patient began to have visual difficulty and an opthalmologic consultation was requested and obtained. It was at this time that the diagnosis of Wilson's disease was made by the Department of Neurology. The positive findings of the physical examination, during this period, consisted of slight hyperactivity of the reflexes of the lower extremities, Kayser-Fleischer rings, an action tremor, moderate cogwheel rigidity of all four extremities, terminal dysmetria and some dysdiadochokinesis, and a desquamating hyperpigmented dermatosis involving the distal portions of the extremities and the axillae with smaller pigmented areas over the body.

Twelve days before his death the patient was found lying on the floor in a semi-comatose state. It was at this time that the patient was transferred to the Robert W. Long Hospital. Five days before his death papilledema and a right flaccid hemiparesis were noted. A ventriculogram was unrevealing and he died two days after his operative procedure.

Laboratory Findings

Laboratory findings upon admission included the following—urinalysis: 1.018 specific gravity, albumin 2+; red blood count: 5.17 million; hemoglobin: 15.5 gm/100 ml; white blood

* Trainee of the National Cancer Institute, NC-FIDB-T, and resident instructor in the Department of Pathology, Indiana University Medical Center, Indianapolis.

count: 9,750. Special laboratory findings upon admission included the following: total serum copper: 87.4 mgm/100 ml; direct reacting copper: 56.0 mgm/100 ml; indirect reacting copper: 31.4 mgm/100 ml; copper oxidase: 0.034 units by Ravin's method.

Laboratory findings at death included the following—bilirubin: 0.4 mgm/100 ml direct, 1.2 mgm/100 ml indirect, and 1.6 mgm/100 ml total; cephalin flocculation: 3+; thymol turbidity: 16.0 units; blood urea nitrogen: 73 mgm/100 ml; acid phosphatase: 10.3 K-A units; and cholesterol: 224 mgm/100 ml.

Anatomic Findings

Gross Examination

Externally the patient was slightly underdeveloped and emaciated. A scaling dermatitis was noted over the trunk and extremities, more marked over the inner aspect of the thighs. The patient was slightly jaundiced and the Kayser-Fleischer rings were prominent.

The liver weighed 1410 grams and the surface was yellow and finely nodular. The lobular pattern was quite pronounced on cut surface, and the parenchyma was extremely firm. The brain weighed 1300 grams and was covered with subarachnoidal hemorrhage. The right lateral ventricle was distended and filled with blood. The blood extended out into the paraventricular white matter. No gross abnormalities of the basal ganglia could be identified. The spleen was enlarged and weighed 320 grams. Bronchopneumonia was noted in both lungs. The yellow pigment of the adrenals was moderately depleted.

Microscopic Examination

Again the nodularity of the liver parenchyma was prominent. The nodules were separated by trabeculae composed of fibrous connective tissue, which had been infiltrated by lymphocytes and plasma cells. An increased number of bile ducts were noted in the interstitial connective tissue. The microscopic findings noted were not different from those of the usual case of portal cirrhosis. (Figure I)

Numerous focal areas of encephalomalacia, less than 1 mm in diameter, were noted in the white matter of the frontal lobes. A few areas of cystic degeneration were noted in the putamen and globus pallidus. Similar lesions were not found in the subthalamic nuclei, dentate nuclei, the superior cerebellar peduncles, or the substantia nigra. The small cystic areas were irregular, and the surrounding brain substance had an increased number of reactive astrocytes. In the immediate paracystic substance there was a loss of myelin and fibers, as noted on the Spielmeyer's myelin stain (Figure II) and the silver carbonate stain (Figure III). Large oval and round cells with distinct cellular borders and nuclei and with finely granular cytoplasm are noted filling the cystic spaces (Figure II). Large reactive astrocytes, Alzheimer cells, are noted in the surrounding parenchyma on the brain. These findings are



FIGURE 1

CASE I: Nodular pattern of the liver. Note the dense connective tissue trabeculae typical of cirrhosis. (Masson's trichrome stain. X75)

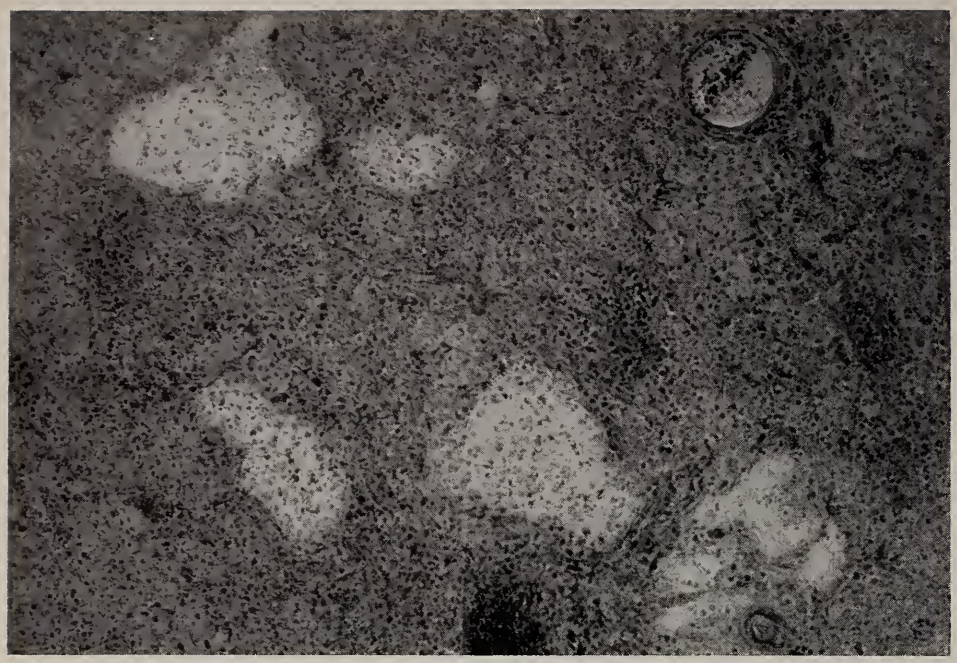


FIGURE 2

CASE I: Cystic areas in the putamen associated generalized loss of myelin. Note compound granular corpuscles. (Spielmeyer's myelin stain. X150)

typical for the entity called Wilson's disease or hepato-lenticular degeneration.

The microscopic findings of the skin lesions were not characteristic for any specific skin lesion, but were suggestive of acanthosis nigricans. Acanthosis and hyperkeratosis were noted. There were some papillomatous projections from the surface of the epithelium resulting in the formation of small cystic spaces containing keratin. Slight atrophy of the rete pegs was noted. A small amount of melanin was noted in the basal layer of the epithelium. No abnormalities of the vasculature, dermal connective tissue or skin appendages were noted, (Figure IV).

Case II

The second patient was a 53-year-old white male who was first seen at the Indiana University Medical Center four years before his death. At this time the chief complaint of the patient was nervousness. The actual date of onset of this symptom is not clear; the symptom probably began some 15-20 years before his death. Following a carbuncle and resulting septicemia approximately 18 years before death, the patient experienced progressive nervousness to the point of an actual intention tremor and ataxic gait. The patient had been unable to walk unassisted for the past eight years and for the past five years had been confined to a chair or bed. The family history revealed that his father had died of cirrhosis.

Physical examination upon his first admission revealed intention tremor, severe ataxia, Kayser-Fleischer rings, slurred speech and bilateral adiadochokinesis.

Shortly after admission to this medical center the patient developed severe chills and a high temperature. Pus cells were reported in the urine at this time. The patient was treated with penicillin and sulfasoxazole and responded quite well. During this hospital stay the patient was treated with BAL; and following a 12 day course of 2.5 gm of BAL daily, he showed little change. The patient was discharged from the medical center to be followed in the outpatient medicine clinic.

During the next four years the patient was seen at the medical center seven times. At each admission he received antibiotic treatment for pyelonephritis and BAL for his hepato-lenticular degeneration. On one occasion the patient received edathamil instead of BAL. The urine copper before the edathamil therapy was 278 mgm per liter, after 5 days, 505 mgm per liter, and at the end of 10 days, 560 mgm per liter; however, there was little clinical change in his disease state.

The patient was seen at the medical center for the last time five months before death, because of severe urinary tract infection and an ingravescent neurological course. Physical examination at this time was productive of the following positive findings: Kayser-Fleischer rings, advanced muscular rigidity, flexion contracture of the right leg, advanced flapping tremor of all extremities and loss of contact with his surroundings. The patient was soon transferred to a custodial home



FIGURE 3

CASE I: Extensive patchy loss of fibers in the putamen. Note increase number of astrocytes. (Silver carbonate fiber stain. X150)

for the care of terminal neurologic problems. He was not traced again until he was presented dead-on-arrival at the Community Hospital, Indianapolis.

Laboratory Findings

The laboratory findings upon admission included the following: serum bilirubin: 0.7 mgm /100 ml indirect, 0.3 mgm/100 ml direct, 1.0 mgm/100 ml total; total protein: 4.03 grams/100 ml albumin, 2.87 grams/100 ml globulin, 6.9 grams/100 ml total; alkaline phosphatase: 6.3 K-A units; prothrombin time: 100%; bromsulphalein test: 6% retention in 45 minutes; and cephalin flocculation: 3+.

Laboratory findings upon last admission included the following: serum bilirubin: 0.2 mgm /100 ml indirect. 0.3 mgm/100 ml direct, 0.5 mgm/100 ml total; total protein: 4.03 grams/100 ml albumin, 1.72 grams/100 ml globulin, 5.75 grams/100 ml total; cephalin flocculation: 2+; thymol turbidity: 2 units; and blood urea nitrogen: 19 mgm/100 ml. The only special laboratory test obtained at that time was the copper oxidase: 0.032 units by Ravin's method.

Anatomic Findings

Gross Examination

The patient at the time of the autopsy was emaciated. The Kayser-Fleischer rings noted distinctly early in the course of his illness were not mentioned at the time of the autopsy.



FIGURE 4

CASE I: Papillomatosis and keratin cysts formation in skin of lateral chest wall. The melanin of the basal layers of epithelium is not distinct. (Hemotoxylin and eosin. X75)



FIGURE 5
CASE II: Nodularity of liver and fibrous connective tissue trabeculae of portal cirrhosis. (Hemotoxylin and eosin. X150).

Grossly the liver appeared similar to Case I. The liver weighed 1440 grams. The surface was nodular and the parenchyma firm. The brain weighed 975 grams. The convolutions were prominent due to widening and deepening of the sulci. The lateral ventricles were dilated, apparently due to atrophy of paraventricular brain substance. The spleen weighed 590 grams and was not unusual other than for size. The right kidney weighed 300 grams and the left kidney 205 grams. The right kidney was not unusual. The capsule of the left kidney stripped with difficulty revealing a grossly scarred kidney with yellow streaks. A 2 cm calculus was noted in the pelvis of the left kidney. The lipid of the cortices of the adrenals was depleted.

Microscopic Examination

Similar findings of portal cirrhosis as noted in Case I were noted in this case (Figure V). The brain, however, was unusual because of its relative lack of pathologic lesions when compared with the clinical course of this patient. Several small areas of encephalomalacia were noted in the cerebral cortex. There was a slight astrocytic proliferation in both the cerebral grey and white matter, and a slight loss of pigment in the substantia nigra; however, the basal ganglia were singularly impressive from the standpoint of their normality. The acute and chronic pyelonephritis was obvious.

Discussion

These two patients illustrate certain manifestations of the complex and protean entity called hepato-lenticular degeneration. The first patient depicts the usual classical clinical course and pathology of hepato-lenticular degeneration. The biochemical findings were also quite consistent. Markowitz in analyzing the sera of 10 normal individuals found that the total serum copper averaged 108 mgm/100 ml; the direct-reacting copper, 5 mgm/100 ml; the indirect-reacting copper 103 mgm/100 ml; and the oxidase activity averaged 3.9 mm of O_2/ml/hr. Using the same procedure Markowitz, *et al.*, analyzed the sera from 14 patients with hepato-lenticular degeneration and found that the total serum copper ranged from 35 to 100 mgm/100 ml; and that there was an increase in direct reacting copper and a decrease in the oxidase activity. The findings in the first case were similarly affected.

Pathologically in both cases, the liver and the brain coincide with the lesions described originally by Westphal, by Strumpell, by Rumpel, and more recently by Scharenberg and Drew. According to Scharenberg and Drew, it is the glia, predominantly astroglia, which responds to the pathologic metabolism in Wilson's Disease. According to Scharenberg and Drew, Alzheimer cells represent hypertrophic elements, many of which were in a state of advanced degeneration in the corpus striatum. Diffuse proliferation of astroglia was noted in the hemispheres. Extensive areas of ameboid degeneration of the astroglia in the nuclei of the pons and dentate nucleus of the cerebellum were observed.

The association of acanthosis nigricans and

hepato-lenticular degeneration has been reported by Ezzo, *et al.,* and many other authors. Acanthosis nigricans has been reported in association with severe hepatic cirrhosis by Kok and many others. Curth and Hermann stress the distinction between the benign childhood form of acanthosis nigricans and the adult type associated with malignancy of internal organs. It is the benign childhood variety that has been reported in patients with hepato-lenticular degeneration. The exact pathologic mechanism of this disease entity is still in its infancy of investigation; however, the association of hyperpigmented skin lesions with certain metabolic, endocrine, hepatic and neoplastic disease is well documented.

The clinical syndrome of hepato-lenticular degeneration may be evident, and the central nervous system findings may be slight. The lack of central nervous system findings was found in an occasional case in the early reports of this entity. Lawrie and Carter reported a case in which the clinical and biochemical findings were those of hepato-lenticular degeneration but the pathologic changes in the brain were of a minor nature. Chalmers, *et al.,* reported five cases of a "so-called" abdominal form of hepato-lenticular degeneration. This condition had been alluded to by Bramwell in 1912 and definitely stated by Barnes and Hurst in 1926. Before the recognition of the importance of copper in hepato-lenticular degeneration, Foster reported the case of an 18-year-old girl who died of cirrhosis. For some reason heavy-metal poisoning was suspected, and her tissues were found to contain negligible amounts of arsenic, mercury and lead, but a kidney had 200 mgm of copper per gram and the liver 332 mgm per gram. Thus, she probably had the abdominal form of Wilson's Disease. Both our cases had the clinical, physical and biochemical findings of Wilson's hepato-lenticular degeneration; both had portal cirrhosis; but in only one case was there central nervous system lesions of Wilson's Disease.

Summary

Two cases of hepato-lenticular degeneration with autopsies are reported. The first case was a 22-year-old white male with a two year history of neurologic signs and symptoms and a diagnosis of organic mental disease. Kayser-Fleischer rings and a dermatosis were prominent in the first. Special laboratory findings included the following: total serum copper: 87.4 mgm/100 ml; direct reacting copper: 56.0 mgm/100 ml; indirect reacting copper: 31.4 mgm/100 ml; and copper oxidase: 0.034 units. The autopsy findings included: acanthosis nigricans, cirrhosis of the liver, cystic degeneration in the globus pallidus and putamen, intraventricular hemorrhage of the brain, splenomegaly and bronchopneumonia.

The second case was a 53-year-old white male with a 15-20 year history of neurologic signs and symptoms. Kayser-Fleischer rings were noted early in the course of the patient's disease but were less prominent at death. Special laboratory findings included only a copper oxidase of 0.032 units. The autopsy findings included the following: cirrhosis of the liver, cerebral atrophy with small areas of encephalomalacia, splenomegaly, nephrolithiasis, and acute and chronic pyelonephritis.

Acknowledgments

We wish to thank Dr. A. L. Drew, Department of Neurology, for his assistance; Dr. M. Ray Schmoyer, Community Hospital, Indianapolis, who performed the second autopsy and kindly supplied the tissues; Dr. Orville T. Bailey, professor of neuropathology, who supplied the special preparations and aided with interpretations.

The illustrations were prepared by Messrs. James F. Glore and Paris C. Johnson of the Department of Medical Illustrations.

REFERENCES

1. Barnes, S., and Hurst, E. W., Hepato-lenticular Degeneration. *Brain* 48: 279-333, 1925. Further note on hepato-lenticular degeneration. Ibid 49: 36-60, 1926.
2. Bramwell, B., Clinical studies; Familial Cirrhosis of Liver: From Cases of Acute Fatal Cirrhosis of Liver in Same Family, patients being respectively 9, 10, 14 and 15 years of age: suggested relationship to Wilson's progressive degeneration of lenticular nucleus. *Edinburgh M. J.* 17: 90-99, 1916.
3. Bickel, H., Neale, F. C., and Hall, G., A Clinical and Biochemical Study of Hepato-lenticular Degeneration (Wilson's Disease). *Quart. J. Med.* 26: 527-558, 1957.
4. Chalmers, T. C., Ceber, F. L., and Uzman, L. L., Hepato-lenticular Degeneration (Wilson's Disease) as a Form of Idiopathic Cirrhosis. *New Engl. J. of Med.* 256: 235-242, 1957.
5. Curth, H. O., The Significance of Acanthosis Nigricans. *Arch. Derm. & Syph.* 26: 80-100, 1952.
6. Drew, A. L., Robinson, E. V., Hanson, K. M., A Biochemical-genetic Study of Hepato-lenticular Degeneration. Not in print.

7. Ezzo, J. A. Rowley, J. F., and Finnegan, J. V. Hepato-lenticular Degeneration Associated with Acanthosis Nigricans. *Arch. Int. Med.* 100: 827-832, 1957.

8. Fleischer, B., Die Periphere Braungrunliche Hornhauverfarbung als Symptom Einer Eigennartigen Allgemeinerkrankung. *Munchen. Med. Wchnschr.* 56: 1120- , 1909.

9. Hall, H. C., La Degenerescence Hepatolenticulaire, *Masson,* Paris, 1921.

10. Hermann, H., Zur Erbpathologie der Acanthosis Nigricans. Z. Menschl. *Vererb.-Un. Konstitutionslehre* 33: 193-202, 1955.

11. Kayser, B., Ueber Einen Fall von Ausgeborener Grunliche Verfarbung der Cornea. *Klin. Monatsbl. Augenh.* 40: 22, 1902.

12. Kok, D. A., Acanthosis Nigricans: Report of a Case Associated with Hepatic Cirrhosis. *Brit. J. Derm.* 63: 317-322, 1951.

13. Lawrie, N. R., Carter, R. A., Acute Case of Wilson's Disease (Hepato-lenticular Degeneration). *Lancet* 1 (7034): 1309-1311, 1958.

14. Markowitz, H., Gubler, C. J., Mahoney, J. P., Cartwright, G. E., and Wintrobe, M. M., Studies on Copper Metabolism XIV. Copper, Ceruloplasmin, and Oxidase Activity in Sera of Normal Human Subjects, Pregnant Women and Patients with Hepato-lenticular Degeneration and the Nephrotic Syndrome. *J. Clin. Invest.* 34: 1489-1508, 1955.

15. Ravin, H. A., Rapid Test for Hepato-lenticular Degeneration. *Lancet* 270: 726-727, 1956.

16. Rumpel, A., Uber das Wesen und die Bedentung der Leberveranderungen und der Pigmentierungen bei den Damit Verbundenen Fallen von Pseudosklerose, Zugleich ein Beitrag zur Lehre von der Pseudosklerose (Westphal-Strumpell). *Deutsche Ztschr. Nervenh.* 49: 54, 1913.

17. Scharenberg, K. and Drew, A. L., The Histopathology of Wilson's Disease. *J. Neuropath. & Exp. Neuro.* 13: 181-190, 1954.

18. Strumpell, A., Ueber die Westphal'sche Pseudosklerose und Uber Diffuse Hirnsklerose, Insbesondere bei Kindern. *Deutsche Ztschr. Nervenh,* 12: 115-149, 1898.

19. Westphal, C., Ueber Eine dem Bilde der Cerebrospinalen Grannen Degeneration Ahnliche Erkrankung des Centralen Nerensystems ohne Anatomischen Befund, Nebst Einigen Bemerkurgen Uber Paradoxe Contraction. *Arch. Psychiat.,* 14: 87-134, 1883.

20. Wilson, S.A.K., Progressive Lenticular Degeneration: A Familial Nervous Disease Associated with Cirrhosis of the Liver. *Brain,* 34: 295-509, 1912. ◄

Notice to Our Contributors:

Due to the increased size of the JOURNAL, we have had to change our deadline.

ALL EDITORIAL COPY MUST BE IN THE JOURNAL OFFICE ON OR BEFORE THE 5TH DAY OF THE MONTH PRECEDING MONTH OF ISSUE

Rare form of scalp infection is now on the increase in Indiana. Efficacy of Griseofulvin in treatment is being studied.

Trichophyton Tonsurans Infection Of the Scalp in Central Indiana

HOWARD R. GRAY, M. D.
JOHN ERIC DALTON, M. D.
HELENE STARCS, M. S.
Indianapolis

TRICHOPHYTON tonsurans infection of the scalp can no longer be considered rare in the United States. It has been a major cause of tinea capitis in Mexico since before World War II[1] and in recent years its incidence has crept northward and has been noted in many sections of this country. This type ringworm infection of the scalp differs in several respects from Microsporum Audouini or lanosum which are the more common varieties. The absence of or only weak fluorescence of the involved hair is an important point of consideration.[2] Should an epidemic occur, the Wood's light examination could not be used as a screening test. The persistence of this disease past adolescence and its occurrence in adults also creates new problems.[3] A new public health problem exists and its recognition is important.[4]

Incidence

Incidence of this disease varies in different areas. In San Antonio, Texas 11% of cases of tinea capitis seen in a private practice were of this type.[5] A recent survey of 3,365 school children in Phoenix, Ariz. revealed 32 cases of tinea capitis and 3 or 9.3% were of this type.[6] In California the percentage of cases of tinea capitis of this type have varied from 11.78% in the Los Angeles area[7] to 16% in the San Francisco Bay area.[1] Cases have been reported from Indiana,[8] Maryland,[9] Massachusetts,[10] Michigan,[11,12,13] Minnesota,[14] Missouri,[15] Ohio,[16] Pennsylvania,[17] and Tennessee.[18]

In the past few years many of these cases have been presented at different society meetings throughout this country. Virginia Medical College noted an increase from 1.33% in 1951 to 8.08% cases of this type in 1955.[19] At Bellevue Hospital in New York 44 cases of superficial mycotic disease out of 664 seen during a six-year period ending in 1953 were caused by Trichophyton tonsurans. In 29 of these cases the scalp was involved.[20] At New York Skin and Cancer Clinic, however, no increase in incidence for the 20-year period ending in 1955 was noted.[21]

A recent tabulation of cases of tinea capitis cultured and identified at The Peter C. Reilly Laboratory of Mycology of The Alembert Winthrop Brayton Skin and Cancer Foundation of the Marion County General Hospital, Indianapolis, was done. This tabulation and follow up studies conducted on the cases of Trichophyton tonsurans seen during this period indicated the importance of this disease in Indiana and prompted this paper. During the period from July 1, 1953 through June 30, 1959, 655 cases of tinea capitis were seen, cultured and identified. The number and percentage of the different

From The Peter C. Reilly Laboratory of Mycology of The Alembert Winthrop Brayton Skin and Cancer Foundation of Marion County General Hospital, Indianapolis. Chairman: John Eric Dalton, M.D.

TABLE I

TABULATION of tinea capitis cases at Marion County General Hospital during the period July 1953 through June 1959.

	1953 July-Dec.		1954		1955		1956		1957		1958		1959 Jan.-June		Total	
	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
Microsporum Audouini	13	65	42	87.5	57	83.8	72	70.5	113	75.8	135	75.4	71	79.7	503	76.7
Microsporum lanosum	3	15	5	10.4	6	8.8	20	19.6	20	13.4	34	18.9	13	14.6	101	15.4
Microsporum gypseum	4	20	1	2.08	3	4.4	5	4.9	4	2.7	3	1.7			20	3.05
Trichophyton tonsurans					1	1.5	1	.98	9	6.04	4	2.2	5	5.6	20	3.05
Trichophyton Schoenleini							3	2.9							3	.45
Trichophyton verrucosum							1	.98			3	1.7			4	.6
Trichophyton violaceum									1	.67					1	.15
Trichophyton mentagrophytes					1	1.5			2	1.3					3	.45
Total	20		48		68		102		149		179		89		655	

TABLE II

Pt.	No.	Age	Sex	Duration	Stage of Disease When First Seen	Duration of Disease Before Kerion Formation	Comment
DS	1	5	F	42 mos.	Non Inflam.	No Kerion	X-ray Epilation
IG	2	10	F	2½ mos.	Kerion	1-2 Weeks	Very Severe
WS	3	8	M	2½ mos.	Kerion	2 Weeks	
PD	4	6	F	5 mos.	Kerion	10 Weeks	
SG	5	11	M	2½ mos.	Kerion	1-2 Weeks	
DB	6	3	M	3½ mos.	Non Inflam.	3-4 Weeks	
EB	7	3	M	2½ mos.	Non Inflam.	2-3 Weeks	Mild Kerion
EP	8	2	M	6½ mos.	Non Inflam.	20 Weeks	
CG	9	7	F	3 mos.	Mildly Inflam.	6 Weeks	Mild Kerion
LC	10	3	M	18 mos.	Non Inflam.	No Kerion	Cleared Without Kerion Formation
DG	11	3	F	2 mos.	Mildly Inflam.	1-2 Weeks	
OS	12	5	M	3 mos.	Kerion	2 Weeks	
RS	13	10	M	8 mos.	Kerion	24 Weeks	
SH	14	6	M	5½ mos.	Mildly Inflam.	No Kerion	X-ray Epilation
CK	15	6	F	5½ mos.	Kerion	10 Weeks	Severe Kerion
GH	16	4	F	3 mos.	Kerion	2 Weeks	
JJ	17	9	M	3½ mos.	Non Inflam.	No Kerion	Still under Treatment
BE	18	4	F	20 mos.	Mildly Inflam.	No Kerion	Still under Treatment
RE	19	3	M	11 mos.	Non Inflam.	No Kerion	Still under Treatment

Summary of Case Data

species are given in Table 1. For the whole six-year period 3.05% were Trichophyton tonsurans. A similar survey from this hospital covering a previous 5½-year period revealed 2.2% of the cases to be Trichophyton tonsurans.[8]

The increased incidence of Trichophyton tonsurans is more obvious when the last 2½ years are considered alone. During the past six years 20 cases of this type have been seen and all but two of these were in the past 2½ years. The percentage of tinea capitis caused by Trichophyton tonsurans was 6.04% in 1957, 2.2% in 1958 and 5.6% for the period January through June 1959. This points out the importance of keeping this disease in mind when treating diseases of the scalp especially in view of the varied clinical manifestations that may occur.

Out of the 20 cases of Trichophyton tonsurans infection of the scalp, adequate follow up, done either at the time the patient was originally seen or done since this study was started, was available on 19. These findings will be presented. The cases are listed in Table II.

Clinical Manifestations and Course

Ringworm of the scalp due to Trichophyton tonsurans usually fits clinically into one of three types. These are as follows: (1) Non-inflammatory type, (2) Mildly inflammatory type and (3) Kerion type.

The non-inflammatory type (Figure 1A) may present only patchy scaliness, resembling seborrheic dermatitis of the scalp and may at times give a typical "black dot" appearance. Seven (36.8%) of this group of 19 patients presented this picture when first seen. Many of the others gave a history of having noted the above slight changes prior to the onset of an inflammatory stage.

The second or mildly inflammatory type (Figure 1B) is characterized by the presence of a slight folliculitis or pustulation. This type may be associated with the scaly non-inflammatory type, with some areas of the scalp showing only patchy scaliness and other areas showing a folliculitis. There may be associated crusting. Four cases or 21%, when first seen, presented this picture.

The third or kerion type (Figure 1C) shows marked inflammation. This kerion formation does not differ from that due to other species of fungi. There is evidence of a great deal of tissue reaction in the areas of kerion formation with boggy elevated plaques being formed. These are usually crusted and show obvious secondary bacterial infection. Regional lymphadenopathy is usually present. Eight cases or 42% presented this picture when first seen.

Examination under Wood's light of these types of this infection is usually negative. Occasionally a whitish fluorescence is noted due to a small scale that attaches to the involved hair and plugs the follicle. When present this whitish fluorescence is of great value in selecting involved hair for culture and KOH examination. This was noted in four cases of this group.

The average duration of the non-inflammatory type was 12.2 months, the mildly inflammatory type 7.6 months and the kerion type 4 months. All of the patients in this group were Negro except one who was a Caucasian. In this series of cases there were eight or 42.1% females and 11 or 57.8% males. The inflammatory types seem to be more common in the female as only one out of the eight cases in females was the non-inflammatory type. Three of the eight were the mildly inflammatory type and four of the eight presented with kerion formation. The 11 male cases presented as follows: six cases were non-inflammatory, one case was mildly inflammatory and four cases had kerions. The age when first seen varied from two to 11 years with an average age of 5.6 years. No adults were noted in this group even though many were examined in the process of checking parents and siblings of infected patients. However, this type ringworm is a major cause of adult tinea capitis in some areas.[3]

The lower incidence of this type tinea capitis in females of this group corresponds to that noted in the other types of ringworm of the scalp.[10,18] This lower incidence along with the tendency for the females in this group to present with the inflammatory types would suggest that females possess more immunity or resistance to this infection. When infection does occur in the female it seems to be more apt to result in kerion formation. This is thought to represent reaction on the part of the host by the immune mechanism in overcoming the infection.

Treatment

Duration of this disease varies as noted above. In the past the course has not been appreciably altered by treatment with the exception of x-ray

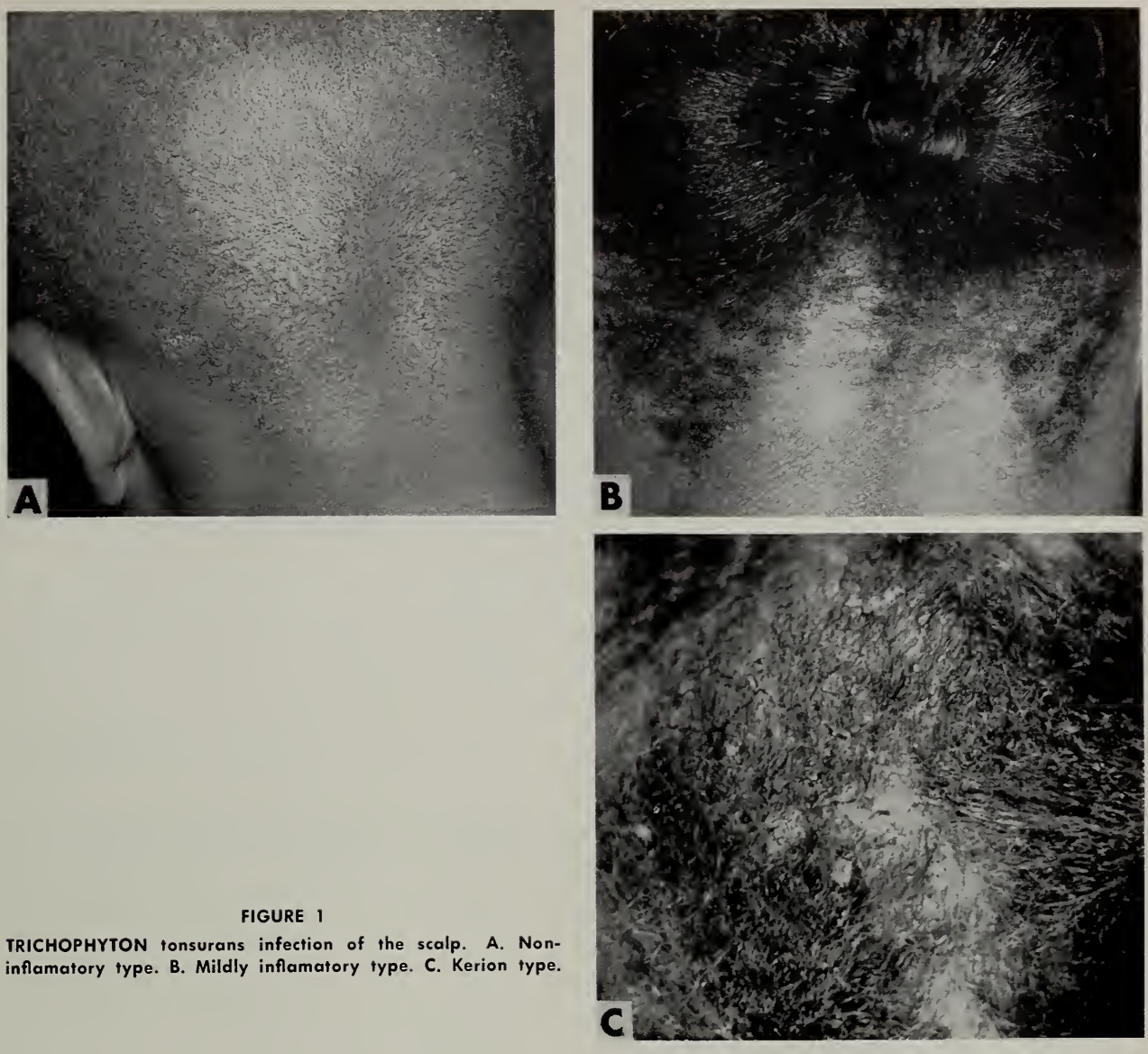


FIGURE 1

TRICHOPHYTON tonsurans infection of the scalp. A. Non-inflamatory type. B. Mildly inflamatory type. C. Kerion type.

epilation. This has been considered the treatment of choice for the non-inflammatory type in the past. Since the advent of griseofulvin, treatment will have to be reevaluated.[22] Three of these cases, case numbers 17, 18 and 19, still had the disease at the time this paper was written. These three patients were placed on griseofulvin and the results of this treatment will be reported later.

In this group of 19 cases two received x-ray epilation and were cured after this. One had the disease 3½ years and one 5½ months before the x-ray epilations.

All of the cases began either as mildly inflammatory or as non-inflammatory before forming a kerion. After kerion formation occurred, 6 to 12 weeks were required for the reaction to subside. The time required depends upon the severity of the reaction. Only one case of this group eventually cleared without forming a kerion and this was a three year old boy that remained the non-inflammatory type throughout its course of 18 months of topical therapy.

Permanent baldness or scarring is usually not noted in this type ringworm of the scalp. It could conceivably occur though should the inflammatory changes be severe enough. This was not noted with any of these cases. Discoid lupus erythematosus-like changes have been noted in some cases.[11, 23]

Summary

Trichophyton tonsurans infection of the scalp has had an increase in incidence in Central Indiana the past few years. A previous survey from this hospital revealed 2.2% of cases of tinea capitis were of this type. In 1957 6.04% were of this type, 2.2% in 1958 and 5.6% in January

through June 1959. There is a tabulation of all cases of tinea capitis seen, cultured and identified during the past six years at Marion County General Hospital, Indianapolis, Indiana. Twenty cases of Trichophyton tonsurans infection of the scalp were seen and adequate follow up was obtained on 19 of these. Results of this follow-up are presented.

REFERENCES

1. Joseph, H. L., and Halde, C.: Tinea Capitis Due to Trichophyton Tonsurans Incidence, Diagnosis, and Epidemiology in the San Francisco Bay Region, *Calif. Med.* 83:371-375 (Nov.) 1955.
2. Levin, O. L., and Behrman, H. T.: The Problem of Nonfluorescent Ringworm of the Scalp, *J.A.M.A.* 128:350-352 (June) 1945.
3. Pipkin, J. L.: Tinea Capitis in the Adult and Adolescent, *A.M.A. Arch. Dermat. and Syph.* 66:9-40 (July) 1952.
4. Georg, L. K.: Trichophyton Tonsurans Ringworm, New Public Health Problem, *Pub. Health Rep.* 67:53-56 (Jan.) 1952.
5. Lehmann, C. F., Pipkin, J. L., and Ressmann, A. C.: Cultural Survey of Tinea Capitis in San Antonio, Texas, *A.M.A. Arch. Dermat. and Syph.* 61:488 (Mar.) 1950.
6. Mullins, J. F.: Trichophyton Tonsurans Infection in Tinea Capitis Survey, *A.M.A. Arch. Dermat. and Syph.* 69:438-440 (Apr.) 1954.
7. Price, H. and Taylor, D. R.: Trichophyton Tonsurans (Crateriforme) Infection of the Scalp, *Calif. Med.* 76:283-288 (Apr.) 1952.
8. Jones, R. W., Holsinger, R. E., Armstrong, B. H., and Lohrman, R.: Cultural Survey of Tinea Capitis in Central Indiana, *A.M.A. Arch. of Dermat. and Syph.* 69:494 (Apr.) 1954.
9. Sullivan, M. and Wood, J. L.: Trichophyton Tonsurans Infection of the Scalp, *A.M.A. Arch. Dermat,* 71:398-399, 1955.
10. Swartz, J. H., Rockwood, E. M., and Glicklich, E. A.: A Survey of Tinea Capitis, Including Favus, *A.M.A. Arch. Dermat. and Syph.* 60:486-494 (Oct.) 1949.
11. Georg, L. K., Hand, E. A., and Menges, R. A.: Observations on Rural and Urban Ringworm, *J. Invest. Dermat.,* 27:335-351, 1956.
12. Slaughter, J. C. Jr., and Cawley, E. P.: Infection of the Glabrous Skin Instigated by the Fungus Trichophyton Sulfureum, *J. Invest. Dermat.,* 9:63-64, 1947.
13. Hand, E. A., and Georg, L. K.: Trichophyton Tonsurans Ringworm, *J. Mich. M. Soc.* 54:687-690 (June) 1955.
14. Hill, E. M., Zelickson, A. S., and Orkin, M.: Trichophyton Tonsurans in Minnesota, *A.M.A. Arch. Dermat.* 76:206-207, 1957.
15. Moore, M., and Wooldridge, W. E.: Kerion Caused by Trichophyton Sulfureum, *A.M.A. Arch. Dermat. and Syph.* 61:460-465 (Mar.) 1950.
16. Simon, C. R., and Schwarz, J.: Trichophyton Sulfureum in Southern Ohio Area, *A.M.A. Arch. Dermat. and Syph.* 68:335-336 (Sept.) 1953.
17. Kligman, A. M., and Constant, E. R.: Family Epidemic of Tinea Capitis Due to Trichophyton Tonsurans (Variety Sulfureum), *A.M.A. Arch. Dermat. and Syph.* 63:493-499 (Apr.) 1951.
18. Shaw, C.: Tinea Capitis in Southeastern Tennessee, *A.M.A. Arch. Dermat. and Syph.* 55:258-259 (Feb.) 1947.
19. Reid, J. D., and Carter, E. B.: Tinea Capitis Infection in Virginia, *Va. Med. Mon.* 83:261-262, 1956.
20. Reiss, F.: Trichophyton Tonsurans Ringworm; Contribution to Epidemiology and Rare Clinical Manifestations, *Brit. J. Dermat.* 66:239-243 (July) 1954.
21. Franks, A. G., and Taschdjian, B. S.: Incidence and Etiology of Tinea Capitis, *A.M.A. Arch. Dermat.* 74:349-351, 1956.
22. Blank, H., and Roth, F. J. Jr.: The Treatment of Dermatomycoses with Orally Administered Griseofulvin, *A.M.A. Arch. Dermat. and Syph.* 79:259-266 (Mar.) 1959.
23. Howell, J. B., Wilson, J. W., and Caro, M. R.: Tinea Capitis Caused by Trichophyton Tonsurans (Sulfureum or Crateriforme), *A.M.A. Arch. Dermat. and Syph.* 65:194-205 (Feb.) 1952. ◄

Recipe for Happiness

Adopt a degree of pleasant mediocrity with no regret for the past. Regret gnaws as deeply at our health as worrying about the future.

Dr. Sara M. Jordan
Quote



PATCH TESTS reactions—right thorax. (1.) Sulfur precipitate and resorcin 1% each in petrolatum vesicular reaction with flaring. (2.) Sulfur precipitate 1% in petrolatum, vesicular reaction with flaring. (3.) Hexachlorophene 1% in petrolatum, negative. (4.) Resorcin 1% in petrolatum, negative. (5) Acne remedy containing sufur precipitate, resorcin, hexachlorophene, vesicular reaction with flaring.

A Case Report:

Sensitivity to Elemental Sulfur

L. EDWARD GAUL, M.D.

Evansville

QUITE OFTEN, the unexpected is found in patch test results. The case in point is a white male, aged 20, who was seen in February, 1959 for an acute and edematous dermatitis affecting the face and neck. The onset followed the use of an acne remedy containing sulfur and resorcin. Patch tests disclosed a 3+ reaction to the remedy, but no response to resorcin. A mild primary irritant action from sulfur is rather common, but its ability to act as a sensitizer was not suspected. More tests were refused, but the patient promised to call at once if another attack developed.

Four months later there was a recurrence. This attack was the same as the first one. Again, an acne remedy containing sulfur, resorcin, allantoin and hexachlorophene had been applied to the face. The reaction time was less than 24 hours. A shower of "ids" develops over the upper torso at the height of the most severe phase of the dermatitis which was the third day following the onset. This was taken to indicate the presence of a sensitizer. A patch test with the remedy provoked a 3+ reaction; the resorcin was negative. Patch tests performed to isolate the sensitizer and the results are shown above.

A cursory review of recent literature disclosed only a few references. Allington[1] obtained a positive reaction to sulfur precipitate 2% in an ointment in a patient sensitive to matches. Elemental sulfur seemingly can produce an allergic eczematous contact dermatitis. This etiology can be confirmed by positive patch test to sulfur precipitate 1% in petrolatum.

BIBLIOGRAPHY

1. Allington, H. V., Sulfur Dermatitis Due to Matches with Flare-up Secondary to Internal Administration of sulfur. *Arch. Derm. & Syph.* 40:507, 1939. ◄

wherever there is inflammation, swelling, pain

VARIDASE®

Streptokinase-Streptodornase Lederle

BUCCAL Tablets

conditions for a fast & comfortable comeback

Host reaction to injury or local infection has a catabolic and an anabolic phase. The body responds with inflammation, swelling and pain. In time, the process is reversed. VARIDASE speeds up this normal process of recovery. By activating fibrinolytic factors VARIDASE shortens the *undesirable phase,* limits necrotic changes due to inflammatory infiltration, and initiates the constructive phase to speed total remission. Medication and body defenses can readily penetrate to the affected site; local tissue is prepared for faster regrowth of cells. In infection, the fibrin wall is breached while the infection-limiting effect is retained. In acute cases, response is often dramatic. In chronic cases, VARIDASE Buccal Tablets can stimulate a successful response to primary therapy previously considered inadequate or failing.

for routine use in injury and infection
...new simple buccal route

VARIDASE Buccal Tablets should be retained in the buccal pouch until dissolved. For maximum absorption, patient should delay swallowing saliva.
Dosage: One tablet four times daily usually for five days. When infection is present, VARIDASE Buccal Tablets should be given in conjunction with ACHROMYCIN® V Tetracycline with Citric Acid.
Each VARIDASE Buccal Tablet contains: 10,000 Units Streptokinase and 2,500 Units Streptodornase.
Supplied: boxes of 24 and 100 tablets.

1. Innerfield, I.: Clinical report cited with permission
2. Clinical report cited with permission

Lederle LEDERLE LABORATORIES, a Division of AMERICAN CYANAMID COMPANY
Pearl River, New York

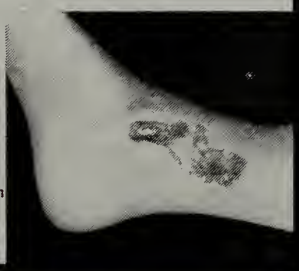


FORCE INJURY
severe bruises
. . . swelling
. . . cleared
by fifth day[2]





VARICOSE ULCER
15 years duration
. . . resolved with
VARIDASE[1]



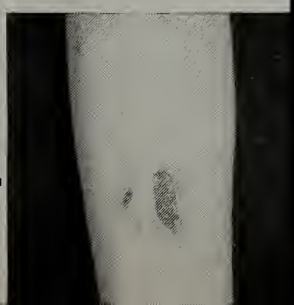


INFLAMMATORY DERMATOSIS
rapidly spreading
rhus dermatitis
healed within
a week[1]





INFECTED LACERATION
marked reversal
in 3 days . . .
returned
to school . . .
closure advanced[1]





THROMBOPHLEBITIS
back on his feet
in a week after
recurrent episode[1]





REFRACTORY CELLULITIS
normal routine
resumed after 4 days
of VARIDASE[1]



The stomach is not invulnerable. What goes into it may cause trouble.

Salicylates and the Stomach

*J. W. HURLEY, M.D.**
*J. H. IVY, M.D.**
*B. A. McART, M.D.***
Elkhart

"The Too Constant Use of Even Good Things is Hurtful." Publius Syrus.

SALICYLATES HAVE BEEN effectively employed in clinical medicine for over 2,000 years.[1] Hippocrates, Celsus and Pliny used willow leaves containing salicin and methyl salicylate to treat labor pains, sciatica and gout. In 1763, Reverend Edward Stone[2] reported the antipyretic effect of willow bark; however, it remained until 1874 for Kolbe and Lautemann[3] to make available synthetic salicylates, which opened the modern chapter of their use.

The ubiquitousness of salicylates in recent times is attested by the abundance of advertising copy directed at the medical profession and the public urging increased utilization of the readily available salicylates and related compounds. The American industry's production of 20 million pounds of salicylates (representing 28 billion aspirin tablets) yearly substantiates the effectiveness of the advertising and the availability of these medicants. Most individuals tolerate salicylates well even when self administered. However, many experience gastrointestinal symptoms after the use of relatively small amounts of the drug. Although Balz[1] pointed out gastric disturbances could result from the ingestion of salicylates, there are no criteria presently available to predict with certainty which individuals will be so affected. It is the purpose of this report to review the data relating to the effect of salicylates on the stomach and to attempt to determine what factors may be important in anticipating adverse reactions. Several cases illustrating these effects will be presented.

* From the Department of Medicine, Elkhart Clinic and Elkhart General Hospital.
** From the Department of Surgery, Elkhart General Hospital.

Salicylates and the Normal Gastric Mucosa

The effect of large doses of aspirin on the gastric mucosa of the experimental animal was first reported in the European literature by Chistoni and Lapresa[4] in 1909. Following the administration of 150 to 200 milligrams of aspirin, edema and petechael hemorrhages were noted in the stomach of the dog. Stutzman[5] in 1941 described gastric ulcers in rabbits given 300 milligrams of aspirin in a single dose and in dogs in whom 200 milligrams per kilogram of body weight were administered orally for five days.

Gastric retention and an increase in gastric acidity in humans given 1 to 2 gm of salicylates was described by Schnedorf, Ivy, *et al.*[6] Sodium bicarbonate, and to a lesser extent, calcium gluconate increased the pH of the stomach and decreased retention. Wolf and Wolff[7] noted the local application of aspirin on Tom's stomach had no effect. Gompertz[8] injected salicylates intra-

venously in a comatose patient and found no change in the stomach.

The gastroscope has been used by several investigators to evaluate the effects of aspirin and related compounds on the human stomach. Doughwaite[9] found mucosal reactions varying from slight hyperemia to submucosal hemorrhage when aspirin was introduced into the fasting, aspirated stomach. Interestingly, the response was elicited primarily on the lesser curvature and was not, in his opinion, related to acidity. Calcium salicylate, a more soluble compound than acetyl salicylate, produced considerably less mucosal change. Muir[10] was able to consistently produce acute gastritis and hemorrhage upon giving a patient two 0.3 gm aspirin tablets prior to gastroscopy. When the relatively insoluble particles lodged in a gastric fold, an acute ulcer could often be found beneath it. Significantly, this investigator noted some patients had more tolerance to aspirin and the gastroscopic picture was relatively normal in these.

Contrary to these findings, Paul[11] studied 107 patients to whom 0.9 gm of aspirin was administered immediately prior to gastroscopy. No abnormality except pylorospasm was found. This work has been criticized by Doughwaite because the stomachs were not aspirated prior to the introduction of the drug. The study was, however, confirmed by Cervanti[12] who, in 20 endoscopic examinations, found no mucosal changes after either intravenous or oral administration of salicylates.

Gastric Hemorrhage and Salicylates

The possibility of salicylates causing upper gastrointestinal hemorrhage has been studied from a statistical standpoint by numerous investigators. In 166 consecutive patients with upper gastrointestinal bleeding, Muir[10] found 35% had taken aspirin in the 6 hours preceding the onset of bleeding. Twenty two (69.5%) of 32 patients who had bleeding duodenal ulcers and 26 (72%) of 36 patients with hemorrhage from gastric ulcers studied by Brown[13] took salicylates in the week prior to hospital admission and 20.8% of both groups had taken the drug in the 24 hours prior to hemorrhage. Although Waterson[14] analyzed 165 patients with hemorrhage from the standpoint and found salicylates "were not too important"; Lange[15] in Norway found 56% of the patients studied with no x-ray evidence of a probable source of bleeding had taken aspirin significantly close to the bleeding episode. He also found 37% of the patients who hemorrhaged and had positive x-rays of the upper intestinal tract had ingested salicylates. Alverez[16] studied 103 patients with peptic ulcer in whom massive bleeding as well as melena occured. Over 40% of these hemorrhages closely followed ingestion of salicylates. This author stated bleeding is much more likely to occur in patients with peptic ulcer than in non-ulcer patients.

Occult bleeding from the gastrointestinal tract in arthritic patients before and after salicylate therapy was investigated by Lange.[17] The ratio of benzidine positive to negative stools before treatment was 1 to 7. However, after treatment, the ratio decreased to 1 benzidine positive to 2.8 negative. The more soluble calcium salicylate produced less occult bleeding. Enteric coating of the drug made no difference in the frequency of the occult bleeding and the conclusion was the coating material was ineffective or, less likely, the small bowel may have been effected.

Mechanism of Action of Salicylates on the Stomach

Roskam[18] said the salicylate's action was mediated through the adrenal pituitary system. While increased adrenal secretion is an attractive hypothesis, there is little conclusive evidence such exists. Smith[19] and Bayliss[20] found circulating blood levels of salicylates up to 38 mgm % did not increase the serum or urinary adrenal cortico steroids. Kirsner[21] pointed out adrenal hormones produce few peptic ulcers nor consistent elevation of the gastric acid.

Although a "hemorrhagic diathesis" resulting from salicylates had been a popular concept in the past, there is little to substantiate it. Freck[22] noted some increase in the capillary fragility when the dose level reached 10 gm per day. Beaumont,[13] in Paris, stated aspirin produced some decrease in platelet adhesiveness, and a tendency toward prolongation of bleeding time. This worker agreed with Alverez[16] that salicylates do not significantly effect the prothrombin time. Kirsner[21] summarized the consensus of opinion by stating the bleeding after salicylates was not related to its effect on capillaries or prothrombin time.

Increased gastric acidity after aspirin ingested noted by Schnedorf[6] and Muir[10] is probably an important mode of action of salicylates. Acid

secretion is not the only mechanism; however, since, Alverez[16] reported a patient with pernicious anemia who bled from the stomach following salicylates. Muir[10] in arguing against the acid mechanism of action, could find only one instance of perforation of a peptic ulcer after salicylates. Kirsner[21] found the single dose of aspirin produced no significant change in the secretion of hydrochloric acid. He felt the increased tissue susceptibility of certain patients, particularly those with peptic ulcers, was the basis for the production of bleeding or gastritis following salicylates. It is possible, therefore, the bleeding in patients with peptic ulcer may be occuring from the gastric mucosa which is not sufficiently resistant to the irritating action of salicylates.

Muir[10] stated the low solubility of the aspirin particles was the cause of the acute erosive gastritis. In a few patients, Doughwaite[9] found the more soluble calcium salicylates less irritating. However, Alverez[16] noted the more soluble salicylates equally capable of producing occult bleeding. An allergic mechanism, demonstrated by Barbour,[24] who injected salicylates intravenously and produced gastritis in sensitized rats, has not been accepted to account for the change in humans.

Case Material

Five cases are briefly presented to illustrate the possible relationship between salicylates and gastric disturbances.

CASE 1.* A 32-year-old male was admitted to St. Peter's Hospital Oct. 28, 1957, with severe epigastric pain. For the preceding 18 months he experienced post-prandial eructation of a mild nature. An upper gastro-intestinal x-ray performed at another hospital four months before admission was considered normal. Because of malaise and an upper respiratory infection occuring in the week preceding admission, several aspirin tablets were taken each day. Severe epigastric pain commenced on the day of admission. Physical examination revealed only marked tenderness in the epigastrium without signs of peritonitis. Subsequent x-rays of the stomach suggested gastritis. Gastroscopy performed several days after therapy consisting of a bland diet, anticholinergic drugs and antacids, revealed two shallow, benign appearing gastric ulcers on the lesser curvature.

CASE 2. On Jan. 12, 1959, a 49-year-old salesman who complained of intermittent epigastric pain for about 10 years was admitted to the Elkhart General Hospital. Repeated gastrointestinal x-rays in the past had disclosed no abnormalities. He had a moderately heavy alcohol intake for years. Epigastric pain with hematemesis and melena started several days before admission and followed the ingestion of 6 salicylate-containing tablets. Physical examination revealed only pallor and a slightly enlarged liver. Neither an upper gastrointestinal x-ray nor an esophagoscopy disclosed the source of bleeding. Because of continued severe hemorrhage, surgical exploration was undertaken. The resected stomach contained superficial mucosal erosions and ecchymoses. No duodenal ulcer could be found.

CASE 3. A 71-year-old male, who was admitted to the Elkhart General Hospital on Dec. 30, 1958, stated lower abdominal cramp-like pain and constipation started 3 months prior to admission. For the relief of pain, he took 0.6 to 1.8 grams of aspirin daily. Four weeks prior to admission, epigastric pain was noted for the first time and vomiting occurred for several days preceding admission.

Physical examination revealed a tender epigastrium and a succusion splash. Gastric aspiration removed 1800 cc of dark, liquid stomach contents. The gastrointestinal x-ray performed five days after relief of gastric retention was normal; however, the presence of diverticulitis of the sigmoid colon was discovered on x-ray examination of the colon by means of a barium enema. Gastroscopy 7 days later revealed a diffuse, acute superficial gastritis.

Comment

Cases 1, 2 and 3 represent examples of gastric ulceration, gastritis and gastric retention occuring in close relationship to the ingestion of relatively large amounts of salicylates. In Case No. 2, bleeding was massive and required emergency gastrectomy. Two of these individuals (Cases 1 and 2) had preceding symptoms suggesting a peptic ulcer although roentgenographic studies had been negative.

CASE 4.* On Jan. 29, 1957, a 62-year-old clerk entered St. Peter's Hospital because of hematemesis which occured after taking "considerable quantities" of a salicylate-containing

compound because of an upper respiratory infection in the three days prior to admission. A duodenal ulcer was said to be responsible for two previous episodes of bleeding; however, symptoms had not occured in the three preceding years. In spite of blood transfusions and careful management, bleeding recurred after 36 hours of hospitalization and gastric resection was carried out after the ligation of a bleeding vessel in a very shallow duodenal bulb ulcer.**

Comment

Salicylates in this case may have been instrumental in reactivating, via acid production, a relatively quiescent duodenal ulcer.

CASE 5. A physician, 40 years of age, entered Elkhart General Hospital on Jan. 9, 1959, with sudden severe upper abdominal pain. Mild epigastric pain had been present for 6 months. In the 2 months preceding admission, 4-6 aspirin tablets had been taken daily to relieve a persistent backache. Physical examination revealed a rigid abdomen and free air was demonstrated by x-ray examination of the abdomen. A perforated gastric ulcer located on the anterior wall near the pylorus was closed surgically. Very little induration was noted in the surrounding gastric tissue. The recovery was uneventful.

Comment

Perforation of a peptic ulcer has been *rarely* attributed to salicylates. While the ulcer in this case may have been of long standing, its fulminating course may have been influenced by the effect of aspirin.

Summary and Conclusion

Enormous quantities of aspirin are ingested by the American public with apparent impunity. However, experimental, as well as statistical, evidence indicates salicylates can account for serious gastric disturbances, particularly bleeding. The familiar pattern of exacerbation of ulcer symptoms in the spring and fall may be related to increased salicylate ingestion because of respiratory infections prevalent at these times. This, however, is speculative at the moment. The mechanism of action of salicylates upon the stomach is not certain. In many instances, the basic lesion may be an erosive gastritis produced by local action of the salicylate particle; however, increased production of hydrochloric acid may also be a factor in producing activity in existing peptic ulcers. It does seem reasonable some individuals, particularly those with peptic ulcer, may be exceedingly sensitive to the irritating action of these drugs. In these patients, salicylate therapy should be undertaken with extreme caution.

405 South Second Street,
Elkhart

---

* Cases 1 and 4 observed at St. Peter's Hospital, Olympia, Washington by one of us (JWH).

** Surgery performed by T. R. Hazelrigg, M. D., Memorial Clinic, Olympia, Wash.

BIBLIOGRAPHY

1. Gross, M., Greenburg, L. A., *The Salicylates,* Hillhouse Press, New Haven, 1948.
2. Stone, E., An Account of The Success of The Bark of The Willow in Cure of Agues, *Philos. Trans.* 53:195-700, 1763. Cited by Gross, M., & Greenburg, L. A., *The Salicylates,* Hillhouse Press, New Haven, 1948.
3. Kalbe, H., & Lautemann, Ueber die Constitution and Bosecitat der Salicylsoure, *Tiebigs. Ann.* 115:157-306, 1860. Cited by Gross, M., & Greenburg, L. A., *The Salicylates,* Hillhouse Press, New Haven, 1948.
4. Christoni, A., & Topresa, F., Richerche Farmalologiche Sull Asspirinia, *Arch. Farrmarol* 8:63-80, 1909. Cited by Gross, M., & Greenburg, L. A., *The Salicylates,* Hillhouse Press, New Haven, 1948.
5. Stutsmann, J. W., Orth, O. S., Mellish, C. H., A. Comparison of Calcium Acetylsalicylate to Acetylsalicylic Acid, *J. Pharmocol.,* 43:420-430, 1941.
6. Schnedorf, J. G., Bradley, W. B., Ivy, A. C., Effect of Acetylsalicylic Acid Upon Gastric Activity and The Modifying Action of Calcium Gluconate and Sodium Bicarbonate, *Am. J. Digest., Diseases & Nutrition* 3:239-244, 1936.
7. Wolf, S., Wolff, H. G., *Human Gastric Function,* Oxford Univ. Press, London, 1943.
8. Gumpertz, M. L., Schlenher, F. S., Kier, J. H., Marjoral, J. W., Crews, J., Gastric Secretory Studies During Prolonged Salicylate Administration in a Comatose Patient, *Gastroent.* 35:369-373, 1958.
9. Doughwaite, A. H., Tintatt, G. A., Gastroscopic Observation of the Effect of Aspirin and Certain Other Substances, *Lancet* 235:1222-1224, 1938.
10. Muir, A., Cossor, I. A., Aspirin and Ulcer, *Brit. M. J.,* 2:7-12, 1955.
11. Paul, W. D., The Effect of Acetylsalicylic Acid on the Gastric Mucosa, *J. of Iowa State Med. Assoc.,* 33:155-158, 1943.
12. Cervanti, C. M., Cosgrove, E. F., Salicylate Toxicity: The Probable Mechanism of Action, *Ann. of Int. Med.,* 24:618-624, 1946.

13. Brown, R. K., Mitchell, N., Influence of Some of The Salicyl Compounds (and Alcoholic Beverages) On the Natural History of Peptic Ulcer, *Gastroent.* 30:198-203, 1956.

14. Waterson, A. P., Aspirin and Gastric Hemorrhage, *Brit. Med. J.* 2:1531-1533, 1955.

15. Lange, H. F., Salicylates and Gastric Hemorrhage, Manifest Hemorrhage, *Gastroent.* 33:778-787, 1957.

16. Alvarez, A. S., Summerhill, W. H. J., Gastrointestinal Hemorrhage and The Salicylates, *Lancet* 2:920-925, 1958.

17. Lange, H. F., Salicylates and Gastric Hemorrhage I: Occult Bleeding, *Gastroent.* 33:770-777, 1957.

18. Roskam, J. A., VanCauwenberge, H., Musters, A. S., Effect of Sodium Salicylates on Circulating Eosinophiles and Urinary Uric Acid: Creatinine Ratio, *Lancet* 2:378-381, 1951.

19. Smith, M. J. H., Gray, C. H., Lumin, J. B., Urinary Secretion of Adrenocortical Steroids by Patients Receiving Salicylates, *Lancet* 1:1008-1009, 1954.

20. Bayliss, R. I. S., Steinbeck, A. W., Salicylate and Plasma Level of Adrenal Steroid, *Lancet* 1:1010-1011, 1954.

21. Kirsner, J. B., Drug Induced Peptic Ulcer, *Ann. Int. Med.* 47:666-669, 1957.

22. Freck, P. G., Hemorrhagic Diathesis With Increased Capillary Fragility Caused by Salicylate Therapy, *Am. J. of Med.,* 231:402-406, 1956.

23. Beaumont, J. L., Communication to the Editor, *Lancet* 2:1287-1288, 1958.

24. Barbour, H. G., Dickerson, V. C., Allergic Responses to Salicylates, *Arch. Int. Pharmacodyn,* 58:78-81, 1938. ◄

Tetanus Protection Should be in Polio Vaccine

The Student American Medical Association, Chicago—All polio vaccine should contain tetanus toxoid to help control the horrible disease, lockjaw. Each year, tetanus kills almost twice as many children and adults as polio, yet only one out of four persons are protected.

In an editorial in the December, 1958 *New Physician,* official journal of The Student American Medical Association, Dr. Edward R. Pinckney, the journal's editor, made a two-fold plea to the medical profession and the pharmaceutical industry to wipe out lockjaw. Doctors should make as much a habit to ask about tetanus immunizations as they do about polio immunizations. The drug companies should combine tetanus toxoid with polio vaccine so one series of "shots" will protect against both dangers.

"Of equal importance, doctors must make patients aware of the fact that they, or their children, have been immunized, in order to inform any doctor in the future who may have to treat a subsequent injury," Dr. Pinckney said.

With 75% of those who have "tetanus-prone" wounds *needing* antitoxin (which can be as dangerous as the disease itself because of possible allergic reactions) there can be no doubt that prevention is almost mandatory. That the vaccine works has been proved during World War II when there was only one case of lockjaw in more than 160,000 battle injuries. Tetanus prophylaxis was mandatory for service men.

Doctor Pinckney is associate professor of preventive medicine at the College of Medical Evangelists and in the private practice of internal medicine in Beverly Hills, Calif.

Prompt recovery from quinidine induced purpura due to early recognition of sensitivity.

A Case Report:

Quinidine Purpura

D. EDMUND STOREY, M. D.

Indianapolis

THROMBOCYTOPENIC PURPURA, secondary to quinidine administration, has been recognized since 1927; however, Bishop, Spencer and Bethell[1] in a paper published in May, 1959 stated that up to the time of the writing of their paper only 47 cases of purpura due to quinidine administration had been recorded in the literature. This included six cases which they reported in the *Annals of Internal Medicine*. They state that purpura due to quinidine sensitivity is undoubtedly rare when the total number of patients receiving quinidine is considered. Bolton and Dameshek[2] have pointed out that quinidine now seems to be the most common cause of thrombocytopenia as a manifestation of hypersensitivity to chemical substances.

It is the object of this report to detail a case of thrombocytopenia associated with quinidine administration in a 71-year-old white male.

Case Report

A 71-year-old white male was seen in the office initially on Dec. 19, 1958 complaining of intermittent irregular heart action usually associated with tension for one month prior to the time of the visit. He stated it was relieved by reading, resting or using small amounts of whiskey. He stated that he had previously been treated with quinidine for "spasms." Other cardiovascular symptoms elicted from the patient was a past history of hypertension and a "lightning-like" pain which radiated up from the epigastrium into the sternum and into the shoulders. The past history revealed a sensitivity to sulfa drugs which was manifested by a skin rash and petechiae. According to the patient, these had cleared promptly with the cessation of the drug and the administration of Vitamin K. The family history was negative for hemopoietic diseases.

Physical examination revealed a well developed, well nourished, white male who appeared to represent his chronological age. His color was good without evidence of cyanosis or jaundice. There was no evidence of skin rash. He was very tense and hyperkinetic and had several habit tics of his speech and of the muscles of the abdomen. The fundi could not be visualized because of bilateral cataracts. The weight was 177 lbs., the temperature was 100 and the respirations were 16 per minute. The systolic blood pressure in the left arm sitting was 168 while in the right arm it was 158. The diastolic blood pressure in the left arm was 100 while in the right arm it was 90.

Examination of the heart revealed an irregular rhythm with a pulse deficit which seemed to occur with every third pulsation. The heart tones were normal and no murmur was detected. The liver was not palpable. Proctosigmoidoscopy examination of the rectum and sigmoid colon was normal. Examination of the prostate revealed moderate enlargement of the left lobe of the prostate. There was no peripheral edema. Neurological examination was normal with an

intact vibratory sense. The remainder of the physical examination was within normal limits for a man of this age.

Fluoroscopic examination of the chest revealed some widening and calcification in the aorta with slight enlargement of the heart. The lungs were clear. The mediastinum appeared normal and both diaphragms moved well.

A standard 12 lead electrocardiogram revealed changes consistent with an old anterior myocardial infarction plus multiple premature ventricular systoles. There were about 20 premature ventricular systoles occuring every minute. The only changes when compared with a 1957 electrocardiogram were the multiple premature ventricular systoles.

The hemoglobin was 16 gm. with a hematocrit of 47%. The sedimentation rate was 6 mm/hr. The white blood count was 4750 with 44 lymphocytes, 45 neutrophils, 5 eosinophils, 1 basophil and 5 monocytes. The cholesterol was 286 mg%. Urinalysis was normal.

Because of the history of previously having taken quinidine the patient was placed upon quinidine 200 mg. three times daily. The patient returned to the office on December 26 at approximately 1:00 p.m. He reported that his heart action was markedly improved and that he could detect no changes in the rhythm of his heart. Examination revealed an occasional premature beat occurring one with every 20 cardiac pulsations. The patient was instructed to reduce the quinidine to 200 mg. twice daily. At approximately 11:00 p.m. on the same date, Dec. 26, 1958, the patient reported by phone that he had developed a generalized rash of the body with "petechiae" and had a large "blood clot" on his tongue. He also reported he had been spitting up small amounts of blood which seemed to be coming from his naso-pharynx. He was instructed to stop the use of quinidine immediately.

The patient was examined the next day on Dec. 27, 1958. He had generalized petechiae covering his whole body. There were petechiae scattered throughout the mucous membranes of the mouth and pharynx and the patient had a large hemorrhage on the dorsal surface of his tongue measuring approximately 2½ cm in diameter. This patient disliked taking any medication but he was nonetheless carefully questioned and denied taking any drugs or chemicals except quinidine. Examination of the blood on Dec. 29, 1958 revealed a prothrombin time of 13.5 seconds or 94% and a platelet count of 105,000 per cubic mm. Clot retraction revealed partial retraction only in 24 hours. On the advice of a hematologist the patient was placed upon Medrol 4 mg every six hours plus Vitamin K1 15 mg daily.

Examination of the patient on Jan. 2, 1959 revealed that the hemorrhagic areas were subsiding rapidly although the patient had a slough on his tongue covering the site of the previous hemorrhage. The temperature was 100.4, the systolic blood pressure was 165 and the diastolic blood pressure was 75. The pulse rate was 95 per minute and multiple premature systoles were present at about 9-10 premature systoles per minutes without a pulse deficit. The liver was down approximately 1 cm. below the right costal margin and there was a friction rub in the left lower chest.

A platelet count on Jan. 6, 1959 revealed 775,000 per cubic mm. Examination of the patient on Jan. 15, 1959 revealed that all evidence of the previous hemorrhagic disease had subsided. He reported that his cardiac palpitation had stopped and examination of the heart revealed only 1-2 premature systoles per minute. The Medrol was gradually reduced over the next week. The patient had no recurrences of his hemorrhagic phenomenon.

Discussion

It is our opinion that this represents a case of quinidine sensitivity manifested by an acute thrombocytopenic purpura. According to Bolton[3] the mechanism of thrombocytopenia in quinidine purpura in the sensitive individual is a quinidine platelet combination which forms an antigen against which a plasma factor is produced. With the combination of all three substances — platelets — quinidine — antibody — platelets are removed from the circulation and thrombocytopenia results. According to the report of Bishop, Spencer and Bethell two deaths have been attributed to quinidine purpura. It is their belief that the incidence of this form of purpura is higher in the older age group where quinidine is used more frequently. They state that purpura due to an idiosyncracy to quinidine is not a rare phenomenon. Bolton and Dameshek have pointed out that quinidine is rapidly elimi-

nated from the plasma. When this occurs, the platelet will rise sharply and will usually reach normal levels in seven days.

Summary

A case of quinidine purpura in a 71-year-old white male is presented. Although platelet agglutination tests and other in vitro studies were not done, it is our opinion that this is a true manifestation of quinidine sensitivity. It has been shown by others that the quinidine is rapidly eliminated from the plasma and that the platelet count returns to normal in seven days as shown in our patient. The adminstration of the corticosteriod and Vitamin Kl in this case probably did not significantly change the course of his recovery.

6225 Broadway,
Indianapolis

REFERENCES

1. Bishop, R. C., Spencer, H. H. and Bethell, F. H.: Quinidine Purpura: Report of Six Cases, *Ann. Int. Med.* 50:1227-1239, 1959.
2. Bolton, F. G. and Dameshek, W.: Thrombocytopenic Purpura due to Quinidine I. Clinical Studies, *Blood* 11:527-546, 1956.
3. Bolton, F. G.: Thrombocytopic Purpura due to Quinidine II. Serologic Mechanisms, *Blood* 11:547-564, 1956. ◄

Journal DEADLINE

FOR EDITORIAL COPY

has been changed to

5th Day of Month

PRECEDING

MONTH OF ISSUE

The Journal

of the INDIANA STATE MEDICAL ASSOCIATION

Devoted to the interests of the medical profession of Indiana

Editor: Frank B. Ramsey, M.D., 1802 North Illinois Street, Indianapolis 2, Indiana

Associate Editors: A. W. Cavins, M.D., 221 South Sixth Street, Terre Haute, Indiana; Lall G. Montgomery, M.D., Ball Memorial Hospital, Muncie, Indiana; David A. Bickel, M.D., 515 Odd Fellows Building, South Bend, Indiana; Stephen L. Johnson, M.D., 521 Sycamore Street, Evansville, Indiana.

Editorial Board:	Term Expires
George M. Johnson, M.D., Richmond	Dec. 31, 1960
Irvin W. Wilkens, M.D., Indianapolis	Dec. 31, 1960
Harold D. Lynch, M.D., Evansville	Dec. 31, 1961
Jene R. Bennett, South Bend	Dec. 31, 1961
Samuel R. Mercer M.D., Fort Wayne	Dec. 31, 1962
Franklin F. Premuda, M.D., Hammond	Dec. 31, 1962

Necrologist: James B. Maple, M.D., 117 West Washington Street, Sullivan, Indiana.

Assistant Editor: Corki Wilson

Editorial Assistant: Sara M. Snyder

Business Manager: James A. Waggener

1019 Hume Mansur Building, Indianapolis 4, Indiana

Medical Education

WHAT DO medical students think of medical education? What do physicians think of medical education? A survey has been made to determine the reactions of both these groups to certain aspects of medical education and to curriculums in medical schools.

Questionnaires were sent to 9,862 of the 30,000 medical students in the United States, and to 5,065 physicians. Responses exceeded 23%. Results of the survey have been published in *Patterns of Disease,* a professional publication of Parke, Davis and Company.

Premedical preparation was one point of disagreement between the students and physicians. Almost all the students had either an undergraduate or graduate degree; only 11% had no degree. Eighty percent of the students thought their premedical schooling was valuable, and usually gave as a reason "background broadened in non-scientific areas."

Almost half of the physicians felt that a 4-year premedical course was not necessary.

Both groups agreed that there should be more emphasis on liberal arts than on science. Eighty-five percent of the students had majored in science, only 20% said they would recommend such a course for others. About 40% of the physicians favored an emphasis on liberal arts, 30% preferred premedical training heavy with science.

When queried concerning clinical training in the first year of medical school, 4% of the students reported that such was the custom in their school, but 25% of the entire group felt that it should begin then.

Approximately half of the physicians felt that their medical school training had not been practical enough. Fifty-three percent of the general practitioners and 46% of the specialists comprised this group. Principal reasons for this response in the case of general practitioners were "too much emphasis on obscure diseases and problems of specialties" and "too little emphasis on business aspects of medical practice,"

and in the case of specialists, "too little emphasis on business aspects of medical practice."

Most of the students (67%) indicated that they expected to specialize, 13% intended to enter general practice, 15% were interested in research.

A majority of the doctors announced that they would like for their children to enter medicine. This answer was given by 65% of the general practitioners and 56% of the specialists. "Personal satisfaction from service" was the most often quoted reason.

The survey also included a look at the changes in medical education. The trend in most schools is away from so much formal instruction and departmental rigidity. Today there are fewer didactic lectures, more and earlier clinical work with patients. The tendency is to conduct more and more teaching at the bedside and to study the patient as a whole in conferences.

Two of the biggest problems are the shortage of medical schools and teachers. Twelve medical schools have been activated in the past 16 years. In order to maintain a ratio of one physician to 750 population it is estimated that two or three new medical schools must be added each year in the next decade. It is expected that the number of applicants for medical training will double in the same period of time.

The main shortage of teachers occurs in the field of basic science. Today there are 619 unfilled faculty positions in the United States, more than seven per school. There has been a steady increase in students studying for advanced degrees in basic sciences during the past four years. It is hoped that this will help provide the teachers that are and will be needed, but the problem is still a serious one.

The practice of medicine has never been static. Today the changes are more sweeping than ever before. So, also, medical education is undergoing a constant change. Experimental teaching programs and curriculum changes are the order of the day—nothing else will keep the teaching of medicine in tune with its practice.

No Such Thing As an Unloaded Gun!

ACCIDENTAL DEATH from guns has remained at an unsatisfactorily high and non-decreasing level during the past decade.

According to the *Statistical Bulletin* of The Metropolitan Life Insurance Company, the United States experiences a death rate from this cause of 1.4 per 100,000 population year after year. The growth in population from 1955 to 1958 increased the absolute number of deaths from 2100 to 2400.

Nearly half of the people killed in firearms accidents are injured in or about the home. Nine tenths of the victims are males. The peak of the accidental firearms mortality is during the fall months, due no doubt to the hunting season.

The most significant statistic is that adolescent boys are the one group that is most affected. Young men between the age of 15 and 19 comprise about 3% of the population. They suffer 16% of the fatal gun accidents.

It is obvious that inexperience, or more properly, lack of proper education and training is a large factor in all firearm accidents and especially in the young males. Gun clubs, rifle associations and the military services have an enviable safety record in this regard. A common characteristic of such organizations is that safety precautions and proper handling of a gun are drilled into new members until safety becomes second nature.

What is needed is an extension of such training into every home in which weapons are kept. Systematic and thorough instruction in firearms should be as universal for young men as safe automobile driving courses are for all prospective drivers.

Safety precautions should be instilled into the older members of households to the extent that firearms are kept safely out of the possession of younger members who are too young to have acquired the necessary training.

To avoid the too often repeated exclamation "I didn't know it was loaded!" every weapon should be prominently labeled with the admonition "There is no such thing as an unloaded gun."

Health Information Foundation

HEALTH INFORMATION Foundation is completing its first 10 years of research into the complex system of health care in the United States. It was founded by leaders of the drug, pharmaceutical, chemical and allied industries with the following objectives:

1. To document through research the accomplishments of the present system of medical care.
2. To define areas in the health field in need of improvement and to investigate possible solutions to current problems.
3. To bring research findings, needed facts and new knowledge to active organizations in the health field and to the public.

The foundation was born of the knowledge that the tremendous advances in medicine and in health care, and the changing socio-economic pattern of living had produced many problems about which there was little factual information. The careful collection, correlation, study and dissemination of these facts has been the program of the foundation. It's tenth anniversary affords an opportunity for an appraisal of its work to date and for consideration of its plans for the future.

Voluntary health insurance was the first phenomenon to be studied. Medical advances, changes in public attitude with greater appreciation of what medical science is able to accomplish, the increased use of health services, and a demand for more effective medical care present a constantly changing complexity. Much of the foundation's research has been concerned with this facet of health services. Study of experimental insurance programs and the determination of the extent to which insurance meets family health expenses are other research problems.

The observation of government health programs in England and Canada and an inquiry into the forces in our own country in the same direction has been in progress. Tendencies to curtail health services in an attempt to lower cost, and the corollary problem of the relation of increased costs and "over-use" have also been included in the items for research.

The foundation has been interested in the health needs and resources available in the case of the rapidly increasing segment of the population over 65 years of age. A definition of the role of the hospital—necessary in any determination of "over-use"—is being sought.

All these questions and others have been and will be studied. One of the functions of the foundation is the dissemination of the knowledge obtained. This is accomplished by numerous publications, by speeches which are made to interested organizations by staff members, and by consultations between foundation researchers and staffs of health agencies.

The foundation is supported by contributions from the member companies. Eugene N. Beesley, president of Eli Lilly and Company, Walter R. Beardsley, president of Miles Laboratories, D. Mead Johnson, president of Mead Johnson and Company, and Kenneth F. Valentine, president of Pitman-Moore Company, represent Indiana industry on the Board of Directors. Mr. Beesley is chairman of the Board. ◄

NOTICE

Due to the increased size of the Journal which has resulted in additional time for printing, the DEADLINE for editorial copy, changes in listings, physicians directory changes or kills, commercial ads, etc., has been moved back to:

5th day of the month Preceding Month of Issue

President's Page

The problem of attendance at Indiana State Medical Association meetings is one of concern to all of us. Each year new methods are tried in an effort to produce a meeting that will appeal to more people. It has been suggested that there be more entertainment and this has been tried. Having a high-caliber professional speaker and variations in program is another method that has been tried. The sports such as golf, trap-shooting, etc. have been utilized also. In conjunction with this, teaching experience by classes have been given at the time of the meetings. All of these are worthwhile; however, attendance at state meetings is not as good as it should be.

As one looks about for reasons for this, it soon is apparent that there has been a marked splintering of the medical profession. The specialty groups have interests which are divergent to the point that they require special types of meetings. This has led more and more to the specialty groups concerning themselves with the welfare of their group more than they have concerned themselves with the welfare of medicine in general.

One state—Texas, noting this, has started a plan whereby all the specialty groups have a meeting during the time of the state meeting. By this method more and more doctors are brought to the meetings of the state association. In so doing the effectiveness and strength of the organization has been enhanced rather markedly.

The Indiana State Medical Association is studying such a plan now. The commission having to deal with this problem and the executive committee of the state are planning to meet with the heads of all the specialty groups in the near future and they hope to arrive at some means of enhancing attendance at the state meetings so that the organization will be stronger and thereby more effective.

We are confronted by many problems which require the attention of all. Organized medicine needs the aid of the people who are in specialties. After all, one's first obligation is to medicine in general. Certainly any specialist can readily see, I believe, that his own future is definitely linked with medicine generally. If any ill befalls medicine generally, the specialist certainly will be caught in the process. The same applies to the general practitioner of medicine. His future likewise is concerned with medicine in general.

The state medical association is the only association in the state in which all doctors, regardless of what type work they are doing, can belong. This is the group that will be a vanguard to provide for our practitioners the best climate that can be arranged for them; consequently, the help of all is needed. It is the sincere hope of the officers of the association that better attendance at state meetings can be effected.

Earle W Agnew M.D.

The Woman's Auxiliary

REPORTS TO I.S.M.A.



AT THE A.M.E.F. exhibit during the 1959 ISMA Convention: Mrs. Charles Alvey, Muncie; Mrs. Gordon Cook, South Bend; Mrs. Irvin Sonne, New Albany; Mrs. William Matthews, Indianapolis, and Mrs. Eli Rubens, South Bend. Not present for the picture, Mrs. David Condit of South Bend, treasurer, and Mrs. Milton Gervirtz of Hammond.

Dear Doctor:

WE CAN AFFORD to support our Medical Schools!
WE CAN NOT AFFORD to lower their standards!

With the mounting cost of medical training the medical schools depend on American Medical Education Foundation's unrestricted financial support. "Without the help of these grants, we would not be able—to maintain the standards which all of us desire" was said by the dean of a medical school.

With the future of medical education at stake, it is understandable that American Medical Education Foundation is the PRIORITY PROJECT of the Auxiliary program.

When your auxiliary decides upon an A.M.E.F. project, give it your active financial support. Use the Utility, Sympathy and In Appreciation Cards to honor friends. The cards are available through your A.M.E.F. chairman.

Sincerely,
Muriel Rubens (Mrs. Eli)
A.M.E.F. Chairman
South Bend

Let's all work together to keep up the high standards of our medical schools for this and future generations. Please urge your wives to participate in our A.M.E.F. program. Thank you!

Mary Annette Black
President

The Journal of the Indiana State Medical Association

MEDICAL ESSAY CONTEST

for

Interns and Residents of Indiana Hospitals

During the intern and resident year of 1959-60 The Journal is sponsoring a medical essay contest open to interns and residents of hospitals in Indiana. The subject matter will be limited to clinical experience observed primarily in the teaching hospital of the author. Presentations may contain up to 4,000 words and preferably should be illustrated with clinical pictures, graphs or tables.

A first prize of $100.00, a second prize of $75.00 and a third prize of $50.00 will be awarded. All entries are eligible for consideration for publication in The Journal.

Manuscripts will be judged by a prize award committee selected by the Editorial Board of The Journal and by the Dean, Indiana University School of Medicine.

Manuscripts should be prepared in accordance with the specifications outlined on the masthead page of The Journal.

Entries must be submitted prior to May 1, 1960.

The manuscript itself is to be identified only by the title. The author's name must not appear in the manuscript. Instead, a special title page bearing the title and the author's name and address should accompany the paper. Mail entries to Mr. James A. Waggener, 1021 Hume Mansur Bldg., Indianapolis 4.



Hoosier

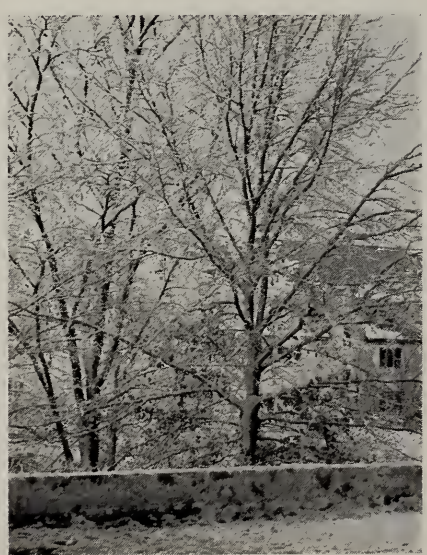
Snowflakes . . . one of the miracles of nature . . . as many shapes as there are flakes . . . floating, swirling, settling to cover the land with a shimmering white coat—Ice, freezing to tree limbs to create a dazzling piece of nature's art as sun makes of it a relief in glaze.

A snow blanket at night with the lights of man reflecting a path that crunches underfoot . . . or, and even more beautiful, reflecting moonlight to almost daylight proportions, again creating in bold relief the artwork of nature—trees, streams, bridges silhouetted against the white.

These things make up a Hoosier Winterland. And not to be forgotten are children capering in the delicious white stuff—having snowball fights, building forts, and the inevitable snow man to guard their castles of winter fun.

(Photos, including the cover picture, courtesy of Indiana University *Arbutus* with exception of the children and snow man which is from Cobb Shinn.)









Winterland



American Medical Association release covers some of the many important actions taken at the 13th clinical meeting held December 1-4 at Dallas.

AMA House of Delegates Acts Favorably On 3 Indiana Resolutions at Texas Meeting

DALLAS, Dec. 4—Freedom of choice of physician, relations between physicians and hospitals, a scholarship program for deserving medical students and relative value studies of medical services were among the major subjects acted upon by the House of Delegates at the American Medical Association's Thirteenth Clinical Meeting held December 1-4 in Dallas.

(Three Indiana resolutions were acted upon favorably by the House. Passed was a resolution calling for investigation of the need, desirability and feasibility of establishing a home for aged and retired physicians.

A resolution concerning accreditation requirements of hospitals, along with a similar one from Colorado, was held until the AMA Joint Commission on Accreditation of Hospitals reports in June on a survey of this subject it currently is undertaking. The third to be passed concerning intern training and hospital outpatient departments, was a resolution recommending that a committee of private physicians be appointed to study the overall problem.)

Dr. Chesley M. Martin of Elgin, Okla., was named as the 1959 General Practitioner of the Year for his outstanding contributions to the health and civic affairs of his home community. Dr. Martin, who has practiced in Elgin for the past 44 years, was the 13th recipient of the annual award and the first Oklahoman to be so honored.

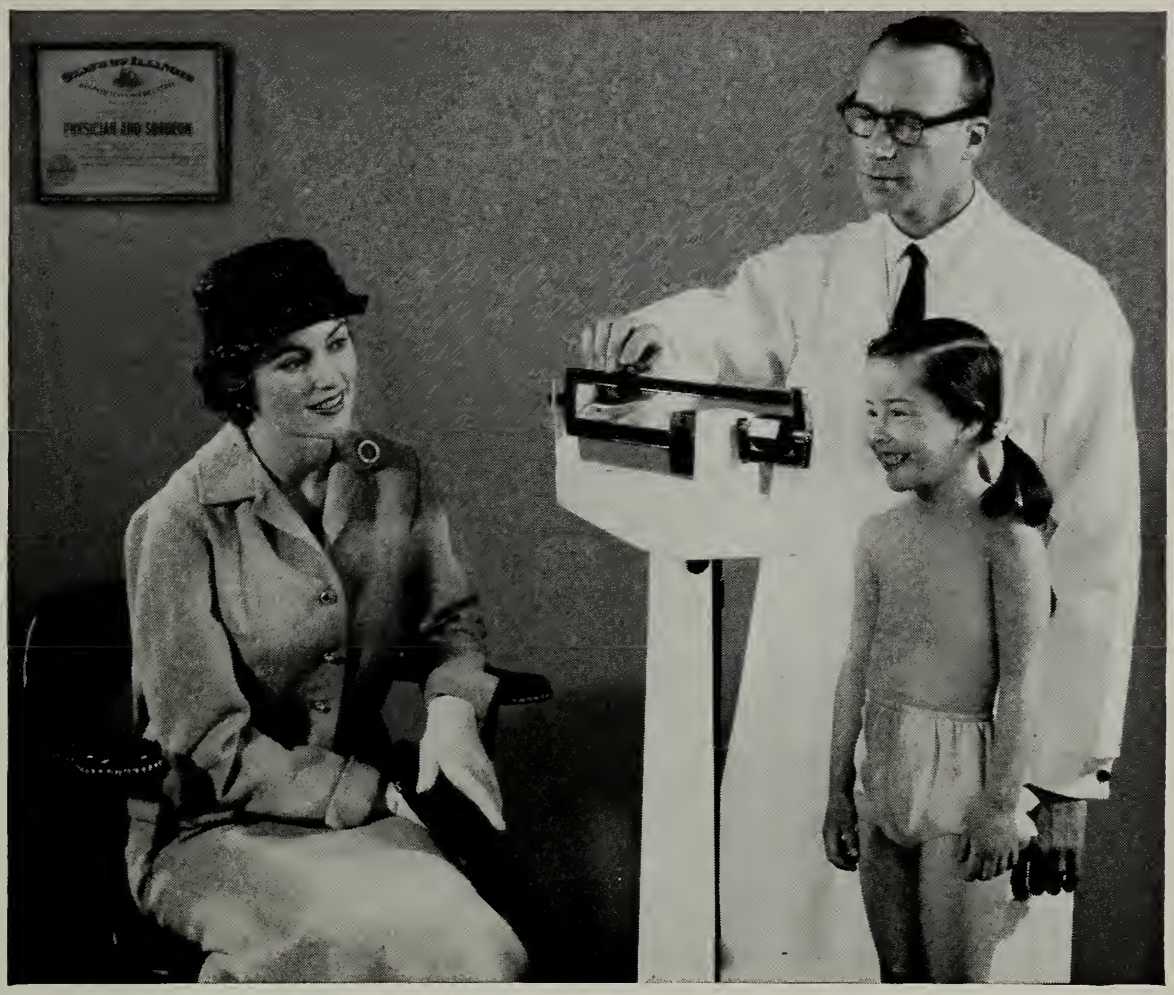
Speaking at the Tuesday opening session of the House, Dr. Louis M. Orr of Orlando, Fla., AMA president, urged the nation's physicians to take a more active interest in the whole area of politics, public affairs and community life. Dr. Orr also asked physicians and medical societies to do a more effective job of telling medicine's positive story, adding that "if more people knew more about the things we support and encourage, they would listen to us much more carefully about those occasional things that we oppose."

Two nationally known political leaders from Texas also addressed the Tuesday morning session. Senator Lyndon B. Johnson, majority leader in the U. S. Senate, called for a "politics of unity" which will enable Americans to exert strength and determination in an effort to create a world in which all men can be free. Speaker of the U. S. House of Representatives Sam Rayburn urged greater attention to the task of educating young people in the principles of American government and giving them a desire to perpetuate it.

Total registration through Thursday, with half a day of the meeting still remaining, had reached 4,727, including 2,742 physicians.

Freedom of Choice

In considering four resolutions which in various ways would have changed or replaced the statements on freedom of choice of physician which the House adopted in June, 1959, when acting upon the recommendations in the report of the Commission on Medical Care Plans, the



Underweight Children Gain and Retain Weight with Nilevar®

One of the most convincing evidences of the anabolic activity of Nilevar, brand of norethandrolone, has been its ability to improve appetite and increase weight in poorly nourished, underweight children.

A highly important feature of the weight gain thus produced is that it is not ordinarily manifested by deposition of fat but as muscle tissue resulting from the protein anabolism induced by Nilevar.

Anorexia and "Weight Lag" Study—Brown, Libo and Nussbaum have reported* consistent and definite increases in rate of weight gain in eighty-six patients, ranging in age from 7 weeks to 15½ years. This beneficial action of Nilevar was observed in the patients with organic and traumatic disorders as well as those whose only complaints were poor appetite and/or persistent failure to gain weight.

In this study, the weight gained was not lost after discontinuance of Nilevar therapy although many patients did not continue the sharp gains effected by the drug.

The authors are of the opinion that Nilevar is a highly useful anabolic agent for influencing weight gain in underweight children.

When Nilevar is administered to children a dose of 0.25 mg. per pound of body weight is recommended and continuous dosage for more than three months is not recommended.

Nilevar is supplied as tablets of 10 mg., drops of 0.25 mg. per drop and ampuls of 25 mg. in 1 cc. of sesame oil. Further dosage information in Searle Reference Manual No. 4.

G. D. Searle & Co., Chicago 80, Illinois.
Research in the Service of Medicine.

---

*Brown, S. S.; Libo, H. W., and Nussbaum, A. H.: Norethandrolone in the Successful Management of Anorexia and "Weight Lag" in Children, Scientific Exhibit presented at the Annual Meeting of the American Academy of Pediatrics, Chicago, Oct. 20-23, 1958.

AMA House

Continued

House reaffirmed the following two statements approved in Atlantic City:

1. "The American Medical Association believes that free choice of physician is the right of every individual and one which he should be free to exercise as he chooses."

2. "Each individual should be accorded the privilege to select and change his physician at will or to select his preferred system of medical care, and the American Medical Association vigorously supports the right of the individual to choose between these alternatives."

However, in order to clarify and strengthen its position on the issue of freedom of choice of physician, the House also adopted this additional statement which was submitted as a substitute amendment on the floor of the House:

3. "Lest there be any misinterpretation, we state unequivocally that the American Medical Association firmly subscribes to freedom of choice of physician and free competition among physicians as being prerequisites to optimal medical care. The benefits of any system which provides medical care must be judged on the degree to which it allows of, or abridges, such freedom of choice and such competition."

Physician-Hospital Relations

The House received 12 resolutions on the subject of relationships between physicians and hospitals. To resolve any doubt about its position, the House did not act upon any of the resolutions but instead reaffirmed the 1951 "Guides for Conduct of Physicians in Relationships with Institutions." It also declared that "all subsequent or inconsistent actions are considered superseded."

The House also accepted recommendations that (1) the House of Delegates acknowledge the need to strengthen relationships with hospitals by action at state and local levels, (2) the Board of Trustees of the Association continue to maintain liaison with the Board of Trustees of the American Hospital Association, and (3) the Council on Medical Service review this entire problem to ascertain if there have been actions inconsistent with the 1951 guides.

Those guides summarize the following general principles as a basis for adjusting controversies:

"1. A physician should not dispose of his professional attainments or services to any hospital, corporation or lay body by whatever name called or however organized under terms or conditions which permit the sale of the services of that physician by such agency for a fee.

"2. Where a hospital is not selling the services of a physician, the financial arrangement if any between the hospital and the physician properly may be placed on any mutually satisfactory basis. This refers to the remuneration of a physician for teaching or research or charitable services or the like. Corporations or other lay bodies properly may provide such services and employ or otherwise engage doctors for those purposes.

"3. The practice of anesthesiology, pathology, physical medicine and radiology are an integral part of the practice of medicine in the same category as the practice of surgery, internal medicine or any other designated field of medicine."

Scholarship Program

To help meet the need for an increasing number of physicians in the future, the House approved the creation of a special study committee which was asked to:

1. Present a scholarship program, its development, administration and the role of the American Medical Association in fulfilling it.

2. Ascertain the maximum to which medical schools could expand their student bodies while maintaining the quality of medical education.

3. Ascertain what universities can support new medical schools with qualified students and sufficient clinical material for teaching—either on a two-year or a full four-year basis.

4. Investigate the securing of competent medical faculties.

5. Investigate financing of expansion and establishment of medical schools.

6. Investigate financing of medical education as to the most economical methods of obtaining high quality medical training.

7. Develop methods of getting well-qualified students to undertake the study of medicine.

8. Investigate the possibility of relaxing rigid geographic restrictions on the admission of students to medical schools.

The House urged that the special committee be implemented promptly with adequate funds and staff so that it may make an initial report by June, 1960.

Relative Value Studies

Reaffirming a previous policy statement, the House approved in principle the conducting of

AMA House

Continued from page 102

relative value studies by each state medical society, rather than a nationwide study or a series of regional studies by the AMA. The House also reiterated its authorization for the Committee on Medical Practices to inform each state medical association, through regional or other meetings, of the purpose, scope and objectives of such studies, the steps to be followed in conducting studies, the problems which may be encountered and the manner in which the results can be applied.

The House recognized, however, that some state medical societies are either not interested in relative value studies or are actively opposed to them. It pointed out that some state medical associations fear that the regional conferences of the Committee on Medical Practices will put pressure on them to carry out such studies and that this will result in the adoption of "fixed fees."

Since the regional conferences are educational in nature, the House said, it remains for each state or county medical association to accept or reject the idea of a study in its area.

The House expressed awareness of the fact that this is still a controversial matter. However, it commended the Committee on Medical Practices for its effort to carry out the instructions of the House, and it urged the committee to continue its educational work.

Miscellaneous Actions

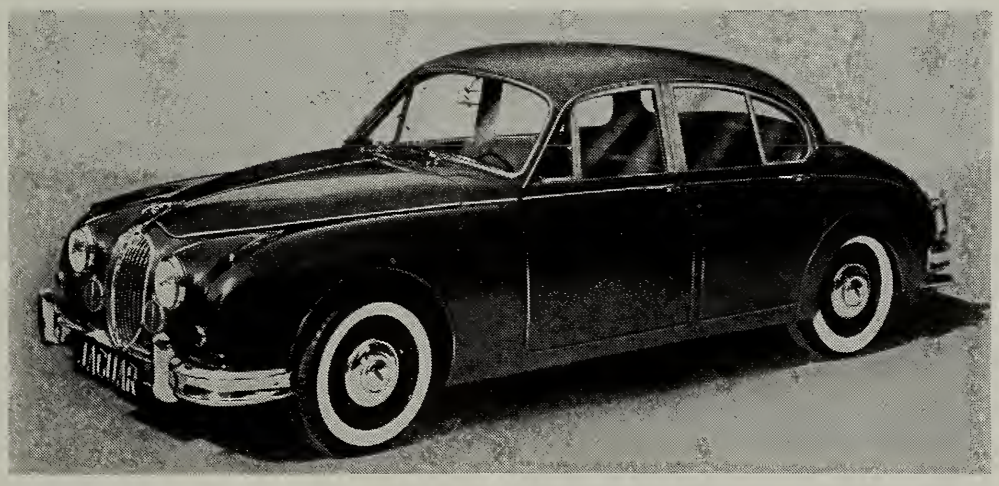
In considering 44 resolutions and a large volume of annual, supplementary and special reports, the House also:

Learned that the A.M.A. Board of Trustees has appointed a liaison committee to meet with a similar committee of the *American Osteopathic Association* to consider matters of common concern;

Emphasized that local medical societies should insure that no member violates ethical traditions as they relate to ownership of *pharmacies* or stock in pharmaceutical companies;

Approved the plan of the Committee on Medical Rating of Physical Impairment to publish its new guide on the *cardiovascular system* in the *A.M.A. Journal;*

Recommended that Association councils and



Newest, Finest Jaguar . . . the 3.8 Litre Sports Sedan!

The brilliant new 5-passenger "Three-Point-Eight" sedan is the ideal Jaguar for the sports cars enthusiast with a family! COMPACT, without sacrificing roominess, comfort and luxury, it incorporates such features as optional power steering, automatic transmission, 4-wheel disc brakes, polished walnut dashboard and glove leather upholstery. Powered by the new 3.8 litre XK engine, this proud new Jaguar has a top crusing speed of 120 m.p.h. . . . the "fastest sedan of its class in the world!" See the other 1960 Jaguars, too . . . the 3.4 litre sedan, the luxurious Mark IX and the XK 150 sports models. Convenient terms!

JAGUAR

2330 NORTH MERIDIAN STREET

MIDWEST DISTRIBUTORS, Inc.

• INDIANAPOLIS

AMA House

Continued

committees, whenever feasible, hold their meetings in the remodeled *Chicago headquarters;*

Commended *Dr. F. S. Crockett,* retiring chairman of the Council on Rural Health, for his many years of devoted duty;

Urged active promotion and careful study of the newly developed "Guides for Medical Care in *Nursing Homes* and Related Facilities";

Suggested that fees for consulative examinations under programs of the *Bureau of Old Age and Survivors Insurance* should be adjudicated directly between the state medical society and the state agency involved;

Registered a strong protest to the *Veterans Administration,* urging stricter screening of non-service-connected disability patients admitted to government hospitals;

Reiterated the Association's support of the *Blue Shield* concept and directed the Council on Medical Service to submit at the June, 1960, meeting its recommendations concerning a policy statement on A.M.A. relationship with Blue Shield plans;

Suggested that S. J. Res. 41, a bill which would institute a separate program of *international medical research,* be delayed until an overall assessment can be made of proposals now before Congress dealing with domestic and international medical research;

Endorsed the program of the Educational Council for *Foreign Medical Graduates* but also urged that judicious consideration be given to local problems involved in the July 1, 1960, deadline for certification of foreign graduates;

Urged that *medical schools* include in their curricula a course on the social, political and economic aspects of medicine;

Delared that the threat of *nuclear warfare* has imposed a tremendous responsibility on the medical profession, which must be prepared to assume a critically important role in such an event;

Suggested that the A.M.A. make aavilable to school libraries *information and literature* showing the advantages of private medical care and the American free enterprise system;

Stated that examinations to determine the physical and mental fitness of *aircraft crew* members should be made by doctors of medicine with special knowledge and proficiency in certain technics;

Urged the American people to get proper *tetanus toxoid,* original and booster, and other immunizations as indicated from their physicians, and called on A.M.A. members to cooperate in an educational program on tetanus immunization;

Recommended that all state and county medical societies establish programs for the inspection and testing of all *fluoroscopes and radiographic equipment;*

Approved the speaker's proposal that the opening session of the House, at the *Interim Meeting,* be moved from Tuesday morning to Monday morning, with the references committees meeting on Tuesday and the House reconvening on Wednesday afternoon;

Called upon each individual physician to wage "a vigorous, dynamic and uncompromising fight" against the *Forand type of legislation;*

Urged state and local medical societies and individual physicians to implement the A.M.A. program for recruitment of high-grade *medical students;*

Changed the title of the Section on Surgery, General and Abdominal, to the Section on *General Surgery;*

Accepted with appreciation a $2,500 contribution by Smith, Kline and French Laboratories toward establishment of a suitable award honoring the name of *Dr. Thomas G. Hull,* retiring secretary of the Council on Scientific Assembly, and

Reaffirmed the "Suggested Guides to Relations Between Medical Societies and *Voluntary Health Agencies,*" which were adopted at the December, 1957, meeting in Philadelphia.

At the Tuesday opening session, six state medical societies presented nearly $250,000 to the American Medical Education Foundation. The checks turned over to Dr. George F. Lull, president of AMEF, were: California, $156,562; Indiana, $35,570; New York, $19,546; Utah, $10,355; New Jersey, $10,000, and Arizona, $9,263.

F. J. L. Blasingame, M.D.
Executive Vice President
American Medical Association

New from Lederle

a logical combination in appetite control

BAMADEX®

meprobamate with dextro-amphetamine sulfate LEDERLE

meprobamate eases
tensions of dieting

d-amphetamine
depresses appetite
and elevates mood

...without
overstimulation

...without
insomnia

...without
barbiturate hangover

Each coated tablet (pink) contains:
d-amphetamine sulfate .... 5 mg.
meprobamate ..... 400 mg.
Dosage: One tablet taken one-half to one hour before each meal.

Lederle

LEDERLE LABORATORIES, A Division of AMERICAN CYANAMID COMPANY, Pearl River, New York

Indiana's Psychiatric Care, Treatment and Rehabilitation

Who is Eligible?
Types of Admission?
Facilities for Specialized Treatment?

HISTORICALLY, the state government of Indiana has been responsible for the care, treatment, training or detention of its mentally ill citizens. The state, through the Division of Mental Health, provides this service for the welfare of the mentally ill and for the welfare of others in the community. Any resident of the state who is mentally ill is entitled to receive medical care and treatment in a state psychiatric hospital.

The Division of Mental Health operates a professional, psychiatric treatment program in 10 state psychiatric hospitals. The division is financed through appropriations by the General Assembly and functions as a civil government activity. But its operations are not hindered by partisan political actions.

Besides directing and supervising medical and psychiatric treatment of patients, the division conducts studies of the problem of mental illness in Indiana. It encourages and financially assists communities throughout the state interested in establishing community psychiatric clinics.

The division promotes and helps to develop training programs for physicians, nurses, psychiatrists, social workers, psychologists and other professional workers as well as to conduct mental health educational programs for professional and lay groups. It also has the responsibility for the examination and confinement of persons who have been adjudged to be criminal sexual psychopathic persons.

Reprint of a brochure published by the Division of Mental Health, Department of Health, State of Indiana, 1315 W. 10th St., Indianapolis. S. T. Ginsberg, M.D., commissioner.

Definitions

Under Indiana law, the term "psychiatric hospital" includes the two state schools for the mentally retarded as well as the other state institutions having the word "hospital" in their names. The term "state mental institutions" refers to both "hospitals" and "schools."

Also, under Indiana law, a "mentally ill person" is an individual who has some form of psychiatric disorder (such as a psychosis, a psychoneurosis, mental retardation, epilepsy or other form of mental disorder), and who requires care, training, treatment or detention for his own welfare or for the welfare of others of the community.

Who is Eligible

Any mentally ill person residing in the state of Indiana and having legal settlement in any county therein, is entitled to receive medical care and treatment in the psychiatric hospital of the hospital district in which such mentally ill person resides.

Any mentally ill person residing in the state of Indiana *not* having legal settlement in any county is entitled to admission to Indiana's institutions under the provisions of the Interstate Compact on Mental Health. The compact provides for hospitalization irrespective of legal settlement or citizenship and permits transfer to, or retention in, whatever compact state might be most therapeutic for the patient.

Cost

The charge for patient care is established annually by the commissioner of mental health. It cannot exceed the lowest per capita cost of the operation of any of the psychiatric hospitals of the state, nor $15 per week for a patient in Fort Wayne School or in Muscatatuck State School. (Acts 1959, Ch. 324.) Reduction or waiving of the fee is possible when financial circumstances preclude this payment. (Acts 1955, Ch. 339, Sec. 2, as found in Burns' 1950 Supp. Sec. 22-4217; Acts 1955, Ch. 339, Sec. 5, as found in Burns' 1957 Supp. Sec. 22-4220; Acts 1959, Ch. 324.)

Types of Admission

There are several admission procedures available, depending on the type of and extent of illness and the need for specialized treatment. The procedures for various types of admissions are as follows:

Civil Rights

Persons admitted to state mental institutions by voluntary admission, temporary commitment or alcoholic commitment do not lose their civil rights by virtue of such admission. Persons who are admitted by regular commitment, however, do lose some of their civil rights. In order for these rights to be restored, the committing court, after discharge of the patient from the hospital as no longer mentally ill, must hold a hearing and make a judicial finding that the person is no longer a mentally ill person. (Acts 1955, Ch. 338, Sec. 3, as found in Burns' 1957 Supp. 22-4242.)

Voluntary Application: Admission by voluntary application is a procedure involving the physician, the patient, and the superintendent of the hospital or school. It is very similar to the admission of a patient to a general hospital. Application forms can be secured from the institution upon request. Applicant must agree to abide by the established rules and regulations of the hospital or school and to give 10 days' notice in writing to the superintendent of his desire and intention to leave.

Voluntary application for admission can be made to all state mental institutions. In the case of minors, application is made by the parent or guardian. The application must be accompanied by a statement from a physician who is licensed



Psychiatric Care

Continued

to practice medicine in the state of Indiana. The statement shall contain a detailed history of the patient, the symptoms of his illness and a certificate certifying to the residence of the applicant and that the applicant is in need of treatment in a psychiatric hospital.

With this information, together with a personal observation of the applicant, the superintendent or staff physician designated by him, may, in his judgment and discretion, admit the applicant, providing there are accommodations available. The superintendent may grant leaves to or discharge any voluntary patient, when, in his judgment, the mental condition of the patient warrants it. A patient voluntarily admitted does not suffer the loss of his civil rights. (Acts 1957, Ch. 359, Sec. 301, 302, and 304, as found in Burns' 1957 Supp. Sec. 22-4704, Sec. 22-4705, and Sec. 22-4707.)

Temporary Commitment By A Court Of Competent Jurisdiction: This procedure is used when a mentally ill person does not have the necessary insight to recognize his need for care and treatment in a psychiatric hospital. Even though this is a judicial action, the patient does not suffer the loss of his civil rights.

Temporary commitments can be made to all state mental institutions. It is anticipated that most commitments made will be temporary in nature and that a regular commitment will be used only if the patient fails to improve sufficiently for release after 180 days of active treatment. The provisions of the law require that a member of the family, or any reputable citizen who is a resident of the State of Indiana, make a statement giving the name and address of such mentally ill person and such additional facts that are available to support the allegation that, in the opinion of the petitioner, such person is mentally ill.

The allegation must be accompanied by a statement by a licensed physician, usually the family physician, that he has examined the person who is alleged to be mentally ill and that the person is in need of treatment in a psychiatric hospital. When the required allegation and statement have been completed and sworn to, they are filed with the clerk of the court of the county in which the person who is alleged to be mentally ill resides.

As soon as practicable, the judge of the court shall consult with the petitioner and the attending physician to determine the extent of the illness and the most realistic treatment plan. When it is determined that treatment or further evaluation is needed, and that the best interests of the patient will be so served, the judge of the court enters an order for the temporary commitment of the person, for the purpose of observation, diagnosis, care and treatment, to a psychiatric hospital of the district. The commitment is for a period of not to exceed 90 days.

In the event an extension of time of a temporary commitment is found to be in the best interest of the person temporarily committed, the psychiatric staff of the hospital may recommend to the committing judge that the time of the temporary commitment be extended. Thereupon the judge may grant one additional indeterminate period of temporary commitment of not to exceed 90 days.

After a temporary commitment to the hospital, the patient may be released at any time before the expiration of the period of commitment upon the finding of the psychiatric staff of the hospital that, in the interest of the patient and society, it is no longer necessary to continue hospitalization. The superintendent of the hospital notifies the committing judge of the release and the judge then dismisses the court action. (Acts 1957, Ch. 359, Sec. 502 and 503 as found in Burns' 1957 Supp. Sec. 22-4712 and 22-4713)

Change Of Temporary Commitment To Regular Commitment: In the event a person on temporary commitment is found by the psychiatric staff to be in such condition that he needs extended treatment, the psychiatric staff makes a written report, including a psychiatric evaluation, to the committing judge. The written report is made at least 10 days prior to the expiration of the temporary commitment. The judge upon receiving this report arranges for a hearing.

If it is the opinion of the judge, after the hearing, that the patient is mentally ill, the judge enters an order of regular commitment. The judge may, instead of using the report of the psychiatric staff, follow the procedure for a regular commitment as given below. (Acts 1957, Ch. 359, Sec. 503 and 504 as found in Burns' 1957 Supp. Sec. 22-4713 and 22-4714)

Regular Commitment By A Court of Compe-



no irritating crystals[1] · uniform concentration in each drop[2]

STERILE OPHTHALMIC SOLUTION

NEO-HYDELTRASOL®

PREDNISOLONE 21-PHOSPHATE-NEOMYCIN SULFATE

2,000 TIMES MORE SOLUBLE THAN PREDNISOLONE OR HYDROCORTISONE

"The solution of prednisolone has the advantage over the suspension in that no crystalline residue is left in the patient's cul-de-sac or in his lashes . . . . The other advantage is that the patient does not have to shake the drops and is therefore sure of receiving a consistent dosage in each drop."[2]

1. Lippmann, O.: Arch. Ophth. 57:339, March 1957.
2. Gordon, D.M.: Am. J. Ophth. 46:740, November 1958.

supplied: 0.5% Sterile Ophthalmic Solution NEO-HYDELTRASOL (with neomycin sulfate) and 0.5% Sterile Ophthalmic Solution HYDELTRASOL®. In 5 cc. and 2.5 cc. dropper vials. Also available as 0.25% Ophthalmic Ointment NEO-HYDELTRASOL (with neomycin sulfate) and 0.25% Ophthalmic Ointment HYDELTRASOL. In 3.5 Gm. tubes.

HYDELTRASOL and NEO-HYDELTRASOL are trademarks of Merck & Co., Inc.

MSD MERCK SHARP & DOHME Division of Merck & Co., Inc., Philadelphia 1, Pa.

Psychiatric Care

Continued

tent Jurisdiction: This procedure is used when the court initially feels that the best interests of the patient will be served by a regular rather than a temporary commitment or, if desired, when the time limitation of the temporary commitment has expired, as mentioned above. As given above under temporary commitment, a member of the family or a reputable citizen who is a resident of the state must make a statement setting forth the name and address of the mentally ill person and such additional facts supporting his allegation that, in the opinion of the petitioner, such person is mentally ill.

The allegation must be accompanied by a statement by a licensed physician that he has examined the person who is alleged to be mentally ill and feels the person is in need of treatment in a psychiatric hospital. When the allegations and statements are completed and sworn to, they are filed with the clerk of the court of the county in which the alleged mentally ill person resides.

When the court feels that the best interests of the patient will be served by regular rather than temporary commitment the judge appoints two additional licensed physicians to make an examination of the person alleged to be mentally ill. If, in the opinion of the judge it is practicable, at least one shall be a psychiatrist.

As soon as the statements of the examining physicians are filed, the judge designates a time and place for a hearing to determine whether the person alleged to be mentally ill is in fact mentally ill. The judge orders the sheriff of the county or some other suitable person to notify the person who is alleged to be mentally ill of the nature of the proceedings and the time and place of the hearing.

The judge may, if he thinks it necessary, or upon request made by or in behalf of the person alleged to be mentally ill, issue subpoenas for the person making the allegation of mental illness, for any or all of the examing physicians, for witnesses, for the person alleged to be mentally ill, and for such other persons as the judge may deem to be cognizant of any facts relating to the case. (Acts 1957, Ch. 359, Sec. 601 and 602, as found in Burn's 1957 Supp. Sec. 22-4715 and 22-4716)

At the time and place appointed, the judge hears and examines such cause, and examines, under oath, the witnesses in attendance concerning the matter of the alleged mental illness of the person for the purpose of determining whether such person is in fact mentally ill. If, upon the conclusion of the hearing and examination, it appears to the judge that the person alleged to be mentally ill is mentally ill, the judge enters an order for the commitment of the person, for the purpose of observation, diagnosis, care and treatment, to a psychiatric hospital of the district. (Acts 1957, Ch. 359, Sec. 603 and 604, as found in Burns' 1957 Supp. Sec. 22-4717 and 22-4718)

When a person is ordered committed to a psychiatric hospital, the clerk of the court is to consult with the attending physician in determining the method of taking care of the mentally ill person pending his admission to a psychiatric hospital. Under no circumstances shall any mentally ill person be confined to the county jail unless he is found to be dangerous and violent, and then only on order of the judge of the court. (Acts 1957, Ch. 359, Sec. 702, as found in Burns' 1957 Supp. Sec. 22-4721)

After admission to the state psychiatric hospital, the court retains jurisdiction over the

Yes Doctor

I am happy, thankful and glad you sent me and my family to Heid's for correct shoes—this eliminates one of our handicaps.

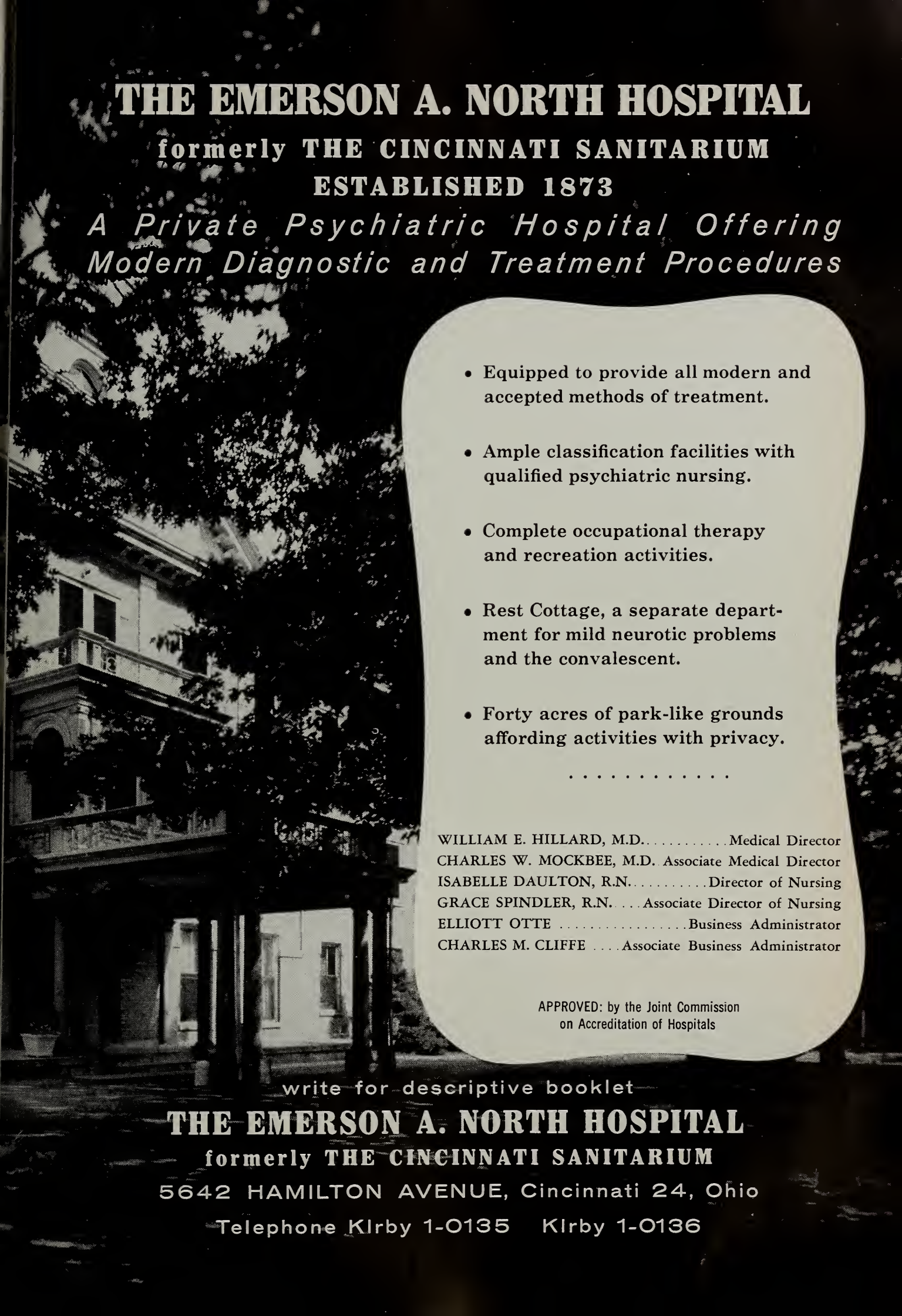


HEID'S 50th Year

Shoes for Men, Women, Children

411 N. Illinois, Indianapolis

Phone MElrose 5-4247 Drive-In Parking



THE EMERSON A. NORTH HOSPITAL

formerly THE CINCINNATI SANITARIUM

ESTABLISHED 1873

A Private Psychiatric Hospital Offering Modern Diagnostic and Treatment Procedures

- Equipped to provide all modern and accepted methods of treatment.
- Ample classification facilities with qualified psychiatric nursing.
- Complete occupational therapy and recreation activities.
- Rest Cottage, a separate department for mild neurotic problems and the convalescent.
- Forty acres of park-like grounds affording activities with privacy.

. . . . . .

WILLIAM E. HILLARD, M.D. . . . . Medical Director
CHARLES W. MOCKBEE, M.D. Associate Medical Director
ISABELLE DAULTON, R.N. . . . . Director of Nursing
GRACE SPINDLER, R.N. . . . Associate Director of Nursing
ELLIOTT OTTE . . . . . Business Administrator
CHARLES M. CLIFFE . . . . Associate Business Administrator

APPROVED: by the Joint Commission on Accreditation of Hospitals

write for descriptive booklet

THE EMERSON A. NORTH HOSPITAL

formerly THE CINCINNATI SANITARIUM

5642 HAMILTON AVENUE, Cincinnati 24, Ohio

Telephone Kirby 1-0135 Kirby 1-0136

Psychiatric Care

Continued

action and may at any time upon proper petition and hearing revoke, terminate or amend such order. Unless such order is so revoked or terminated the superintendent is entitled to keep and retain custody of such person until the superintendent discharges such person, or until such person is cured of his illness. (Acts 1957, Ch. 359, Sec. 704, as found in Burns' 1957 Supp. Sec. 22-4723)

Mentally Retarded Child

Admission Of Mentally Retarded Persons: Such persons are eligible for admission to the Fort Wayne State School or the Muscatatuck State School in the same manner as other mentally ill persons of the state, by voluntary admission, or by temporary or regular commitment.

All such persons residing north of Indianapolis, are admissible to Fort Wayne State School. All such persons residing in Indianapolis and the southern half of the state are admissible to the Muscatatuck State School. At the present time all such persons under the age of six years are located at the Muscatatuck State School, except for a limited number being cared for at Northern Indiana Children's Hospital.

Admission Of Epileptic Persons: All epileptic persons who have a legal settlement in this state are considered admissible to the New Castle State Hospital (formerly known as the Indiana Village for Epileptics). (Acts 1905, Ch. 159, Sec. 14, as found in Burns' 1950 Repl. Sec. 22-2011)

Procedure for admission is similar to the regular commitment of a mentally ill person. It requires an allegation by a reputable citizen accompanied by a physician's statement, a court hearing and appointment of two qualified physicians, and final action by the court of competent jurisdiction. Admission may be accomplished also by voluntary application and by temporary commitment by a court of competent jurisdiction. (Acts 1957, Ch. 359, as found in Burns' 1957 Supp. Sec. 22-4701 et seq.)

Alcoholic Patient

Admission of Alcoholic Patients: Any resident of the state suffering from alcoholism may apply for treatment. Treatment is given in all the mental hospitals except Carter Hospital.

The law provides for two admission procedures:

Direct Application To The Hospital: The alcoholic person may make written application to the superintendent of the hospital. The application is to include a statement indicating that the applicant agrees to abide by the established rules and regulations of the hospital and to give 60 days written notice to the superintendent of his intentions to withdraw from the hospital. The superintendent may accept the applicant for treatment or he may refer the applicant to the appropriate court for commitment. (Acts 1957, Ch. 213, Sec. 8 and 10, as found in Burns' 1957 Supp. Sec. 22-4425 and 22-4427)

Application To The Court: The alcoholic person may make application to the circuit, superior, probate, criminal or juvenile court of the county in which the applicant has a legal residence. The application must be supported by a medical statement, made by a licensed physician, stating that in the opinion of the physician, the applicant is an alcoholic and that the applicant is mentally competent to make such application. If the court determines that the person is an alcoholic, the court may order and direct treatment in a psychiatric hospital having proper treatment facilities. (Acts 1957, Ch. 213, Sec. 8 and 9, as found in Burns' 1957 Supp. Sec. 22-4425 and 22-4426)

Leaving the hospital against medical advice is a misdemeanor, and the patient is subject to a fine, imprisonment, or both, upon conviction. (Acts 1957, Ch. 213, Sec. 11, as found in Burns' 1957 Supp. Sec. 22-4428)

Mentally Ill Child

Admission Of The Mentally Ill Child: The treatment center for children between the ages of six and 12 is located at the Larue D. Carter Memorial Hospital. Admission of children there is essentially the same as for adults, which consists of a voluntary application or a temporary commitment. (Acts 1957, Ch. 359, as found in Burns' 1957 Supp. Sec. 22-4701 et seq.)

The Larue D. Carter Hospital's admission district is the entire state. Children between this age range may be admitted to other mental hospitals if such admission appears to be the most realistic treatment plan. Admission to mental

Raise the Pain Threshold

WITH MAXIMUM SAFE ANALGESIA

Phenaphen with Codeine provides intensified codeine effects with control of adverse reactions. It renders unnecessary (or postpones) the use of morphine or addicting synthetic narcotics, even in many cases of late cancer.

Three Strengths —

PHENAPHEN NO. 2
Phenaphen with Codeine Phosphate ¼ gr. (16.2 mg.)

PHENAPHEN NO. 3
Phenaphen with Codeine Phosphate ½ gr. (32.4 mg.)

PHENAPHEN NO. 4
Phenaphen with Codeine Phosphate 1 gr. (64.8 mg.)

Also —

PHENAPHEN In each capsule

Acetylsalicylic Acid 2½ gr. . (162 mg.)
Phenacetin 3 gr. . . . . (194 mg.)
Phenobarbital ¼ gr. . . . . (16.2 mg.)
Hyoscyamine sulfate . . . . . (0.031 mg.)

PHENAPHEN® WITH CODEINE

Robins

Robins

A. H. ROBINS CO., INC., RICHMOND 20, VIRGINIA

Ethical Pharmaceuticals of Merit since 1878

Psychiatric Care

Continued

hospitals other than Larue D. Carter also follows the same procedure as for adults, by voluntary application, temporary and regular commitment. (Acts 1957, Ch. 359, as found in Burns' 1957 Supp. Sec. 22-4701 et seq.)

Psychotic Teen-ager

Admission Of The Mentally Ill Teen-ager: The admission procedures for persons between the ages of 12 and 18, usually referred to as teen-agers, are essentially the same as for adults. Admission is by voluntary application, temporary and regular commitment. (Acts 1957, Ch. 359, as found in Burns' 1957 Supp. Sec. 22-4701 et seq.)

Teen-agers are cared for in all hospitals and, in addition, a special treatment program has been established at the Dr. Norman M. Beatty Memorial Hospital which includes a school staffed with specialized teachers. Teen-agers applying for admission or commitment by the court from the Dr. Norman M. Beatty Memorial Hospital admission district, will, if accepted, be admitted to the special treatment facility.



All other teen-agers residing outside of the Dr. Norman M. Beatty Memorial Hospital admission district, must make application or be committed to the hospital within their district. If it is decided that the teen-ager can benefit from the special treatment program at the Dr. Norman M. Beatty Memorial Hospital, and is accepted, a transfer of commitment will be effected, and the teen-ager placed at the Dr. Norman M. Beatty Memorial Hospital.

Criminal Sexual Psychopath

Definition: Any person over the age of 16 years who is suffering from a mental disorder and is not insane or feebleminded, which mental disorder is coupled with criminal propensities to the commission of sex offenses, is by law declared a criminal sexual psychopathic person. (Acts 1949, Ch. 124, Sec. 1, as found in Burns' 1956 Repl. Sec. 9-3401)

Plea: When any person is charged with a criminal offense, except the crime of murder or manslaughter, or rape on a female child under the age of 12 or has been convicted of or has pleaded guilty to such offense and has been placed on probation, or has been convicted of or pleaded guilty to such offense but has not yet been sentenced, and it shall appear that such person is a criminal sexual psychopathic person, then the prosecuting attorney, or someone on behalf of the person charged, may file with the clerk of the circuit court a statement in writing setting forth facts tending to show that such person is a criminal sexual psychopathic person. (Acts 1949, Ch. 124, Sec. 3, as found in Burns' 1956 Repl. Sec. 9-3403)

Upon filing of such statement by the prosecuting attorney the court shall, or if filed on behalf of the accused may, appoint two qualified physicians to make a personal examination of such alleged criminal sexual psychopathic person who shall file with the court a report in writing of the results of the examination together with their conclusions. Said alleged psychopath shall be required to answer the questions propounded by such physicians under the penalty of contempt of court.

In the event that both of the examing physicians in their reports concluded that the person examined is a criminal sexual psychopath, then proceedings shall be had, as in this act provided, to determine the psychopathy of such person.

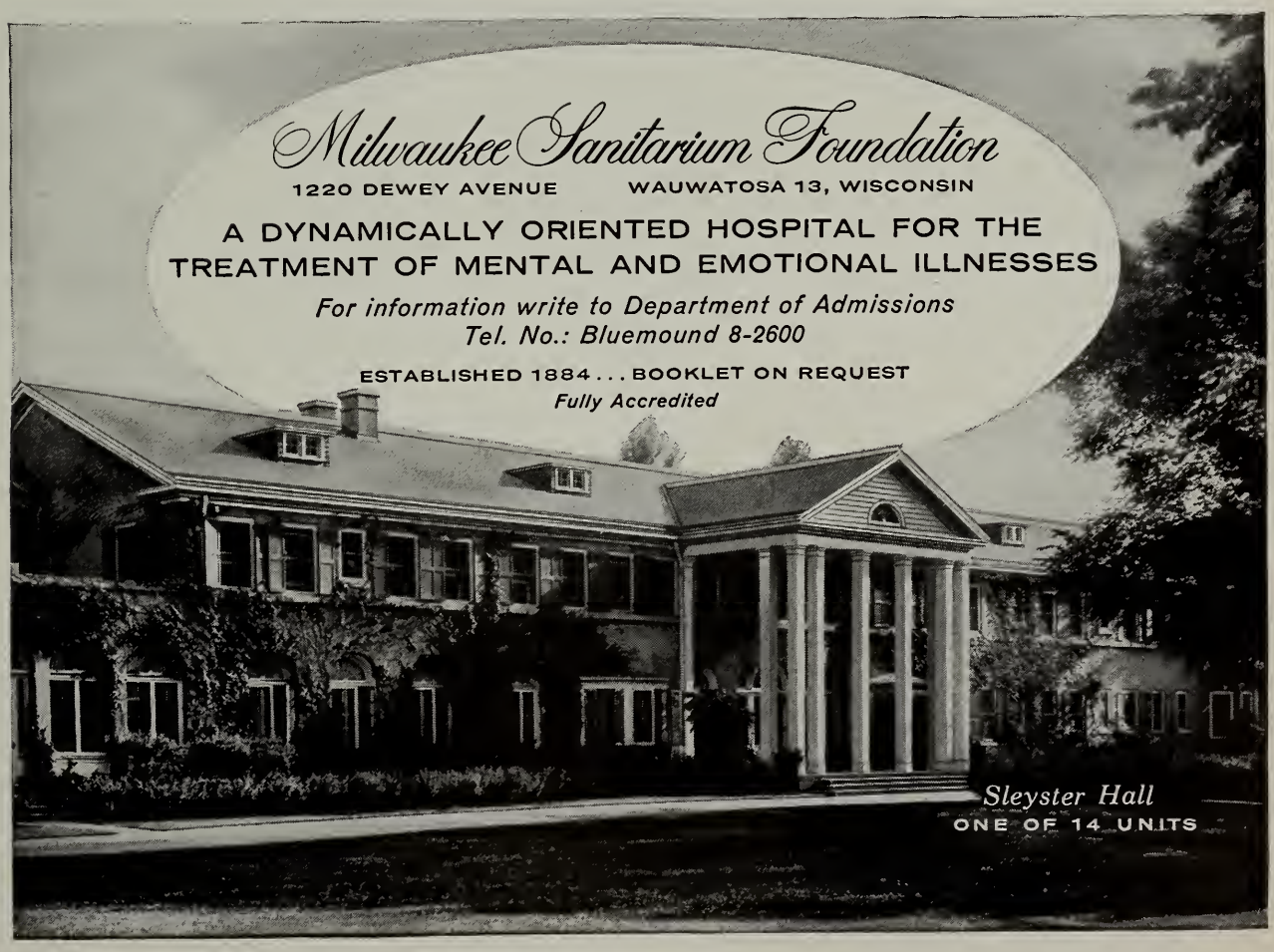
Such proceedings shall be had prior to a trial of such persons upon the criminal offense with which he then stands charged, or prior to sentence if he then stands convicted and has not been placed on probation, or prior to the completion of any probationary sentence imposed.

Upon the filing of the reports of the two examining physicians, the judge of the court shall examine the reports. If the statement containing the allegation of the psychopathy of the accused and the reports of the two examining physicians are found to be in legal form, the judge shall fix a time and place for a hearing for the determination of the alleged psychopathy of the accused. The court shall order and direct the sheriff of the county to notify the accused of the nature of the proceedings and the time and place of the hearing.

The judge may issue subpoenas for any witnesses who may have a knowledge of any facts relevant to the nature of the proceedings. At the time and place appointed, unless an adjournment to another time and place has been ordered, the judge shall proceed to hear such proceedings, and shall examine the witnesses' oath concerning the matter of the alleged psychopathy of the accused.

If, upon the conclusion of the hearing and examination, it shall appear to the judge that the person so alleged to be a criminal sexual psychopath is probably a criminal sexual psychopath, the judge shall commit such person to the Division of Mental Health, such person to be confined by the division in an appropriate state psychiatric institution for an indeterminate period of not to exceed 60 days, for the purpose of observation, evaluation and diagnosis of such person by the psychiatric staff of such institution. The superintendent of the institution shall, within 60 days from the date of admission, file with court a written report of the findings, conclusions and recommendations of the psychiatric staff. Such report shall be open for inspection by the accused and by the legal counsel for the accused, but it shall not be deemed to be competent evidence in any other proceeding brought against the accused except in the proceeding to inquire into the alleged psychopathy of the accused.

In the event the psychiatric staff in its report



concludes that the accused person is a criminal sexual psychopath, the court shall then determine the question of the psychopathy of the accused person and shall enter an order and judgment in accordance with such finding and determination. If such person is found by the court to be a criminal sexual psychopath, the court shall in its order and judgment commit such person to the Division of Mental Health, to be confined by the Division in an appropriate state psychiatric institution until such person shall have fully and permanently recovered from such psychopathy. (Acts 1959, Ch. 356, Sec. 1)

The Division of Mental Health has the right to release such person upon parole to such persons and under such conditions as his condition in the judgment of the Division of Mental Health merits. Such criminal sexual psychopathic person shall be discharged only after he has fully recovered from such criminal psychopathy.

At any time when he shall appear to have so recovered, a petition in writing setting forth the facts showing such recovery may be filed with the clerk of the court by which he was committed and such court shall proceed to determine whether or not he has fully recovered from such criminal psychopathy. If, following such hearing such person is found to have fully recovered from such criminal psychopathy, then the court shall order such person to be discharged from the custody of the Division of Mental Health and the state institution wherein he was confined.

In the event such person is found to have not fully recovered from such criminal psychopathy, then the court shall order such person to be returned to the custody of the Division of Mental Health to be held under the previous commitment of such person. (Acts 1949, Ch. 124, Sec. 7 and 8, as found in Burns' 1956 Repl. Sec. 9-3407 and 9-3408)

No person who is found in such original hearing to be a criminal sexual psychopathic person, and such finding having become final, may thereafter be tried or sentenced upon the offense with which he originally stood charged, or convicted, in the committing court at the time of the filing of the original petition. (Acts 1949, Ch. 124, Sec. 9, as found in Burns' 1956 Repl. Sec. 9-3409)

Criminally Insane

By The Court:

Not Guilty On The Ground Of Insanity: If in any criminal action, the plea of insanity is raised as a defense, it is the duty of the jury, or of the court if so tried, if the defendant is found not guilty, to find whether the defendant committed the act charged, and, if so, whether the defendant was sane or insane at the time of the commission of the act, and whether found not guilty because he was insane at the time of the commission of the act.

If he is found not guilty on the ground of insanity the court shall determine the defendant's sanity at the time of the trial, and if the court finds that the defendant is insane at the time of the trial, he shall order the defendant committed to the Division for Maximum Security of the Dr. Norman M. Beatty Memorial Hospital; or if he finds the defendant sane at the time of the trial, but the recurrence of such an attack of insanity highly probable, he shall also order the commitment of the defendant as above.

At any time after two years from the date of commitment any person so confined may file an application to be discharged, in the court from which committed, and upon satisfactory proof made to such court of the restoration of sanity and that the recurrence of such an attack of insanity is improbable, the court shall order the discharge from such institution.

A second or subsequent application for discharge cannot be made within five years from the time of any previous application. (Acts 1913, Ch. 298, Sec. 3, as found in Burn' 1956 Repl. Sec. 9-1703; Acts 1913, Ch. 298, Sec. 5; Acts 1927, Ch. 102, Sec. 2, as found in Burns' 1956 Repl. Sec. 9-1705; Acts 1951, Ch. 238, Sec. 1, as found in Burns' 1956 Repl. Sec. 9-1704a)

Commitment Before Trial: If at any time before the trial of any criminal cause or during the progress thereof and before the final submission of the cause to the court or jury trying the same, the court, either from his own knowledge or upon the suggestion of any person, has reasonable ground for believing the defendant to be insane, he shall immediately fix a time for a hearing to determine the question of sanity. The court will appoint two competent disinterested

A SPOON LICKIN' GOOD SULFA!



it's delicious cherry-flavored for children

KYNEX®

ACETYL PEDIATRIC SUSPENSION

N[1] Acetyl Sulfamethoxypyridazine Lederle

just 1 dose a day . . . achieves rapid therapeutic levels . . . sustained for 24 hours . . . extremely low incidence of sensitivity reactions and renal complications . . . convenient, highly economical . . .

ALWAYS ACCEPTABLE . . . WHENEVER SULFAS ARE INDICATED

Recommended dosage: first-day dose is 1 teaspoonful (250 mg.) for each 20 lbs. body weight up to 80 lbs. For each day thereafter, ½ teaspoonful for each 20 lbs. For 80 lbs. and over, use adult dosage of 4 teaspoonfuls (1.0 Gm.) initially, and 2 teaspoonfuls (0.5 Gm.) daily thereafter. Administer immediately after a meal.

Supplied: Each teaspoonful (5 cc.) contains 250 mg. of sulfamethoxypyridazine activity. Bottles of 4 and 16 fl. oz.

Lederle LEDERLE LABORATORIES, a Division of AMERICAN CYANAMID COMPANY, Pearl River, New York

Psychiatric Care

Continued

physicians to examine the defendant. Other evidence may be introduced to prove the defendant's sanity or insanity.

If the court finds that the defendant has not comprehension sufficient to understand the proceedings and make his defense, he shall commit the defendant to the Division of Maximum Security of the Dr. Norman M. Beatty Memorial Hospital. Whenever the defendant shall become sane the superintendent of the hospital shall certify the fact to the proper court, who shall order his release and place the defendant on trial for the original criminal offense. (Acts 1951, Ch. 238, Sec. 2, as found in Burns' 1956 Repl. Sec. 9-1706a)

Transfer From The Department of Correction: When an inmate of any penal or correctional institution is in need of care and treatment in a psychiatric hospital, the chief administrative officer of the institution orders an examination of the inmate to determine the need for hospitalization, by a qualified psychiatrist. The psychiatric report is submitted to the chairman of the board of correction, and if the chairman is of the opinion that the inmate is in need of care and treatment in a psychiatric hospital, a request is made to the commissioner of mental health for a transfer to a psychiatric hospital.

After reviewing the report and/or examining the inmate, the commissioner may prepare an authorization of acceptance of the inmate by the superintendent of any psychiatric hospital. Provided, however, that no adult male may be transferred to any psychiatric hospital other than the Division for Maximum Security of the Dr. Norman M. Beatty Memorial Hospital. (Acts 1955, Ch. 324, Secs. 2 and 3, as found in Burns' 1957 Supp. Sec. 22-4229 and 22-4230)

Whenever the inmate has recovered his mental health before the expiration of his sentence or before the expiration of the maximum limit of an indeterminate sentence, the superintendent in charge shall so certify to the commissioner, who, if satisfied as to the mental health of the patient, shall order the inmate to be transferred to the institution from which he was removed to the psychiatric hospital. (Acts 1955, Ch. 324, Sec. 5, as found in Burns' 1957 Supp. Sec. 22-4232)

Continued on page 126

THE HARDING SANITARIUM

WORTHINGTON
OHIO

For the Diagnosis and Treatment of Psychiatric Disorders
and with
Limited Facilities for the Aging

GEORGE T. HARDING, M. D.
HARRISON S. EVANS, M. D.
Medical Directors

CHARLES W. HARDING, M.D.
Clinical Director

GEORGE T. HARDING, Jr., M. D.
HERNDON P. HARDING, M. D.
ARNOLD L. NIELSEN, M.D.
ROBERT L. SMITHWOOD, M. D.
W. W. WINSLOW, M.D.

GRACE M. COLLET, Ph.D.
VERNON W. SHAFER, Ph.D.
Clinical Psychologists

MARY JANE McCONAUGHEY, M.S.W.
BENJAMIN E. WHEATLEY, M.S.W.
Psychiatric Social Workers

PAULINE L. TOOILL, R. R. L.
Medical Record Librarian

JAMES L. HAGLE, M. B. A.
Administrator

ESTHER L. SIMPSON, R. N.
Director of Nurses

Phone: Columbus TUXEDO 5-5381



Doctors, too, like "Premarin"®

THE doctor's room in the hospital is used for a variety of reasons. Most any morning, you will find the internist talking with the surgeon, the resident discussing a case with the gynecologist, or the pediatrician in for a cigarette. It's sort of a club, this room, and it's a good place to get the low-down on "Premarin" therapy.

If you listen, you'll learn not only that doctors like "Premarin," but *why* they like it.

The reasons are fairly simple. Doctors like "Premarin," in the first place, because it really relieves the symptoms of the menopause. It doesn't just mask them — it replaces what the patient lacks — natural estrogen. Furthermore, if the patient is suffering from headache, insomnia, and arthritic-like symptoms due to estrogen deficiency, "Premarin" takes care of that, too.

"Premarin," conjugated estrogens (equine), is available as tablets and liquid, and also in combination with meprobamate or methyltestosterone.

Ayerst Laboratories • New York 16, N. Y. • Montreal, Canada

Ayerst®

5842

Psychiatric Care

Continuel from page 122

Whenever the superintendent of any psychiatric hospital is of the opinion that the mental illness of the inmate will continue beyond the expiration date of the sentence or of the maximum limit of an indeterminate sentence, he will file an application with the court of the county in which the hospital is located requesting that the court order the commitment of the inmate to the psychiatric hospital. Upon receipt of the application and report the court shall provide for a hearing to determine the mental illness of the inmate.

If, upon the conclusion of the hearing and examination it shall appear to the court that the inmate is mentally ill and will continue to be mentally ill beyond the expiration of his sentence or beyond the maximum limit of his indeterminate sentence, he shall order the commitment of the inmate.

In the event any such inmate shall recover his mental health after the expiration of his sentence, or after the maximum limit of his indeterminate sentence, the superintendent of the hospital shall discharge such inmate in the same manner as other patients of the hospital are discharged. (Acts 1955, Ch. 324, Sec. 6, as found in Burns' 1957 Supp. Sec. 22-4233, Acts 1959, Ch. 363)

Emergency Admission Pending Commitment Order

Any health or police officer who has reason to believe that a person is mentally ill and, because of his illness, should not be allowed to go unrestrained pending an examination and certification by a licensed physician or pending court procedure to commit such person, shall take such person into custody and apply to the Dr. Norman M. Beatty Memorial Hospital for his admission. The superintendent may accept such person for admission to the hospital for a period of observation not to exceed 15 days. If during that time the superintendent ascertains such person is mentally ill he shall notify the proper authorities in the county of the person's legal residence. If a proper commitment order is not delivered to the superintendent within 20 days after the person has been accepted for hospitalization, such person shall be released. (Acts 1951, Ch. 238, Sec. 4, as found in Burns' 1957 Supp. Sec. 22-4134)

State Mental Institutions

Indiana Division of Mental Health:

1315 West 10th Street, Indianapolis 7, Indiana
S. T. Ginsberg, M. D., Commissioner of Mental Health
John W. Southworth, M. D., Deputy Commissioner

Mental Hospitals:

Doctor Norman M. Beatty Memorial Hospital, Westville

David P. Morton, M. D., Superintendent

Larue D. Carter Memorial Hospital*
Indianapolis
Donald F. Moore, M. D., Medical Director

Central State Hospital, Indianapolis
C. L. Williams, M. D., Superintendent

Evansville State Hospital, Evansville
Milton H. Anderson, M. D., Superintendent

Logansport State Hospital, Logansport
Ernest J. Fogel, M. D., Superintendent

Madison State Hospital, Madison
Ott B. McAtee, M. D., Superintendent

New Castle State Hospital, ** New Castle
William E. Murray, M. D., Superintendent

Richmond State Hospital, Richmond
Jefferson Klepfer, M. D., Superintendent

Specialized Treatment

Schools for the Mentally Retarded:

Fort Wayne State School, Fort Wayne
Mr. Bernard Dolnick, Superintendent

Muscatatuck State School, Butlerville
Donald H. Jolly, M. D., Superintendent

Section on Alcoholism:

145 West Washington Street
Indianapolis 4, Indiana
Fred E. Lawrence, M. D., Director

Acute and Intensive Treatment—
All State Mental Hospitals

* Does not accept patients by regular commitment.
** Prior to 1955 known as the Indiana Village for Epileptics.

Continued



The clock strikes 2—
and your ulcer patient sleeps undisturbed

ONE 10 MG. DARICON TABLET AT BEDTIME...

controls hypersecretion, hypermotility, and spasm all night long. The sustained anticholinergic efficacy of DARICON is inherent in its structure and does not depend on special coatings.

ONE 10 MG. DARICON TABLET BEFORE BREAKFAST...

provides dependable relief for at least 12 more hours. In a large series of patients with peptic ulcer and other gastrointestinal disorders—some notably refractory to therapy—8 out of 10 responded to DARICON.

DARICON®

oxyphencyclimine hydrochloride

B. I. D. DOSAGE

For 'round-the-clock relief of ulcer and other gastrointestinal disorders

A Professional Information Booklet is available on request from the Medical Department.

Pfizer *Science for the world's well-being™* PFIZER LABORATORIES, *Division, Chas. Pfizer & Co., Inc., Brooklyn 6, New York*

Psychiatric Care

Continued

Treatment and Training of the Mentally Retarded—
Fort Wayne State School
Muscatatuck State School

Treatment and Training of the Epileptic and Neurological Patient—
New Castle State Hospital

Treatment of the Alcoholic Patient—
All State Mental Hospitals (except Carter Hospital)

Criminal Sexual Psychopath—
All State Mental Hospitals (Except Carter Hospital)

The Psychotic Child (age 6-12)—
Larue D. Carter Memorial Hospital

The Psychotic Teen-ager—
All State Mental Hospitals plus specialized program at Beatty Hospital

Nursery Care of the Mentally Retarded Child under Age 6—
Muscatatuck State School
Northern Indiana Children's Hospital (limited facilities)

The Psychotic Criminal Patient—
Dr. Norman M. Beatty Memorial Hospital, Maximum Security Division

The Tubercular Patient—
Logansport State Hospital
Madison State Hospital
Evansville State Hospital
Central State Hospital

Community Psychiatric Clinics

Bloomington *Indiana University Psychological Clinic*
Indiana University
Delton C. Beier, Ph. D., Director
Hours: Daily, except Saturday afternoon
Phone: 6811 Extension 282 and 574

Columbus *Bartholomew County Mental Health and Guidance Center*
1541 Hutchins
Millard L. Hoyt, M. D., Director
Hours: Daily, except Saturday
Phone: Drexel 9-9213

Elkhart **Adult and Child Guidance Clinic of Elkhart County, Inc.*
(The Guidance Clinic)
224 West High Street
John U. Keating, M. D., Director
Hours: Daily, except Saturday and Wednesday evenings
Phone: 2-4522

Evansville **Vanderburgh Child Guidance Center, Inc.*
1 North Barker
Lillian Moulton, M. D., Director
Hours: Daily, except Saturday afternoon
Phone: Harrison 3-4231

Fort Wayne **Fort Wayne Child Guidance Center, Inc.*
1110 West Washington Boulevard
Robert L. Greenlee, M. D., Dir.
Hours: Daily, except Saturday
Phone: Eastbrook 7563-7564

Gary (Main) **Lake County Mental Health Clinic*
400 Broadway
J. L. Bisgyer, M. D., Director
Mrs. Mary L. Fisher, Admin. Dir.
Hours: Daily, except Saturday afternoon
Phone: Turner 3-8508

Hammond (Branch) **Lake County Mental Health Clinic*
5236 Hohman Avenue
Renee Gelman, M. D., Director
Mrs. Mary L. Fisher, Admin. Director
Hours: Daily, except Saturday afternoon
Phone: Westmore 1-3440

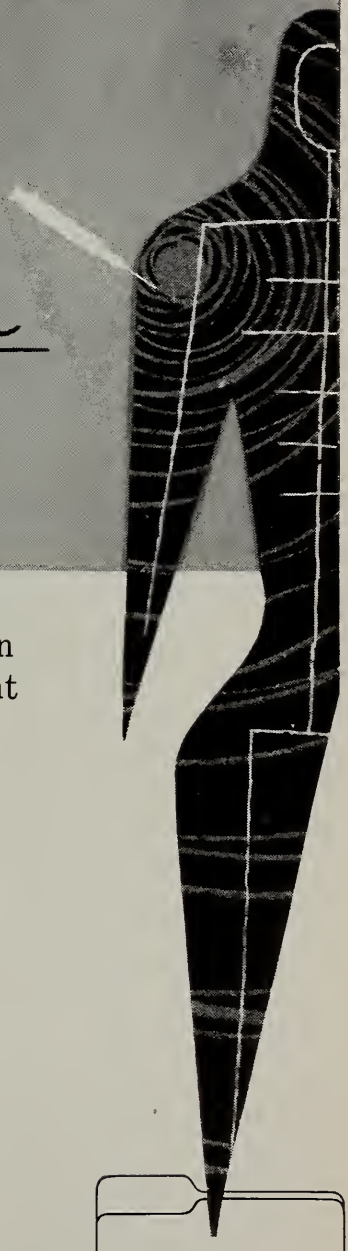
Indianapolis **Child Guidance Clinic of Marion Co., Inc.*
1949 East 11th Street
Gordon T. Brown, M. D., Director
Hours: Daily, except Saturday afternoon
Phone: Melrose 2-5381

NEW

DEPINAR

truly repository injectable B_{12}

quickly achieves and sustains high B_{12} blood levels for a minimum of 28 days



The Depinar special repository base permits slow absorption from the injection site, thus decreasing the need for frequent administration. Depinar continually bathes the tissues in vitamin B_{12} to provide more effective therapy and make patients feel better longer. A recent clinical report* shows over 98% of Depinar is retained after one week . . . and "Serum level vitamin B_{12} . . . sustained for 28 days or more from the single dose."

Each package of Depinar consists of a multiple dose vial, containing cyanocobalamin zinc tannate (lyophilized) equivalent to 2500 mcg. vitamin B_{12}. The vial of diluent contains 5 cc. Sodium Chloride Solution for Injection. When reconstituted, each ml. of Depinar contains 500 mcg. vitamin B_{12}.

*Thompson, R. E., and Hecht, R. A.: Am. J. Clin. Nutrition 7:311-317 (May-June) 1959.

ARMOUR PHARMACEUTICAL COMPANY • KANKAKEE, ILLINOIS

Armour Means Protection

© A. P. Co.

ARMOUR

Psychiatric Care

Indianapolis (Continued)

General Hospital, Department of Psychiatry
960 Locke Street
J. Paskind, M. D., Director
Hours: Monday and Thursday afternoons
Phone: Melrose 6-6331

Marion County General Hospital Department of Neurology
960 Locke Street
Philip T. White, M. D., and A. L. Drew, M. D.
Hours: Monday and Thursday afternoons
Phone: Melrose 6-6331

Indiana University School of Medicine, Section of Psychiatry
Long Hospital, 1100 West Michigan St.
John E. Kooiker, M. D., Director
Service: Minimum Age 16, Entire State
Hours: Daily, except Saturday
Phone: Melrose 5-8441

**James Whitcomb Riley Child Guidance Clinic*
Indiana University Medical Center (Rotary Home)
1100 West Michigan Street
Edward Tyler, M. D., Director
Service: Entire State
Hours: Daily, except Saturday
Phone: Melrose 5-8441

Indiana University Medical Center, Epilepsy Clinic
James Whitcomb Riley Hospital, 3rd Floor
Philip T. White, M. D., Director
Hours: Tuesdays 9:00 A. M. to 4:30 P. M.
Phone: Melrose 5-8441

Veterans Administration—for veterans with service connected disability
Counseling Section for VR&E Division
36 South Pennsylvania Street
Noble C. Lehner, Chief
Hours: Daily, except Saturday
Phone: Melrose 2-1581

Mental Hygiene Clinic
36 South Pennsylvania Street
Carl S. Wright, Ph.D., Chief
Hours: Daily, except Saturday
Phone: Melrose 2-1581

Central Indiana Alcoholism Clinic
145 West Washington Street
Indianapolis 4, Indiana
Fred E. Lawrence, M. D., Director
Phone: Me 2-5421

Kokomo — **Guidance Center of Howard County, Inc.*
416 West Sycamore Street
John M. Hoyt, M. D., Director
Hours: Daily, except Saturday
Phone: Gladstone 2-5667

Lafayette — **Tippecanoe County Mental Health Center*
1625 Kossuth Street
Joe M. Martin, M. D., Director
Service: Adults and Children
Hours: Daily, except Saturday
Phone: 2-4059

Marion — **Grant County Mental Health Clinic*
412 South Boots Street
Jack Oatman, M. D., Director
Hours: Daily, except Saturday
Phone: 2381

Michigan City — **LaPorte County Mental Health Services*
217 West 8th Street
John M. Hoyt, M. D., Director
Hours: Daily, except Wednesday afternoon
Phone: Triangle 2-2193

South Bend — **St. Joseph County Adult and Child Guidance Clinic*
527 West Colfax
R. Charles Eades, M. D., Director
Hours: Daily, except Wednesday afternoon and Saturday, Thursday evening
Phone: 3-5123 and 3-5124

Terre Haute — **Vigo County Adult and Child Guidance Clinic*
415 North 9th Street
Joe M. Martin, M. D., Director
Hours: Daily, except Saturday
Phone: Lincoln 6291

---

* Partially supported by the Indiana Division of Mental Health. ◀


in every arthritic state
long-term therapy
with maximum relief of pain
without steroids
Buffered
Pabirin®
Tablets
improved salicylate therapy
SMITH-DORSEY • a division of The Wander Company • Lincoln, Nebraska

Forces Affecting The Community's Hospital Bill

RAY E. BROWN

Chicago

THIS PAPER is concerned only indirectly with hospital operating costs. It is rather an effort to examine the forces that set the total hospital bill of the community. By forces, we mean causes that are beyond the control of the hospital itself, causes that grow out of the changing environment in which the hospital exists. These forces are cultural, economic and medical. They determine the demands the community makes upon its hospitals. Most of them are cumulative in their impact, and in the long run will more significantly affect the community's total expenditures for hospital care than will the predicted increase in costs per patient-day of care.

One indication of their combined effect is the fact that in the 10-year period, 1948 through 1957, the number of inpatient admissions per 1000 Blue Cross members increased from 117 to 136, or 16.2%. During this period the average length of stay for admission decreased slightly from 7.6 days to 7.5 days. But nevertheless, the average number of days of care utilized per 1000 Blue Cross members in this country increased from 883 to 1021. Even if hospital operating costs had remained completely static, Blue Cross subscribers would have had to pay almost 16% more in 1957 than 10 years earlier.[2]

The Well Now Pay the Bill

The manner in which most hospital care is now being financed makes it important that everyone understand these forces. The spread of hospital prepayment coverage to more than two-thirds of the population means that the hospital bill is becoming largely a community bill, and that it is increasingly being underwritten by the well rather than by the sick.

It means that the public will increasingly visualize hospital costs in terms of the monthly cost of prepayment rather than as charges for services received. Under such circumstances, what they are getting will not be related to what they are paying.

It also means that the hospitals of the nation are becoming increasingly dependent upon the community understanding that these forces are beyond the control of prepayment plans and hospitals and that they evolve out of the community itself. Voluntary hospitals are community agencies and must be responsive to the forces which the communty exerts upon them. Voluntary prepayment plans are community mechanisms utilized by the community to collect from the community and disburse to the hospitals those funds necessary to underwrite the obligations imposed by the community on its hospitals.

Neither the voluntary hospitals nor the voluntary prepayment plans can significantly alter these forces, generated by the community, which promise to continue to rapidly push the community's hospital bill upward. This writer is not at all certain that most of these forces could or should be altered nor that the community would want to alter them. It is urgent, however, that the community understand the source of these forces and their effect on the community's hospital bill before irreparable harm is done to the prepayment movement and to the voluntary hospital system through public misconceptions

* Ray E. Brown is superintendent, University of Chicago Clinics. Much of this material is adapted from a speech presented by Mr. Brown at the Southeastern Hospital Conference in Miami, Fla., May 1958.

Reprinted from *Hospitals,* Journal of the American Hospital Association, Sept. 16—Oct. 1, 1958.

and misdirected intervention by state regulatory bodies.

One set of forces that will importantly influence the community's hospital bill are those involved with the rapid population growth anticipated for this country. It is estimated by the Bureau of the Census that the total population of the nation will exceed 220 million by 1975.[3] Using 1956 as a base, this will represent an increase of 50 million, or approximately 29 per cent during the 18-year period.

As great as this expected growth is, however, it is not the size of the increase that is most significant. If the characteristics of the population remained the same, it could be presumed that the hospital costs per thousand of the population, and the monthly prepayment per subscriber, would not be affected. Under such circumstances the capital expenditures necessary to provide the additional facilities would be the chief complicating feature of a large population increase. Parenthetically, it must be said that those capital expenditures will represent a considerable item. Using current hospital construction costs of at least $20,000 per bed, and ignoring the inevitable inflation that will occur in these costs, it will require approximately four and one-half billion dollars to provide the 225,000 new general hospital beds required just for this added population. Defined in terms of the local community, and at the risk of chilling the enthusiasm of local chambers of commerce, this means that almost $100 for new hospital construction must be found for each new entrant into the community.

A Changing Population

It is the changing characteristics of this population growth that will importantly complicate the community's hospital bill. The slowest growing group of population will be the age range 25-64 years—the segment which bears the major responsibility for the maintenance of families and the payment of Blue Cross. Compared with about 81 million in 1956, their number will rise to 96 million by 1975, or by somewhat less than 20 per cent. At the same time the dependent child population, those under age 18, will increase some 20 million or about 35 per cent. (The above estimates are taken from a report of the Bureau of the Census.[3])

This one aspect of the population change means that the number of dependents covered under prepayment family certificates will be increasing by 35 per cent, while the number of family prepayment certificates will be increasing by only 20 per cent.

This increasing expense per prepayment certificate can be stated another way. We will soon reach a point where the average family will have three children as compared with an average of 2.4 children per family in 1958. In other words, the monthly charge to the subscriber with family coverage will have to reflect the fact that he has 25 per cent more children covered under his prepayment certificate than he did 10 years before.

The increased size of the family means also that there will be more births per prepayment subscriber. And the record shows an increasing percentage of these will be born in the hospital. In 1957, 95 per cent of all births in this country occurred in hospitals as compared with 85 per cent in 1947. This trend means that almost all births will be hospital births and the community will have increased its hospital expenditures for this one particular hospital service by one-tenth since 1947.

It can be argued with some logic that the increased percentage of the population in the younger aged group will tend to reduce the number of hospital admissions because of the lower incidence of hospitalized illness in that group. This advantage will be many times offset, however, by the changing characteristics of the population at the other end of the age scale. The experts say there will be 22 million people at ages 65 and over by 1975, compared with less than 14.5 million in 1956; an increase of 7.5 million or 52 per cent. This compares with the previously mentioned increase in the total population of 29 per cent for the same period. At present one out of every 12 persons is over age 65. This ratio will increase to one out of every 10 by 1975.

Without going into all the complex problems that the aging present to the community, one can determine pretty quickly the implications of the rapid growth of this group on the community's hospital bill. There have been several studies to examine the hospital usage of persons over age 65. One of the most recent and perhaps best documented was that reported by the national Blue Cross Commission in 1957.

This report[4] states "the excess cost for ages

In 1956, the author published a summary of a study on the nature of hospital costs.[1] That study was concerned with the factors that had carried upward the national average costs per hospital patient-day at a rate over three and one-half times the increase in the cost-of-living index for the period from 1946 to 1955. The effect of the factors inherent in the nature of hospital operations upon the unit costs of hospitals was examined in that study. The study summarized in this paper is concerned with the forces influencing the community's total hospital bill. The two studies are concerned with different phenomena, but to some extent the impacts are the same. Any increased cost per patient-day will, of course, be directly reflected by an increase in the total hospital expenditures of the community if the total number of patient days of hospital care remain at least the same. On the other hand, the total hospital expenditures of the community can substantially increase even if costs per patient-day do remain static. The suggestion that costs per patient-day might remain static, however, is made here solely for purposes of illustration and is purely academic. The writer still persists in his prediction of two years ago, that hospital costs per patient-day will continue to increase for many years.

65 and over measured in days of hospitalization would be most probably somewhere between 2.5 and 3.0 days per year per person. This is equivalent to saying that the cost of hospitalization of persons 65 and over is from three to four times that for those under age 65."

Another study[5] was reported recently by the Health Council of North Carolina. It covered all hospitals in that state. This study found that "hospital usage by persons over 65 years of age is over three times greater than for persons under 65 because of both the higher admission rate and the longer length of stay."

Approximately the same findings were made on a national basis in a survey conducted in 1953 by the American Medical Association.[6] This was a special one-day survey of the age and sex of all patients in the hospitals of the nation on that day. The survey disclosed that on the survey day persons over age 65 made up more than 20 per cent of all hospitalized patients. In 1953, persons over age 65 made up less than 8 per cent of the total population.

If one accepts the findings of these two studies, which are in general agreement with other studies of this problem, it is apparent that those over age 65 on the average require more than three times the hospital care of the population under age 65. Relating this fact of dramatically higher usage to the increasing ratio of the over-65 age group to the general population, we have no alternative but to expect an increasing cost for prepayment over the years ahead from this one factor alone.

Increasing life expectancy will also increase hospital usage for those in the age bracket immediately below age 65. A study reported by the Metropolitan Life Insurance Company in 1956, covering insured male personnel of that company, shows the close correlation between increased hospital utilization and age once the individual reaches middle age.

This study[7] showed that the age group 35-44 had an admission rate of 7.3 per 100 individuals and a length of stay of 8.8 days. The age group 55-64 had an admission rate of 13.8 per 100 individuals and a length of stay of 14.0 days. This means that, in terms of hospital days used, the age group 55-64 used 193 days per 100 individuals as compared with a usage of 64 days by the 35-44 age group—or a ratio of three to one.

Far-Reaching Implications

This finding has far-reaching implications for hospital usage. It means that the rate of hospital usage for the upper middle-aged apparently is not very much less than that of the aged. This fact has not been given sufficient recognition in the planning we have done up until now to meet the health problems resulting from increased life expectancy. Our attention and statistics have been riveted on the mounting number of those over age 65 rather than at the major breaking point, medically speaking, of those reaching age 55. More importantly, it has seemingly been ignored in the free-swinging charges of overuse of hospitalization leveled at members of prepayment plans. There might be some connection between the increased utilization year-by-year and the increased number of individuals in the medically critical age group of those over 55.

It is interesting to reflect on the fact that average life expectancy in the United States was about 55 years when the first prepayment plan was founded in 1929. Ever since that date a larger and larger number of individuals have occupied the age group 55-65 and consequently a larger and larger utilization has been made of hospitals by the same individuals. In those intervening years average life expectancy has

WHEN BLOOD PRESSURE MUST COME DOWN...



When hypertensive symptoms such as dizziness, headache and fainting are frequent enough and severe enough to interfere with your patient's activity and safety—then it is time to consider the beneficial actions of Serpasil-Apresoline. Both Serpasil and Apresoline lower blood pressure. When the Serpasil-Apresoline combination tablet is prescribed, blood pressure response is even better. In addition, Serpasil contributes favorable calming and heart-slowing effects. Apresoline increases renal blood flow, decreases cerebral vascular resistance and inhibits the actions of humoral pressor agents. Combined with Serpasil, Apresoline is effective at a lower dosage, thus side effects are rarely a serious problem.

SUPPLIED: *Tablets #2* (standard-strength), each containing 0.2 mg. of Serpasil and 50 mg. of Apresoline. *Tablets #1* (half-strength), each containing 0.1 mg. of Serpasil and 25 mg. of Apresoline. *Samples available on request.*

Serpasil®-Apresoline®
hydrochloride
(reserpine and hydralazine hydrochloride CIBA)

2/2640 RH

CIBA SUMMIT, NEW JERSEY

Community Hospital Bill

Continued

increased steadily year-by-year and is now at the Biblical promise of three score and ten.

The population has been changing in many other ways than in age. These changes have affected, and will further affect, the utilization of hospitals and consequently the amount of the community's expenditures for hospital care. The movement of the population from the farm to the cities has been a natural result of the mechanism of farm work and the improvement of farm technology. In 1940, approximately 20 per cent of the total labor force of the nation was employed on farms. Currently, only about 10 per cent of the total labor force is thus employed.

Population experts predict that by 1975 the proportion will have been reduced to as low as 6 per cent of the total labor force. The labor released from the farm, and their families, have little alternative other than moving to the urban centers where jobs are to be found. The fact that they do move is shown in the following statement by the U. S. Bureau of the Census; "Of the 14.7 million increase in the civilian population between 1950 and 1956, 85 per cent was accounted for by the increase in the population living in the metropolitan areas." That this further urbanization will be an influence for further utilization of hospital care is evidenced by the significantly higher rate of usage of hospital care by urban dwellers over the farm population.

Some idea of the comparative usage of hospital care can be developed by taking the 10 states with the highest percentage of urban population in 1956, and comparing the average number of days of general hospital care used per 100 persons in that year with the same figure for the 10 states with the lowest percentage of urban population in that year.[8,9] It will be found that the more urban states used 31 per cent more general hospital care. The comparable usage was 121.3 days and 93.3 days.*

How much the increasing urbanization and industrialization of the population is influencing the growing accident rate of the country is not computable from available data. How much the accident rate is affecting hospital usage, however, was demonstrated in a survey by Frank G. Dickinson, Ph.D.,[10] of the American Medical Association. For November, 1955, Mr. Dickinson secured from the hospitals of the United States information on all accident patients discharged from the hospitals during that month.

This survey disclosed that accident cases represented 6.9 per cent of the total patients discharged and 8.1 per cent of the total inpatient days of care for the survey month. It showed that in addition to the 1,370,000 days of care provided during November to the 127,800 inpatients admitted because of accidents, the emergency rooms of those hospitals also examined and treated 390,000 accident cases. These are significant percentages of the general hospital's total load and it would be difficult to blame their admission on the doctor or the hospital.

Working Wives

Who does the working is also changing rapidly. A survey[11] in 1956 by the Bureau of the Census showed that the number of working wives had increased by 5 million, or about two-thirds in the last 10 years. All women made up 31.2 per cent of the nation's total civilian labor force, and married women, living with their husbands, totaled 13⅓ million, or more than 60 per cent of this group. Two million of these working wives also had small children at home. The impact of the working wife on the utilization of hospital care can be easily imagined. It means most often that there is now no one at home to take care of the sick husband or child in over 25 per cent of the 50 million families in this country.

The fact that the working wife chooses to send the sick individual to the hospital isn't altogether concerned with her possible loss of wages when absent. She also realizes the hesitation of employers to employ individuals who have family responsibilities that cause absentee-

---

* This calculation is supported by another set of figures reported in the April 1958 issue of *Public Health Reports* by Miss Jean L. Pennock of the U. S. Department of Agriculture. Miss Pennock reported that the level of annual spending of rural families for medical care in 1955 was $63 per person and that of urban families was $81 per person. The differences in utilization would probably be much wider if it were not for the higher age levels of the rural population. Men engaged in farm work comprise over one-fourth of all workers in this country who are over 65 years of age.

ism. The increasing number of positions open to women in industry has a further effect on the availability of help to care for the sick at home. Female servants are disappearing rapidly as higher salaries paid by industry beckon.

Even wealthy families find it impossible to match these salaries. The percentage of families with full-time help in the home, has decreased an estimated 60 to 80 per cent since the start of World War II.

The Vanishing Extra Bedroom

The high price of household help, plus the high cost of construction, has brought about another cultural change that works against the individual being sick at home. We are now in the era of the one-bedroom home and the utility apartment. An increasingly large segment of our population has no extra bedroom at home in which to be sick. Before we talk too much of over-use of our hospital facilities, we should seriously examine the economies involved in this one factor. The purpose of the hospital is to centralize those facilities under one roof that the individual cannot afford to provide for himself, or that can be more economically provided for the individual if he shares their use with other members of the community when they become ill.

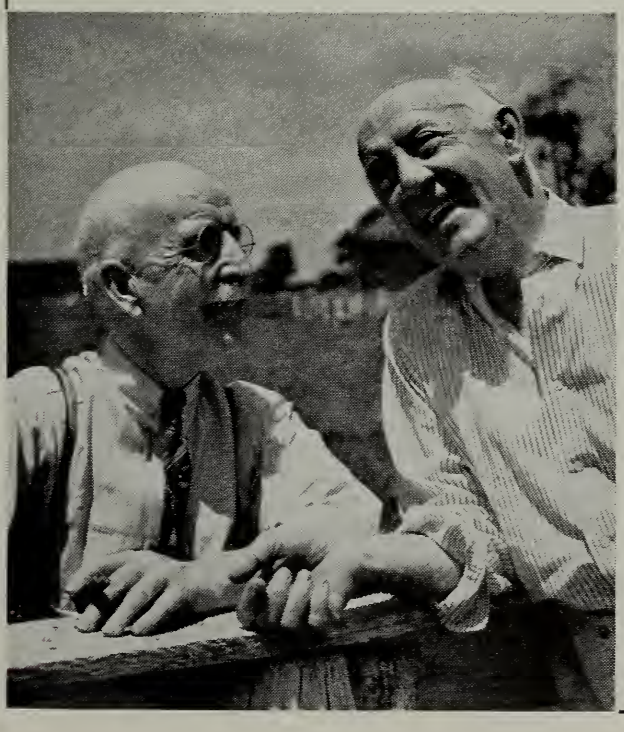
From a dollars and cents standpoint it would seem that the community is much better off if one hospital room is constructed for the use of the 30-odd different individuals who can use the same hospital bed each year and who represent only one out of eight of the population annually. A little bit of arithmetic shows the tremendous savings to the community of pooling the sick rooms in the hospital rather than constructing dwellings that provide that sick room.

Significance of Education

The level of education of the individual apparently has a good bit to do with the readiness with which people enter the hospital. The extent to which this is true is difficult to measure from available published data. In an effort to get an idea as to the effects of educational levels on hospital utilization, the author secured from the Blue Cross Plan of one of the nation's largest cities the pay-out ratios over a period of four

PSYCHIC ENERGIZER

For Your Geriatric Patients



Metalex®

Pentylenetetrazol w/ Nicotinic Acid

METALEX is a vasodilator, a respiratory and central nervous system stimulant. It helps overcome the hypoxia frequently present in athero-arteriosclerosis of old age, its analeptic action increases nerve impulse transmission.

"TONIC" EFFECT—Ameliorates mood, paranoid delusions, loss of memory, confusion, depression, anxiety, apathy, vertigo, insomnia, headache and anorexia due to athero-arteriosclerosis.

IN TINNITUS—When cerebral function and oxygen supply can be improved, visual and auditory improvement is often noticeable.

SUPPLIED: Tablets—bottles of 100.
Elixir—pint bottles.

Composition: Each tablet and each 5 cc. elixir contains 100 mg. Pentylenetetrazol, and 50 mg. Nicotinic Acid.

Send for samples and literature.

STORCK **Pharmaceuticals,** 2326 Hampton Blvd., St. Louis 10, Mo.

years on two sets of the the population having identical Blue Cross contracts. One set was made up of the personnel of the several universities and secondary school system of that city, and the other was made up of personnel employed in the electronics industry. The sets had about an equal number of individuals covered and the distribution as to sex is estimated as being approximately the same. Average annual income per individual is estimated to be fairly similar with the school group being the higher.

The only major difference between the two sets is believed to be the difference in educational level. One set can be described as composed primarily of college graduates and the other as composed of individuals primarily not college graduates. The pay-out ratios for the four-year period are dramatically higher for the primarily college graduates group.

Most any allowance can be made for other factors, and still usage by the group with higher education will be significantly higher. The pay-out ratio was 98.8 per cent for the group with higher education as compared with 68.8 per cent for the electronics industry group. This variance must be attributed to differences in educational levels between the groups.

Whatever significance educational levels have to hospital usage will be increasingly felt in the next several years. We seem to like to criticize our educational institutions in this country but the facts show that more and more of us are using them for longer and longer periods of study.[12] The average schooling of all adults in the nation has risen from an average of 9 years in 1950 to an average of 10½ years in 1957. During the time the number of high school graduates in the population has increased by 31 per cent and the number of college graduates in our population has increased by a resounding 32 per cent. In 1957 there were 7.6 million people with at least a college education as compared with only 5.7 million people in 1950. In 1957 some 2,269,000 of the population had done one or more years of graduate work. Some idea of the pressures on the population to improve its level of education is given in an article in the May 1958 issue of *Fortune*. This article states, "Since 1947 the number of professional and technical personnel in industry has increased an additional 43 per cent, or two and a half times as fast as the labor forces as a whole." To meet the demands of industry and society for a better educated level of personnel, the colleges and universities of the nation are gearing up to handle more than double the present number of students by 1970. Prepayment plans may as well begin gearing their budgets to the increase in hospital utilization that will follow.

New Kind of Sophistication

Another sort of education is having perhaps a stronger influence on the public's use of its hospitals. This is perhaps better described as medical and hospital sophistication. Through the press, radio and television, the public learns quickly of each of the medical discoveries that have been pouring out in an amazing stream for the past two decades. They also learn to know that their hospital is a necessary element in the doctor's use of his new tools and knowledge. The more they learn of medical progress, the more likely they are to go to the hospital. After they go to the hospital for the first time, they are more likely to go again. There is evidence to support this tendency toward the increased use that comes with familiarity. Through the cooperation of the Division of Hospitals of the Illinois State Health Department, the author did a study of nine hospitals constructed in Illinois, with Hill-Burton support, in counties that had previously had no hospitals. These hospitals had been open for an average period of five years at the end of 1957. The percentage of occupancy experienced by each hospital during its first year of operation was compared with the percentage of occupancy during 1957. After correction for population changes, the percentage of occupancy of the nine hospitals showed a growth from an average of 39.9 for the group during the first year of operation to an average of 63.0 per cent for the group during 1957. Another study covering the experience of the Saskatchewan Hospital Service Plan,[13] illustrates the effect of the factor of repetitive admissions upon hospital utilization. The study covered 27,764 male patients who were admitted to Saskatchewan hospitals during 1954, and reviewed their hospital experiences. It was found





1¼ Grs. Ea.
FLAVORED

Living up to a family tradition

There are probably certain medications which are special favorites of yours, medications in which you have a particular confidence.

Physicians, through ever increasing recommendation, have long demonstrated their confidence in the uniformity, potency and purity of Bayer Aspirin, the world's first aspirin.

And like Bayer Aspirin, Bayer Aspirin for Children is quality controlled. No other maker submits aspirin to such thorough quality controls as does Bayer. This assures uniform excellence in both forms of Bayer Aspirin.

You can depend on Bayer Aspirin for Children for it has been conscientiously formulated to be the best tasting aspirin ever made and to live up to the Bayer family tradition of providing the finest aspirin the world has ever known.

Bayer Aspirin for Children—1¼ grain flavored tablets—Supplied in bottles of 50.

● We welcome your requests for samples on Bayer Aspirin and Flavored Bayer Aspirin for Children.

New
GRIP-TIGHT CAP
for Children's
Greater Protection



THE BAYER COMPANY, DIVISION OF STERLING DRUG INC., 1450 BROADWAY, NEW YORK 18, N. Y.

Community Hospital Bill

Continued

that 11,009 of the patients had not had a previous hospital admission. The remaining group, those who had been to a hospital before, of 16,737 patients was found to have had 61,187 admissions during the five year period—an average of almost four admissions each during the period.

Full and adequate hospital care is becoming an accepted component in the average American's standard of living. It is an economic axiom that as national income rises increased demands are made for personal service. This simply reflects the fact that people have a greater proportion of their income left for discretionary spending after the purchase of food, clothes and shelter.

All of us are aware of the dramatic increases in national personal income during the last 20 years. Consumer income, after taxes, appears to have hit a new peak of almost $300 billion.

The dramatic change in income has not been so much in the total, however, as in the manner in which this total has been distributed. This country is apparently undergoing the greatest economic and social revolution of all time. Figures released recently by the U.S. Census Bureau show that 48 per cent, or almost half, of the country's families had total incomes last year of between $5,000 and $15,000. Fifteen years ago only 5 per cent of a smaller number of families had an income of more than $5,000. The median income per family (half the families earned more; half less) in 1957 was $4,971 as compared to a median of $3,890 in 1952, just five years earlier.

In the meantime, the portion going to those at the top of the income ladder slipped again. Only 1.9 per cent of the nation's families had an income of more than $15,000 in 1957. The correlation of income level of the general population with hospital usage can be demonstrated in a general way.

A comparison of average days of general hospital care for the 10 states with the highest per capita income in 1956 and the 10 states with the lowest per capita income in 1956 shows that the first group of states used an average of 123 days of care per 100 members of the population as compared with only 89 days for the second group.

This represents a difference of over 38 per cent in hospital usage by the population in those states with the highest per capita income. It is the author's opinion that this comparison is not so much a measure of the difference in ability to pay for hospital care as it is the increased demand for hospital care that goes along with higher income and a consequent improved standard of living.

The rising standard of living of the American public has not only incorporated adequate hospital care as a usual and expected part of living, but it has also caused a demand for a nicer and more attractive sort of hospital service. Hospitals have been asked by their patients to match the niceties of the motels the motorists finds along the highways. This calls for air-conditioning, piped in radio, perhaps television and certainly drapes at the window. It also calls for a telephone at the bedside and some choice as to the entree served at meal time.

Hospitals have been forced to add these and other niceties as they became commonplace in motels, shops, restaurants, and other establishments serving the general public. Their effect on the patient's recovery is debatable and certainly not highly significant. Their effect on the hospital's unit cost, however, is significant.

Their provision has resulted from the demand of the community that hospitals service be at least as attractive and convenient as the standard of living to which the community has otherwise become accustomed.

The community has added perceptibly to the operating costs of the hospital from another direction. During the early years of the hospital's development in this country, its service was largely confined to the poor who lacked the means to provide in their homes the minimum needs of the sick in the way of food, linens and a sanitary environment. Because hospitals were serving the poor, at no charge or at most a nominal charge, the hospitals were granted immunity from public liability and malpractice claims. The idea was that the hospital was a charity and any recovery against the hospital was actually a recovery against a charity.

The attitude of the community toward hospital immunity started undergoing a change when the advances of medicine made it necessary that everyone use the hospital. The doc-

Continued on page 149

Community Hospital Bill

Continued from page 140

trine of immunity became a barrier against the claims of the citizens who were paying as well as the claims of those who were not. In recent years this change in attitude on the part of the community has caused a rapid erosion of the immunity doctrine.

This erosion is aptly described by the following comment from a recent opinion handed down by the Supreme Court of Ohio when it reversed that state's former rule of immunity: "The immunity of charities is clearly in full retreat in this country. And it may be predicted with some confidence that the end of another decade will find a majority of the American jurisdictions holding that it does not exist."

A few months later, New York's highest court decided, "Hospitals should shoulder the responsibilities borne by everyone else—liability is the rule, immunity the exception."

The New York court is probably correct, and hospitals should shoulder the same responsibilities borne by everyone else. What everyone else must realize, however, is that they are paying the cost of this new burden placed upon the hospital. It is not a small burden. Because of the nature of hospital service, the hospital's exposure to liability claims is much greater than that of other types of enterprise. Also, perhaps because of the mystery surrounding medical and hospital activities, juries have shown a strong sympathy for those who bring reasonably plausible claims against the hospital.

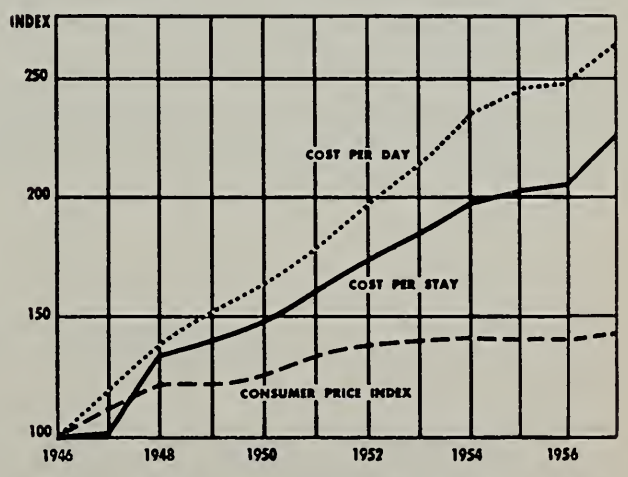
This set of circumstances forces liability underwriters to charge almost prohibitive rates for hospital liability coverage. Many liability underwriters will not even accept hospital business. The added cost to hospitals represented in liability insurance, or court awards, in those states where immunity has been removed is sizable. Inevitably, this added cost becomes a part of the prepayment subscriber's monthly premium.

Community attitudes will affect prepayment rates in another connection. Traditionally, the community has forced the hospital to pass a part —and in many communities all—of the cost of the medically indigent on to the hospital's pay patients. For some reason it has been left up to the hospital to recover the cost of care of those who could not pay by "taxing" the sick through their hospital bills rather than by a tax on the whole community. Prepayment plans have not as yet permitted hospitals to include this cost as part of the reimbursement the prepayment plans make to the hospital for service to members. Further spread of prepayment coverage over a larger segment of the population will make this burden so intolerable to the few remaining pay patients that hospitals will be forced to compel the prepayment plans to cover the cost of service rendered to the medically indigent.

Much has been said about the effect of medical advances on the daily operating costs of hospitals. Indeed, much can be said in that regard, and the full story of the effects of those medical advances would still be only half-told. The mushrooming discoveries of medicine are the reason the modern hospital has developed. The effects of these discoveries on the operating costs of the hospital, however, tell only half the story so far as their influence on the community's total hospital expenditures are concerned.

The effect on the utilization of hospitals is increasingly as important. In the first place these medical advances now permit doctors to offer treatment to patients whose condition was classified as hopeless and incurable a few years ago. These patients represented no expense to the prepayment plans because there was no treatment for them. If one reviews the average hos-

'NATURE OF HOSPITAL COSTS'



The chart above, used to illustrate Mr. Brown's earlier article, "The Nature of Hospital Costs" (HOSPITALS, J.A.H.A., April 1, 1956), has been extended to include 1957 statistics. These statistics show that costs per day and per stay have continued to climb sharply in 1957 when compared to the relatively stable position of the Consumer Price Index.

Community Hospital Bill

Continued

pital's census today it is likely that a goodly per cent of the patients will be undergoing therapy that was unknown just a few years ago. Much of this new therapy is difficult and of long duration. The effort on behalf of these patients consumes an increased number of more costly hospital days that represent a net addition to the pay-out total of the community's prepayment plan.

Hospitals and prepayment plans think it very doubtful that the community would want this work stopped. They hope that the community is equally willing to understand the financial consequences.

The rapid advances of medicine have been necessarily accompanied by a rapid increase in specialization by the doctors. They have been forced to restrict their study and work to smaller areas of medical science in order to keep abreast of the rapid developments in that science. Specialists are in general the largest users of hospital facilities for the same reason they are specialists. The rate of increase in medical specialists can therefore serve as a sort of index to the rate of increase in the utilization of hospital facilities.

The Era of Specialists

Training for a medical specialty is secured through hospital residencies approved by the American Medical Association. As late as 1951 there were a total of 15,851 residents in training. In 1956 their number had increased to 23,012. The number of different medical specialties recognized by the AMA in 1951 was 27. In 1956 these specialized branches of medicine had increased to 30.[14] Some idea of the magnitude of this need for specialized knowledge by doctors, and the extent to which they are seeking it, can be gained from the fact that the number of doctors in residencies in 1956 equaled more than three times the number of medical school graduates for that year.

Medical advances will increase the burden of prepayment plans in another and somewhat paradoxical way. Prepayment plans are chiefly concerned with general hospitals. Two major diseases, tuberculosis and mental disease, have been an accepted responsibility of government and special hospitals for these diseases have traditionally been operated at government expense and without charge to the patient. Important medical advances in both those diseases, however, are causing a shift of many tuberculous and mentally ill patients into community general hospitals. This consequently shifts the expense of their care to the prepayment plans.

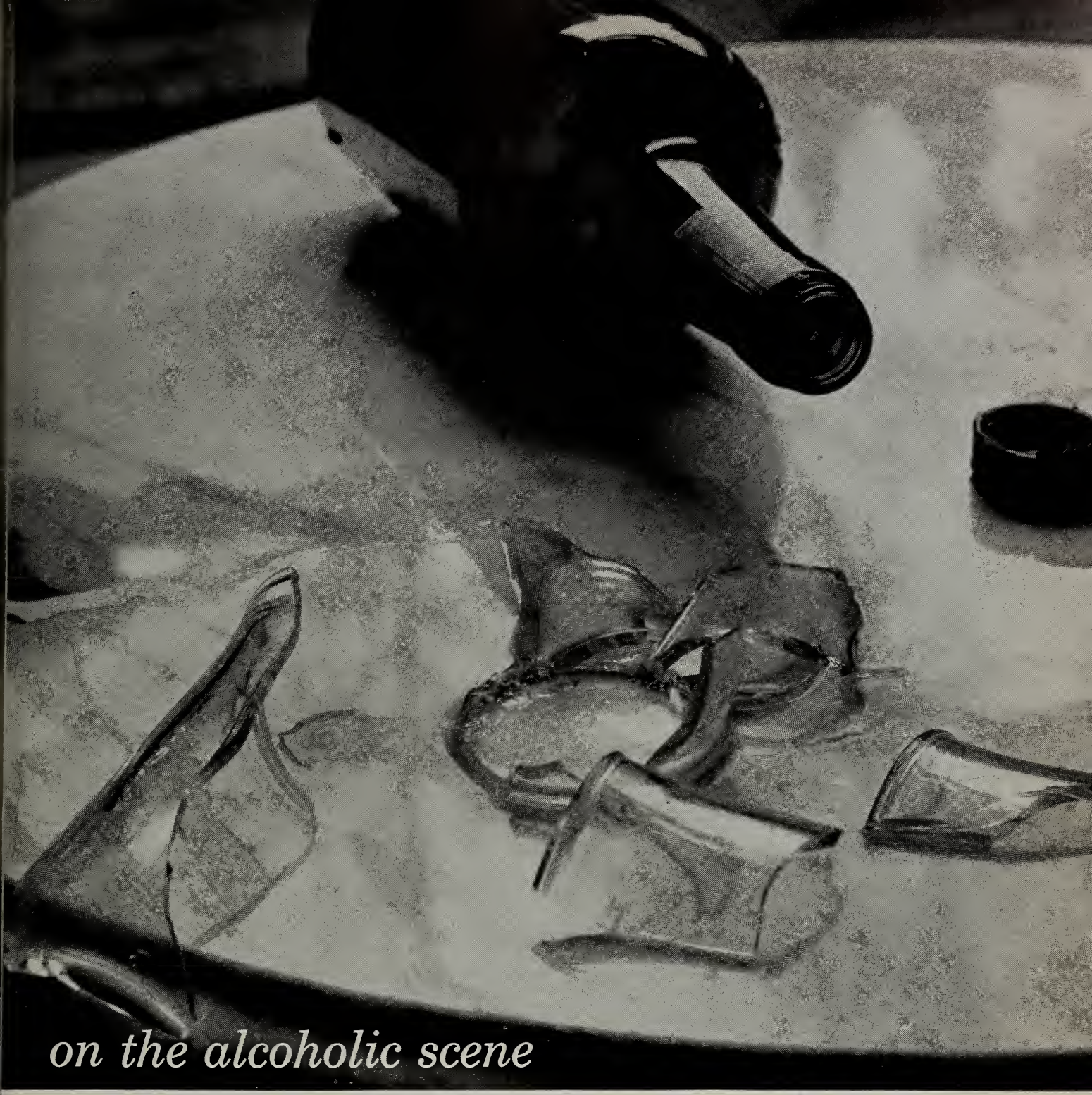
Developments in chemotherapy for the treatment of tuberculosis have reduced the death rate in that disease no less than 70 per cent between 1949 and 1956. The decrease was from 25.5 to 7.6 per 100,000 population.[15] This has meant the closing of many governmentally operated tuberculosis hospitals because of greatly reduced censuses.

In each community, however, there remains, and will remain for many years, a number of tubuculous patients. Such cases will require intensive chemotherapy treatment and follow-up care in their private physicians' offices. The doctor and each patient's family will quite properly insist that the local community hospital provide hospital care for these patients and that their prepayment plan finance such care. The result will be an increase in the number of days of care utilized in the general hospital and a consequent increase in the cost to the prepayment plans.

Already an increasing number of general hospitals and prepayment plans are taking over such patients in their communities. A similar development is occurring in mental disease. The discovery of the tranquilizing drugs has not provided a cure for mental disease, but it has provided a means for safely hospitalizing most of those patients on the open floors of the general hospital.

R. A. Chittick, M.D., superintendent of the Vermont State Mental Hospital, stated recently[16] that due to the use of tranquilizing drugs, "physical restraint and seclusion have been practically eliminated" in the treatment of mental patients. Families of those patients will rightfully insist that they now be treated, as the other sick of the community, by private physicians in local community hospitals. They will likewise insist that the cost of such hospitalization be paid by prepayment plans. To the extent this happens the taxpayer's burden will be decreased, but the prepayment subscriber will discover monthly prepayment rates have taken up the slack in his taxes.

Continued



on the alcoholic scene

Vistaril®

quiets agitation

hydroxyzine pamoate

"... an efficient and convenient means of dealing with the problem of acute agitation in alcoholic intoxication . . . important was the absence of noticeable respiratory depression. . . ."

Miller, R. F.: Clin. Rev. 1:10 (July) 1958

Capsules—25, 50, and 100 mg.
Parenteral Solution (as the HCl)— 25 mg. per cc.,
10 cc. vials and 2 cc. Steraject® Cartridges;
50 mg. per cc., 2 cc. ampules.

Pfizer Laboratories
Division, Chas. Pfizer & Co., Inc.
Brooklyn 6, New York

Pfizer *Science for the world's well-being™*

Community Hospital Bill

Continued

Effect of Prepayment

One of the most important forces affecting the use of hospital care is the prepayment movement itself. The spectacular growth of this movement is well known. Over two-thirds of our population now have some form of hospital coverage. The effects of prepayment coverage on hospital utilization are, in my opinion, clear.

In the report of a nation-wide survey made in 1953,[17] the Health Information Foundation states "the admission rate to hospitals for all persons was 12 per 100 of the population. For persons with (hospital) insurance the rate was 14; for those without insurance the rate was 9. The number of hospital days per 100 persons for all persons per year was 90. For those with insurance there was 100 days per 100 persons, and for those without insurance, 70 days per 100 persons."

Somewhat similar findings can be demonstrated by comparing the 10 states with the highest percentage of population enrolled in Blue Cross in 1956 with the 10 states with the lowest percentage enrolled in that year. The 10 highest enrollment states in 1956 used an average of 128.2 days of general hospital care per 100 of population as compared with 101.1 days for the lowest enrollment states.[18]

Because those with prepayment coverage utilize more hospital service than those without such coverage there has been a tendency to criticize the prepayment movement. The terms "abuse" and "overuse" have been used and somehow the hospitals and the doctors have been associated in a conspiracy to foster this supposed misuse of prepayment.

The question as to whether certain individuals may have gone to the hospital too often and stayed too long has no easy answer. There are no concrete standards by which to determine appropriateness of hospital usage. The question involves a complex of medical, economic and cultural factors as related to the well-being and convenience of the individual patient. The essential question in this connection is not concerned with whether those with prepayment coverage used more hospital care. If prepayment is serving any social purpose at all it would be expected that its members would have had better financial access to hospital care.

The more practical question is: Do patients utilize hospitals' and doctors' services because they have prepayment; or, on the contrary, do patients have prepayment because they want to use hospitals' and doctors' services?

There is some evidence that the latter is the case and that prepayment coverage is a characteristic of those individuals who have built adequate medical and hospital care into their standard of living. In the study by the Health Information Foundation referred to previously it was found that "on the basis of the median, families with insurance incur charges exceeding twice that of uninsured families. If the amount paid by insurance is deleted, leaving out of pocket expenses of $117, this is still twice the (total) charges incurred by uninsured families."

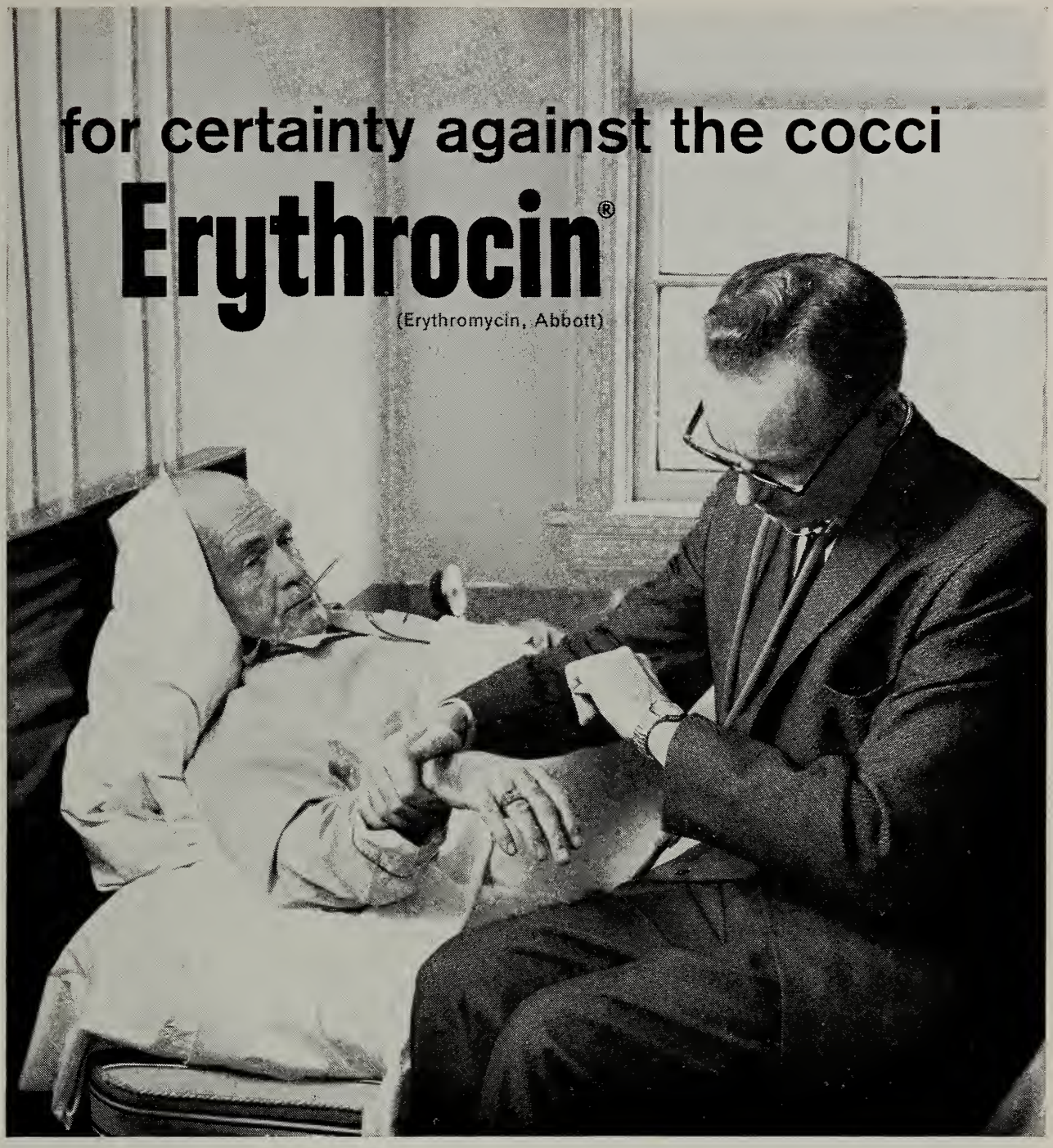
The uninsured themselves present strong evidence that demand for hospital care is increasingly a part of the way of life in the United States and coincidental to prepayment. This past year the uninsured segment of the population had an admission rate to the hospital more than twice that of all the population 25 years ago.

Another way to demonstrate that the public is not after a free ride at the expense of prepayment plans is to examine public usage of medical items which are not covered by prepayment. One such item is prescription sales in drug stores. Such prescriptions give a good index since they can be obtained only from a doctor, are almost never a benefit of prepayment, and occur outside the hospital. The *American Druggist* magazine reports that in 1957 prescription sales by drug stores totaled $1.7 billion, nearly four times the total for 1947. Such a fantastic increase in the out-of-pocket expenditures for one aspect of medical care should offer some proof that the American people are primarily concerned with health care for its own sake and not as a means of beating the prepayment game.

Prepayment is only one of several forces motivating, and making possible, the public's increased utilization of hospital facilities. As mentioned earlier, for example, the average number of days of care used per 100 population was:

—128.2 in those 10 states with highest Blue Cross enrollment.

Continued



an uncommon antibiotic for common infections

Offers fast, high blood levels—plus years of clinical effectiveness. And after all this time, an unparalleled safety record.

Available in easy-to-swallow Filmtabs® (100 and 250 mg.); in tasty, citrus-flavored Oral Suspension (200 mg. per 5-ml. teaspoonful).

ABBOTT

FILMTABS—FILM-SEALED TABLETS, ABBOTT. 001190

Community Hospital Bill

Continued

—121.3 in those 10 states with most urban population.

—122.9 in those 10 states with highest per capita income.

Four states fell into all three categories listed above. The average number of days of care per 100 population used in these four states was 132.2. The three forces together exert a combined influence of dramatic proportions.

The Prepayment Orbit

The percentage of the population covered by prepayment continues to increase and apparently will continue to do so. Currently, the number with prepayment coverage is increasing about three times as rapidly as the population growth. The increasing urbanization and industrialization of the population will bring a larger percentage of the nation's population into the natural orbit of prepayment.

The effects of these changes can be seen in a statement in the report of the Health Information Foundation referred to earlier, "in urban areas 70 per cent of the families have some sort of insurance, and on farms, 45 per cent. Seventy-seven per cent of the families with health insurance obtained it through their place of work, or through another employer." Prepayment plans are employee-group oriented but are working toward developing means and experience in providing coverage for the self-employed and other nongroup individuals.

The influence will be further increased in another way. The quality and scope of benefits continues to grow. Today's prepayment contract is no more comparable to that of 10 years ago than today's automobile is comparable to one of that vintage. Neither is its cost and no one ought to expect it to be. The number of days of coverage per year has had a rather dramatic increase in those years. Many Blue Cross plans have increased the days of coverage provided annually from 30 to 120 in this period. The restrictions as to diseases covered, as well as the items of service covered, has decreased each year.

There is still much room for improvement of scope of coverage, however. This is especially true of commercial insurance coverage which is often tailored to meet competition rather than health needs. Currently, it is estimated that those with prepayment coverage, on the average nationally, have less than 70 per cent of their basic hospital bills covered.

There is a strong feeling on the part of many persons and organizations that prepayment should become fully comprehensive and provide hospital services to ambulatory patients. Some responsible individuals believe that providing prepayment plans for hospital service on an ambulatory basis would remove any financial incentive to enter the hospital as an inpatient in order to have prepayment cover the services.

Support for such thinking was provided recently in a study made under the direction of Paul M. Densen of the Health Insurance Plan of Greater New York and published by the American Hospital Association.[19] This study covered the usage of hospital days of care by two large groups in New York City that were comparable in most all respects. One group, however, had Health Insurance Plan coverage providing full hospital and doctor service on an ambulatory basis. The other group had Blue Shield for inpatient doctor service only. Both groups had the same Blue Cross coverage. During 1955 the group with full hospital coverage on an ambulatory basis utilized 17 per cent fewer hospital days than did the group without such coverage. This study does not cover dollar costs and comparisons of total expenditures under the two schemes are not given. The findings are such, however, as to argue for further study of the extension of prepayment benefits to include hospital services for ambulatory patients.

The cost of the prepayment mechanism iself does, of course, add to the total of the community's expenditures for hospital care. The overhead expenses of prepayment plans run from a minimum of slightly over 6 per cent of the subscribers' payments for the Blue Cross Plans to as much as 30 per cent for a good many of the commercial insurance plans. This is not to say that the opportunity to budget for the costs of hospital care is not worth the overhead. Prepayment plans have more than demonstrated their social worth through placing adequate hospital care within the economic reach of the majority of our population. It is to say, however, that care must be taken by the community in the sort of prepayment mechanism it desires

and the sorts of things it asks its prepayment mechanism to do.

This study has attempted to point out some of the forces that are affecting the total expenditures of the community for hospital care. These forces are generated within the community and are not within the control of hospitals nor prepayment plans. The precise influence of each of the forces cannot be determined. Doubtlessly these forces are interdependent and interacting.

The measurements in this paper probably are also reflections of still other factors in addition to the particular ones examined. This is not consequential so long as the existence of such forces is recognized and their influence is appreciated. The important issue is that recognition be given to the fact that hospitals and prepayment plans must be responsive to the changing characterisics of the community and to those demands which the community itself makes.

Increasing hospital costs and hospital utilization can be rationally explained. There are quite likely some inefficiencies in hospital operations and some inefficient utilization of hospital services. It would be quite surprising if an industry spending over $36 annually for every member of the population and providing a half billion days of care per year did not have some of both occur. Hospitals and prepayment plans must of course continue their efforts to minimize any inefficiencies that do exist.

Inefficiency is not, however, an important factor in the increasing total of the community's expenditures for hospital care. Increasing quality and increasing demand are the two really important influences.

The basic question confronting the American people is what sort and amount of hospital care they want. There are no objective standards as to what they should have. How much hospital care is largely a question of how much hospital care the public wants and is willing to pay for.

The amount of care the public is using does not presently represent any sizable allocation of annual income. During 1956 the total expenditures of all general hospitals of the nation represented only 1.8 per cent of the national disposable personal income, after taxes. The manner in which the nation's income is being increasingly spread across the population, and the increasing use of the prepayment mechanism for averaging the cost of hospital care among the total population, means that there are increasingly fewer individuals for whom hospital care represents in any way a financial problem.

The important thing is that the American people themselves understand the issues and make the decision for themselves. The quality and quantity of hospital care should not be determined by political debate nor through arbitrary rate setting by state regulatory agencies. Such intervention can only lead to deterioration of quality since the public is pretty well demonstrating that it will not decrease the quantity.

REFERENCES

1. Brown, R. E. Nature of hospital costs. HOSPITALS, J.A.H.A. 30:36 April 1, 1956.
2. *Blue Cross Report to the Nation.* 1949, 1958. Chicago Blue Cross Commission.
3. *Current Population Reports.* No. 123 (Series A). U. S. Bureau of the Census.
4. *Survey of Utilization by Age.* Report by Blue Cross Commission, Chicago, February 1957.
5. *The Use of Hospital Facilities in North Carolina.* Report by North Carolina Health Council, 1957.
6. *Age and Sex Distribution of Hospital Patients.* Bulletin 97, American Medical Association, Chicago, 1955.
7. Hospitalization of men at the working ages. *Statistical Bulletin.* Vol. 37 Feb. 1956. Metropolitan Life Insurance Company.
8. Population figures taken from *Current Population Reports.* No. 71 (P-20). U. S. Bureau of the Census.
9. Hospital care figures taken from HOSPITALS, J.A.H.A. 31:15 (Part II) Aug. 16, 1957.
10. Dickinson, F. G. *Accident Burden on Hospitals,* Bulletin 104A, American Medical Association, Chicago, 1958.
11. *Current Population Reports.* No. 166 (Series P-57). U. S. Bureau of the Census, May 1956.
12. *Current Population Reports.* No. 77 (Series P-20). U. S. Bureau of the Census.
13. Roemer, M. I., and Myers, G. W. Multiple admissions to hospitals. *Canad. J. Public Health,* 47:469. Nov. 1956.
14. *Directory of Approved Internships and Residencies* —1957. Chicago, American Medical Association.
15. *Statistical Bulletin.* Metropolitan Life Insurance Company, November 1957.
16. Chittick, R. A. *Minneapolis Tribune,* July 15, 1956.
17. Anderson, O. W., and Feldman, J. J. *Family Medical Costs and Voluntary Insurance.* New York, McGraw-Hill, 1956. Page 26.
18. Hospital statistics from HOSPITALS, J.A.H.A. 31:15 Aug. 1, 1957, Part II. Data on Blue Cross enrollment supplied by Blue Cross Commission, Chicago.
19. Densen, P. M., Balamuth, E.; Shapiro, S. *Prepaid Medical Care and Hospital Utilization.* Chicago, American Hospital Association, 1958. ◄

Where a poly-unsaturated oil is called for in the diet, **Wesson**® satisfies the most exacting requirements

(—and the most exacting appetites).



Compared to other readily available vegetable oils, Wesson is unsurpassed as a serum cholesterol depressant.

Each pint of Wesson contains 437-524 Int. Units of Vitamin E

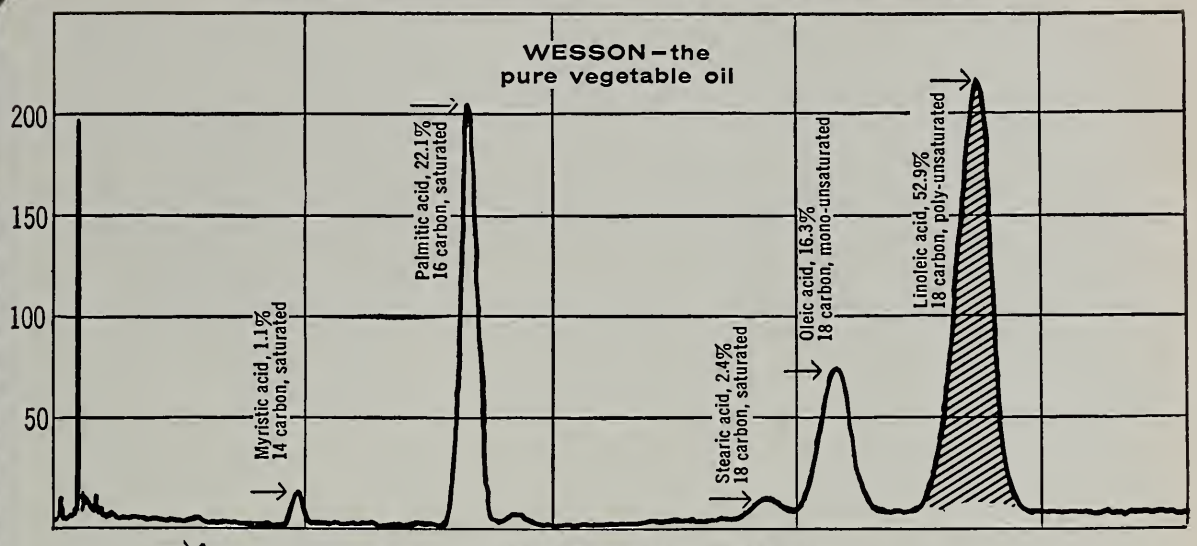
Faithful adherence to any diet is much more likely when foods taste good. The preference for Wesson—amply confirmed by its sales leadership for 59 years—has been reconfirmed in recent tests with brand identification removed. Housewives in a national probability sample indicated marked preference for Wesson, particularly by the criteria of odor, flavor (blandness) and lightness of color.

Wesson's Important Ingredients:

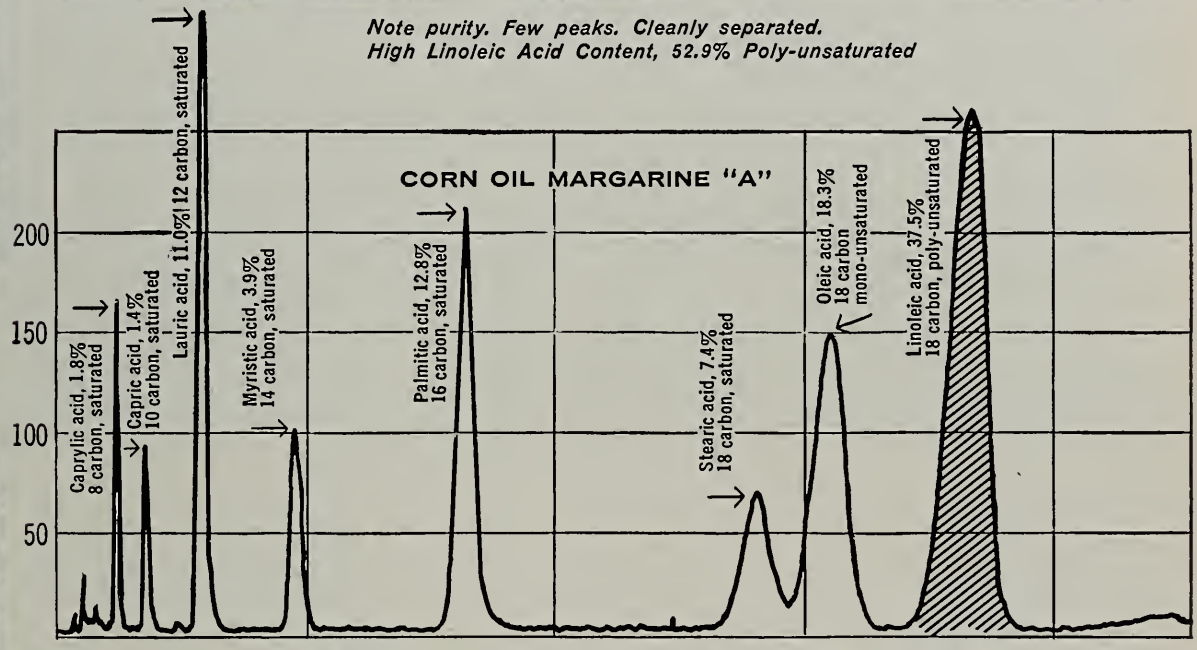
Linoleic acid glycerides	50% to 55%
Phytosterol (predominantly beta sitosterol)	0.4% to 0.7%
Total tocopherols	0.09% to 0.12%

Never hydrogenated—completely salt free

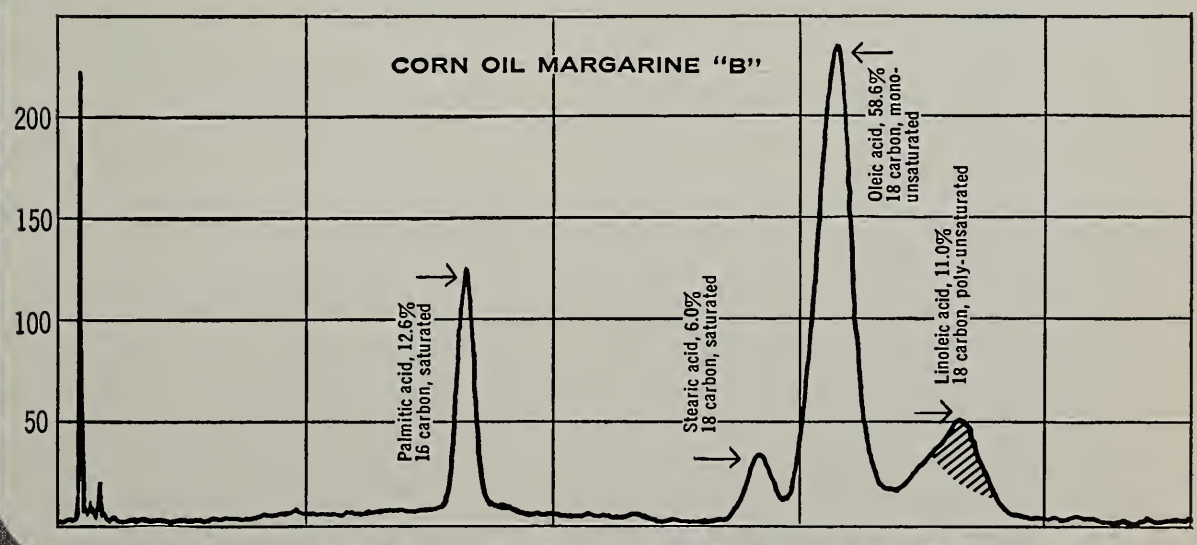
GAS CHROMATOGRAPHS *Produced by Independent Laboratory*



Note purity. Few peaks. Cleanly separated.
High Linoleic Acid Content, 52.9% Poly-unsaturated



Note effect of coconut oil. Medium Linoleic Acid Content, 37.5%



Note effect of hydrogenation. Low Linoleic Acid Content, 11%

NEWS NOTES—from State and Nation

Skiing doctors will be a part of the medical team 'army' organized to care for participants and spectators at the Games in California's Squaw Valley.



Medics and Public Health Officials Organize for the Olympic Games

Is there a doctor on the slope?

There will be, at the VIII Olympic Winter Games at Squaw Valley, Calif. in February.

A squad of 10 skiing physicians will be only a minute's schuss from any competitor injured on the slopes of Squaw Valley during the Games, Feb. 18-28, 1960.

This is only one facet of a sweeping medical and health services plan devised for the Games by the Medical Division of the Olympic Organizing Committee under the direction of Dr. William W. Stiles, a University of California professor of public health.

The Medical Division of the Olympic Organizing Committee is intended "to render emergency medical care to everybody in Squaw Valley who needs it" during the month of February 1960, as well as to prevent sickness by making sure that the Olympic Area meets the highest standards of sanitation in its food service, water supply, housing and sewage disposal.

When Dr. Stiles took over responsibility for this task in December 1958, he had to determine what facilities and services would be needed to accomplish the mission.

He had no precedent to follow, for at nearly all previous modern Olympic Games—both in winter and in summer—complete medical facilities existed in nearby communities. By contrast, in the Squaw Valley-Tahoe area there normally are only a handful of practioners and a 21-bed hospital, the Tahoe Forest Hospital at Truckee.

In planning the medical program, therefore, it was necessary to determine what would be needed in manpower and equipment to protect the health of 1,000 athletes from 34 different countries and some 35,000 daily spectators who would be on hand to see the Games.

It was determined that the program would require a hospital, a pharmacy, first aid stations and physio-therapy rooms as well as sleds and ambulances. To operate the facilities there would have to be a staff of doctors, nurses and public health and administrative personnel. And thousands of dollars worth of medical supplies would be needed.

Dr. Stiles was working within a $25,000 budget for supplying the food and lodging needs of his personnel during February 1960.

Within less than a year, arrangements have been made for these facilities for the Medical Division:

Emergency Hospital Licensed

A 28-bed emergency hospital that will be licensed by (and, therefore, meet the standards of) the State Bureau of Hospitals, five medical aid stations in Squaw Valley, four medical aid stations outside the Valley at points where personnel will be housed (one station, at Tahome, will serve a lodging area and the Mc-



Organizes Olympic Health Team at Squaw Valley

Kinney Creek area where cross-country ski events will be held), a pharmacy, a central supply station, three training or physio-therapy rooms, a mobile and evacuation section with a fleet of six four-wheel drive military ambulances, two over-snow vehicles, eight station wagons as well as sleds for transporting patients over snow, offices for administrative and public health personnel.

Most of the hospital facilities will be located in a one-story permanent building near the athletes' dormitories. Although the hospital's operating room will be equipped for performing major surgery, it is expected that most surgical cases would go to Tahoe Forest Hospital at nearby Truckee or to one of the Reno hospitals 40 miles away.

Hospital beds will be in two quonset huts behind the hospital and connected with it by a sheltered walkway. The quonsets will be fully equipped with heat, insulation, bathrooms, toilets. Food will be supplied from the athletes' dining room 100 feet away where chefs will be preparing for a wide variety of palates and diets of many countries.

Personnel Volunteer

As early as September 1958 a half-dozen physicians had volunteered their services free of charge for the Olympic Winter Games.

There was no public plea for volunteers, but word got around that doctors, nurses and medical technicians would be needed at Squaw Valley for the Games.

The magnitude of the response is indicated by the Medical Division's readiness. Four months before the Olympic Winter Games began it had some 200 people mobilized for service, including a pool of 80 physicians, 60 nurses, a dentist, ambulance drivers, x-ray technicians, laboratory technicians, physio-therapists and public health





experts. All these persons are contributing their time and labor gratis.

Applications have been received from many more doctors and nurses than are needed, and the job billets are full. A hundred doctors applied; 80 doctors were placed on the billet list and the others placed on a reserve list. A hundred and fifty nurses applied for jobs, many of whom said they would work for the entire month of February and supply their own housing.

In For Hard Work

While Dr. Stiles believes that "They're all looking forward to their Squaw Valley duties with the idea they'll get some fun out of it," he notes that "they're in for some hard work and they know it."

Since interest in winter sports influenced the medical people to volunteer, the Division is trying to arrange a six-hour work day and a system of rotating jobs and stations. This will enable the people to see skiing and skating events in various parts of the Olympic area.

Personnel will work a seven-day week, but will be able to take some time off. Peak nursing requirements during the Games will be 30 nurses a day and there is a pool of 60; the 42 doctors needed during the Games period will come from a pool of 78.

Some duty will be of an around-the-clock nature. At the hospital, for example, four doctors and four nurses will be on duty during the day; three nurses and three doctors during swing shift; two doctors and two nurses during graveyard shift.

On 24-Hour Call

Five persons—the head doctor, the assistant medical director, the chief nurse, a laboratory technician and an x-ray technician—will be on 24-hour call.

Most of the doctors will come from California —two-thirds of them from the San Francisco Bay Area. The California Legislature has passed a special law enabling out-of-state physicians to serve professionally at the Games.

Doctors in the Lake Tahoe area have not been organized for participation in the Olympic Winter Games Medical Division program because they are needed to serve their own communities.

Compensation for the Medical Division's staff will be limited to food and lodging. Their housing facilities won't be luxurious. For most of it will mean billets in elementary schools in the Lake Tahoe-Truckee area. A few will be put up at a private lodge in Squaw Valley.

In cases where spectators are receiving more than immediate emergency medical care from doctors on the Medical Division staff, the doctors may submit bills to the patients.

Skiing Doctors!

Some 20 skiing doctors will be available during the Games and during the training period that begins in early February. Of these, 10 will patrol the slopes regularly during the Games period. They will travel with ski patrolmen who are versed in first aid. Skiing doctors will be identified by arm bands.

All professional persons who will serve at Squaw Valley have been carefully screened as to their qualifications, capabilities and personal qualities.

When an athlete is injured, medical aid is always close by. National Ski Patrolmen will note the accident almost immediately. Many of the patrolmen will carry pack radios. Emergency telephones are placed along the courses. A skiing doctor therefore can be immediately summoned to any point.



Rescue Sled on Slopes

If the competitor is lying on the path of a race course, he is immediately removed by men trained in moving injured persons. If an ambulance cannot reach the scene, an Akia rescue sled (an aluminum shell-type sled developed in Australia) is called to transport the athlete.

The victim will go to the nearest medical aid station, or the field hospital, depending on the circumstances.

Arrangements for emergency helicopter service have been made with Stead Air Force Base at Reno in the event that a competitor or spectator must be airlifted to a hospital. The Air Force is also prepared to air-drop medical supplies if snow storms should prevent immediate delivery by land.

Medical care will be made available without charge within the Valley to contestants, officials, employees and volunteers, within the limitations of the available personnel and equipment.

Emergency Care for Fans

Spectators and others for whom the Organizing Committee has only an indirect responsibility will be given initial care on an emergency basis without charge. Spectators may also receive care at the Olympic Hospital for up to 24 hours without charge. Beyond that, specified charges will be made.

Under most circumstances, the spectators will be referred to a physician outside the Valley after he has received emergency attention. If this is not possible, he may receive further care from a Medical Division physician and a fee may be charged, subject to approval of the medical director.

When the facilities for medical treatment at Squaw Valley are completed, they, plus the combined facilities available at Lake Tahoe and Reno, are expected to be more than adequate to meet the needs of persons attending or officiating at the Olympic Winter Games.

In addition to resident physicians in the area, and in addition to the 28-bed Olympic Hospital, there is the modern, 21-bed Tahoe Forest Hospital at Truckee, 12 miles from Squaw Valley and at Reno, 33 miles beyond, there are three hospitals with a combined bed capacity of more than 1,000.

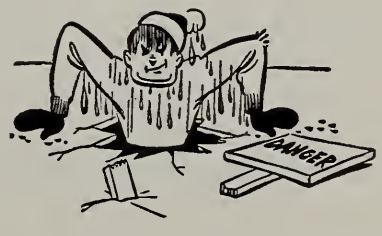
'Fortune' in Equipment

A small fortune would have been needed to outfit the Medical Division's vast facilities. But equipment was borrowed from the Department of Defense, and many other supplies and items of equipment were loaned or donated by private firms. Some pharmaceutical supply houses are loaning medical supplies with the agreement that unused items may be returned and that the Olympic Organizing Committee need pay only for those that are used.

The Medical Division's Public Health Section has a staff of four people headed by Dr. Richard White of Auburn, California, health officer of Placer County. It will be responsible for the sanitary condition of the water supply (the Olympic Area's water supply is under strictest regulation and the water has been certified to be of excellent quality regularly since the distribution system was built in 1959), milk, food preparation and service, sewage disposal, housing, vermin control, communicable disease control. It is also overseeing the responsibility for lost persons and safety.

In the realm of housing, the Public Health Section has a special responsibility. The section will demand that housing meet such minimum standards as: providing at least 400 cubic feet of air space per person; providing rooms of a minimum size; providing at least one lavatory for every 11 people.

Other agencies cooperating with the Medical Division of the Olympic Winter Games Organizing Committee are the health departments of Placer, Nevada and El Dorado Counties; the de-





partments of public health of Nevada and California, the California Industrial Accident Commission and those county, state and national agencies dealing with housing, traffic safety and large scale emergencies.

Coordinator of this complex program is Dr. William W. Stiles, professor of public health at the University of California.

Conference on Adrenal Steroids Scheduled for March

A program on adrenal steroids has been developed for the Third Annual Oklahoma Colloquy on Advances in Medicine to be held March 24-26 at the University of Oklahoma Medical Center, Oklahoma City.

Fifteen guest lecturers and 13 members of the Medical Center faculty will participate.

Scientific papers will cover clinical application of the steroids in endocrinology, infectious diseases, gastroenterology, rheumatic disease, hematological diseases (including the leukemias and immuno-hematological disorders), neoplastic, collagen, renal and allergic diseases.

Others will deal with the basic physiological and biochemical aspects of adrenal steroids. The pharmacology and side effects also will be discussed. In addition to the general sessions, special interest meetings are planned in the fields of medicine, pediatrics, surgery and basic science.

Additional information may be obtained by writing the Office of Postgraduate Education, University of Oklahoma Medical Center, 801 NE 13, Oklahoma City, Oklahoma.

A Whiting, Ind. physician and surgeon, Dr. Clementine E. Frankowski, was recipient of a Medical Women of the Year Award of the American Medical Women's Association at their mid-year meeting in Hot Springs, Ark. in November.

30-Minute "On Location" Color Film Summarizes Current Diabetes Therapy

A new color film on the diagnosis and control of diabetes featuring three outstanding clinicians, has just been completed and is now available for showing to professional audiences.

Entitled, "Current Trends in the Clinical Management of Diabetes," the 30-minute movie was made by The Upjohn Company. It summarizes for physicians the latest information on therapy and management, with emphasis on the milder forms of the disease.

The film also aims to instruct physicians and medical students in the use of Orinase.

Appearing in "Current Trends in the Clinical Management of Diabetes," are Dr. Peter H. Forsham of the University of California, a leading clinical and experimental endocrinologist; Dr. Paul Dudley White of Massachusetts General Hospital, acknowledged dean of cardiovascular specialists, and Dr. Henry Dolger, chief of the Diabetes Clinic, Mt. Sinai Hospital, New York.

The format of the movie is an interesting round-table discussion with actual patients used to illustrate clinical points. The film was shot on "location" in San Francisco, Boston and New York so that each of the principal participants is shown in his usual surroundings.

"Current Trends in the Clinical Management of Diabetes" is available for bookings through local Upjohn representatives or branches.

Dr. Marion E. Hodes Named City of Hope Representative

Appointment of Dr. Marion Edward Hodes, 1100 West Michigan, Indianapolis, as local medical representative for the City of Hope National Medical Center, Duarte, Calif. is announced by Dr. Paul L. Wermer, executive medical director.

Dr. Hodes is authorized to act as liason between physicians in his area and the City of Hope which accepts, only on proper medical referral, medically and economically eligible patients with neoplastic, cardiac, hematologic, thoracic and certain hereditary diseases.

The City of Hope, near Los Angeles, is a free and nonsectarian medical and research center.

Dr. Lewis E. Morrison of Indianapolis was elected as a regional director of the American Rhinologic Society at its recent annual meeting.

Announcing

'ACTIFED'®

Decongestant / Antihistamine

THE POTENTIATED DECONGESTANT



provides symptomatic relief of nasal congestion and rhinorrhea of allergic or infectious origin Many patients whose symptoms are inadequately controlled by decongestants or antihistamines alone respond promptly and favorably to 'ACTIFED'.

'ACTIFED' contains:	in each Tablet	in each tsp. Syrup
'Actidil'® brand Triprolidine Hydrochloride	2.5 mg.	1.25 mg.
'Sudafed'® brand Pseudoephedrine Hydrochloride	60 mg.	30 mg.

safe and effective for patients of all ages suffering from respiratory tract congestion

DOSAGE

	TABLETS	SYRUP (5 cc. tsp.)	
Adults and older children	1	2	three times daily
Children 4 months to 6 years of age	½	1	
Infants through 3 months	–	½	

BURROUGHS WELLCOME & CO. (U.S.A.) INC., Tuckahoe, New York

Board of Health Allocates $4 Million Hill-Burton Share

More than four million dollars in Hill-Burton funds available to Indiana for 1959-60 hospital construction, have been allocated by the Indiana State Board of Health according to A. C. Offut, M.D., board secretary.

The board acted upon recommendations of the Indiana Advisory Hospital and Health Center Planning Council in allocating the available funds to local communities for hospital construction during the fiscal year which will end June 30, 1960.

Under the Federal grant-in-aid program, an Indiana Hospital, Medical Facilities, and Health Center Plan, must be revised annually to reflect changes which have occurred in facilities and current usage of facilities, to recommend the size and location of additional facilities which are considered necessary, and to establish priority for various communities in the state.

Dr. Offutt pointed out, "the plan today covers hospitals, nursing homes, diagnostic and treatment centers and rehabilitation centers, and the funds allocated by the federal government represent only one third of the total amount which will be spent on hospital and/or health center construction this year. The remainder required for construction (two-thirds of the cost) must be borne by the local community in each case."

Indiana's share of the national appropriation for construction of general hospital beds this year is $3,626,621.00, and allocation of this sum, approved by the Board is as follows:

Hendricks County Hospital, Danville	$717,333.00
Sullivan County Hospital, Sullivan	375,000.00
Gibson General Hospital, Princeton	716,875.00
Lafayette Home Hospital, Lafayette	853,650.00
St. Elizabeth Hospital, Lafayette	850,640.00
Daviess County Hospital, Washington	113,123.00

Federal funds appropriated for the construction of diagnostic and treatment facilities in Indiana amounted to $144,679.00, and allocation is as follows:

Daviess County Hospital, Washington	12,000.00
St. Margaret's Hospital, Hammond	25,000.00
Hamilton County Hospital, Noblesville	10,000.00
Porter County Hospital, Valparaiso	30,000.00
Methodist Hospital, Gary	4,007.00
Howard County Hospital, Kokomo	18,792.43
I. U. Dental School Diagnostic and Rehabilitation Unit	44,878.75

In the category of nursing home funds available for construction the total amount available to Indiana from the Hill-Burton program is $235,895, of which $7,217.26 was allocated to the Bartholomew County Hospital at Columbus, and $228,677.74 was allocated to the Good Samaritan Home in Evansville.

Dr. Offut pointed out that there was a total of $171,560.72 available this year for chronic disease facilities, and this amount was allocated to St. Anthony Hospital, Terre Haute.

Since the Hill-Burton program began in 1947, there has been a 40% increase in the total number of hospital beds available in Indiana, Dr. Offut said. "There were 18,029 beds available in 147 hospitals in 1947, while today, there are 25,261 beds available in 134 hospitals and medical facilities. Of the total beds available today, there are about 5,800 beds which should be replaced."

Indiana today has 113 general hospitals, with a total of 11,697 beds; nine tuberculosis hospitals with 967 beds; 10 mental hospitals with a total of 6,426 beds, and two chronic disease hospitals with 421 beds available.

"Exhibits on Film" Available at ISMA Headquarters

Issue III of Exhibits-on-Film, developed, produced and distributed by Lakeside Laboratories, has been received by the headquarters office of ISMA. The filmstrips are made from outstanding scientific exhibits in color slidefilms with recorded commentary.

Filmstrip 7, Part I concerns chemopallidectomy for dystonia and other juvenile involuntary movement disorders, by Irving S. Cooper. This exhibit received the Hektoen Bronze Medal in the AMA Scientific Exhibit. Part II is on care of minor hand injuries by Adrian E. Flatt.

Filmstrip 8 covers the hemodynamic concept of atherosclerosis by Meyer Texon. This exhibit received the Hektoen Silver Medal.

Filmstrip 9, Part I illustrates the intestinal biopsy capsule by William Crosby. Part II illustrates the small intestinal biopsy in steatorrhea by Margot Shiner and Israel Doniach.

Physicians wishing to borrow the filmstrips for showings at staff meetings or similar gatherings may request them from the Headquarters Office, 1021 Hume Mansur Bldg., Indianapolis 4.

Preventive medicine has been practiced here at the Home Lawn Mineral Springs for over 60 years

The activities of the Medical Department here at the Home Lawn Mineral Springs are held to sound medical and scientific standards as it works in close harmony with . . .

the department of hydro-therapy where only trained attendants are in charge of the famous mineral water baths and treatments

the department of electro-therapy completely outfitted with modern equipment and operated by an especially trained person

the department of X-ray, cardiograph, and laboratory supervised by competent and dependable operators

the department of food preparation for those requiring special diets supervised by a trained dietitian.

The Medical Department at Home Lawn Mineral Springs is equipped to care for certain types of rheumatism, arthritis, and allied conditions, as well as nutritional diseases, heart conditions, hypertension, gout, and diabetes.

Various types of mineral baths, as directed by the Medical Department, are highly beneficial in keeping your weight at the proper level according to your activity and time in life.

We in America, young and old, are now much more conscious than ever before as to the need of weight control for good health and a happier, longer life.

Treatment baths in the famous mineral waters here at Home Lawn Mineral Springs under medical direction, along with the health building program, have made Home Lawn known over a wide area of the nation, which justifies the slogan . . . "One of the three best known watering places in America."

HOME LAWN MINERAL SPRINGS

Martinsville, Indiana

M. C. PITKIN, M.D., *Medical Director*

J. W. Gibbs, M.D., *Associate*

Pharmaceutical Industry Leads in Basic Research

Health News Institute, New York—It's no news to most Americans that intensive medical and pharmaceutical research is behind a great majority of the new drugs used so successfully today to combat such one-time killers as tuberculosis, pneumonia, influenza and many other diseases.

The greater part of the research involves the development of new medicines or of new production methods to lower the costs of medicines and thus bring them to more people.

But there is another kind of research which is equally important to the pharmaceutical industry, the Health News Institute points. This is basic research.

Basic research brings in no dollar profits; devises no saleable products; creates no new production shortcuts.

Yet, according to a study conducted by *Science,* American industry in 1953 spent more than $150,000,000 and utilized the talents of almost 6,000 scientists in what the National Science Foundation has defined as "projects which are not identified with specific product or process applications, but rather have the primary objective of adding to the overall scientific knowledge . . ."

To conduct its share of basic research, the pharmaceutical industry employed more than 850 scientists in 1953. These researchers published more than 600 papers on their work . . . approximately 20% of all basic research studies published in that year.

In 1953, basic research cost the pharmaceutical industry more than $16,000,000. This came to more than 10% of all the money spent by private industry on basic research, and from 20 to 25% of the pharmaceutical industry total research budget. In comparison, all American industry during that year spent an average of about 4% of the total research budget on basic research.

The 26 largest pharmaceutical manufacturers alone spent almost $11,000,000 on basic research in 1953. In comparison, the 115 largest petroleum companies spent $10,000,000 on basic research; the 109 largest chemical companies spent $18 million on basic research, and the 186 largest manufacturers of electrical equipment also spent $18,000,0000 on basic research.

Revised Nursing Handbook Includes Greater Detail on Technic

A revised edition of the Home Nursing Handbook of the Metropolitan Life Insurance company will include greater detail in step-by-step technic of actual home care of the patient. The publication, currently being printed, includes information to aid those responsible for the sick in the home.

The revision also contains more emphasis on how the family can face the emotional impact of serious or long-term illness. Copies of the 30-page booklet may be obtained by writing the Metropolitan Life Insurance Company, Health and Welfare Division, 1 Madison Ave., New York 10.

This booklet is intended for use by nurses or professional workers, or for individual distribution to families concerned with acute or chronic patient care. A statement as to the intended use of the booklet should accompany the request.

The pharmaceutical manufacturing industry employed more basic researchers per 1,000 employees . . . 4.5 . . . than any other industry. The chemical industry employs 1.27 basic researchers per 1,000 employees and the electrical equipment industry only .43 per 1,000 employees.

This trend in expenditures on basic research has been maintained, and in some cases, accelerated by the pharmaceutical industry since 1953.

In 1958, the HNI reports, more than $35,000,000 was spent on basic research by the pharmaceutical industry; this amounted to 20% of the $177,000,000 spent by the pharmaceutical industry for all research and development during the year. Seven pharmaceutical companies alone report their total expenditures for basic research at more than $16,000,000.

Why this emphasis on basic research in the pharmacetical industry? The answer is simple. The reason why "grass is green," or what makes "french fried potatoes brown" may be of no interest to some. But to the pharmaceutical industry, the answers to these and other seemingly meaningless questions may mean life to a child dying of leukemia; new hope to a young mother confined to a wheel chair by multiple sclerosis; a normal life for a schizophrenic in a mental hospital, or recovery for a young father stricken by heart disease.

Tell Your Patients about Blue Shield in '60

Your patients are vitally interested in health insurance — insurance against the expense of illness is fast becoming a "must" in the family budget.

Recommend that they investigate membership in BLUE SHIELD—the physicians' own plan for providing an economical method of prepaying the major part of the cost of obstetrical, surgical and medical care.

Blue Shield is continuously developing new coverages and improving services. It is a flexible organization—ready to meet the needs of individuals in an era of changing conditions.

Why not recommend Blue Shield—"the doctors' plan"—in 60?

for further information—write or call

THE DOCTORS PLAN · SPONSORED BY INDIANA STATE MEDICAL ASSOCIATION

Blue Shield

Surgical, Obstetrical, and Medical Coverage

110 North Illinois Street, Indianapolis 9, Ind., ME. 5-9411

Health Service Samples Show Pollution Below "Permissible" Level

A U.S. Public Health Service report on the levels of strontium-90 in the nations' major water courses, based on weekly samples from 51 stations, indicates that the water is substantially below the levels which the National Committee on Radiation Protection and Measurements considers permissible for life-time exposure by the general population.

The data are part of the information being gathered on stream pollution by the national water quality network operated by the Public Health Service. The network includes 17 major rivers.

The study will eventually provide precise measurements of all important forms of pollution in the nation's water resources, including the presence of plankton, and the general chemical, physical and bacteriological characteristics of major rivers and streams.

The water quality network, operated in cooperation with state and local governments, universities and industry, was established in 1956 on recommendation of the President's Advisory Committee on Water Resources Policy. The present 51-station network is expected to increase to 75 during the coming year and will eventually include 250 stations.

Three Hoosier Doctors Speak at Health Conference Program

Three Hoosier physicians took part in the program of the Twelfth Annual Southeastern Indiana Franklin College School Health Conference, Nov. 4 at Franklin College. ISMA, together with seven other organizations, sponsored the meeting.

Program participants include Dr. James H. Belt, epidemiologist, Division of Public Health, Marion County, Dr. Wilson L. Dalton, director of the Shelby County Health Department, and Dr. Walter Portteus, director of the Johnson County Health Department.

The American College of Allergists' graduate instructional course and Annual Congress is scheduled for February 28 to March 4 at the Americana Hotel, Bal Harbour, Miami Beach, Fla.

Inquiries may be addressed to Dr. John D. Gillaspie, 2049 Broadway, Boulder, Colo.

National Nursing League Offers Future Nurses Charter

A national charter for Future Nurses Clubs, high school career clubs helping young people explore nursing and community health programs, will be offered with the beginning of 1960 by the National League for Nursing, New York.

Clubs will be required to meet standards established by an advisory committee in order to be chartered nationally. To be eligible for a charter a club must be organized in a high school, have a minimum of eight members, be open to all who are interested within the policies of the school, have an appropriate advisor or sponsor recognized by the school, devote a substantial part of its program to exploring careers in nursing, and submit reports to headquarters upon request. It may choose its own name and include in its program the exploration of other health careers if it wishes.

A fee of five dollars ($5.00) will be charged for the initial charter, good for the school year following that in which it is originally granted, and the charter may be renewed for two dollars ($2.00) a year upon presentation of a satisfactory report.

There are 3,000 Future Nurses Clubs and clubs with a similar purpose in high schools across the country, the majority of which have been organized since 1950. They became nationally sponsored in 1954 by the Committee on Careers, National League for Nursing. Membership now numbers some 80,000.

Requests for applications for a charter may be made to Future Nurses Clubs, National League for Nursing, 10 Columbus Circle, New York 19, N. Y.

Armstrong Named Resuscitation President; Two-Day Courses Scheduled

Major General George E. Armstrong, former Surgeon General of the U. S. Army and present chief administrative officer of Bellevue Medical Center, New York City, was recently appointed president of the National Resuscitation Society.

The society will conduct several two-day intensive courses in resuscitation to cover both the respiratory and cardiac phases. These are scheduled for Feb. 4-5, April 7-8 and June 2-3, 1960. Inquiries and requests for application forms may be addressed to the National Resuscitation Society, 2 E. 63rd St., New York City, 21.

1958-9 Life Insurance Medical Fund Aids 114 Research Programs, 24 Fellows

The Life Insurance Medical Research Fund aided 114 different heart research programs in the past year, according to the fund's annual report for 1958-59.

In addition, the fund supported 24 research fellows — promising young men and women who demonstrated their interest and ability in heart research.

Nearly 1.2 million dollars were allocated for these research programs and fellowships, Dr. Francis R. Dieuaide, scientific director, pointed out.

"Work on heart problems is going forward today with vigor,' he said. "Helpful results appear in a steady stream. It is wholly reasonable to expect success in gaining control of the major types of cardiovascular disease."

Dr. Dieuaide said that during the past year investigators aided by the fund have obtained new information about hardening of the arteries, coronary artery disease and high blood pressure. Much productive work has also been done on fundamental problems in the functions of the heart and blood vessels.

Since 1945, when the fund was organized, its entire resources have been focused on heart disease, which in its various forms takes a larger toll of human life than any other disease. Thus far the fund has awarded a total of close to 12 million dollars for heart research programs and fellowships. Financial support comes from a membership of more than 140 life insurance companies in the United States and Canada.

New Orleans Assembly Program Includes General Medicine and Specialties

The 23rd annual meeting of the New Orleans Graduate Medical Assembly will be held Mar. 7 to 10, 1960, with headquarters at the Roosevelt Hotel. All physicians are invited to attend.

A faculty of nationally recognized clinicians will conduct a scientific program which embraces all specialties and general medicine. A clinical cruise to the West Indies is being offered after the meeting. Details may be obtained by writing to Dr. Mannie D. Paine, Jr., 1430 Tulane Ave., New Orleans, 12.

Annual Clinical Conference

CHICAGO MEDICAL SOCIETY

MARCH 1, 2, 3 and 4, 1960

Palmer House, Chicago

Daily Half-Hour Lectures by Outstanding Teachers and Speakers on subjects of interest to both general practitioner and specialist.

Panels on Timely Topics — **Teaching Demonstrations**

Medical Color Telecasts — **Instructional Courses**

Scientific Exhibits worthy of real study and helpful and time-saving Technical Exhibits

The Chicago Medical Society Annual Clinical Conference should be a MUST on the calendar of every physician. Plan now to attend and make your reservation at the Palmer House.

Obstetrics-Gynecology Part II Exams Scheduled for April in Chicago

Part II oral and clinical examinations of the American Board of Obstetrics and Gynecology will be conducted at the Edgewater Beach Hotel, Chicago, by the entire board, from April 11 through 16, 1960.

Each candidate will be notified of the exact time for his examination; those who participated in Part I oral examination will be notified of their eligibility soon. Deadline for 1961 applications is Aug. 1, 1960.

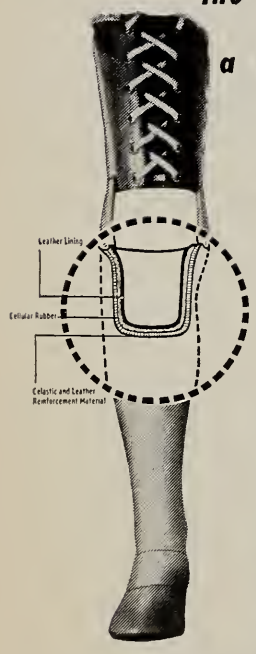
Application requirements may be obtained from the secretary, Dr. Robert L. Faulkner, 2105 Adelbert Road, Cleveland 6, Ohio.

April Venereal Disease Seminar Open to Physicians, Allied Fields

The 11th Annual Symposium on Recent Advances in the Study of Venereal Diseases will be held April 7-8, 1960, in the Palmer House, Chicago. The sessions will be open to all physicians and workers in allied fields. The symposium will follow a venereal disease seminar for public health personnel which begins April 4.

the **SOFT SOCKET**

a new solution for sensitive stumps



The Soft Socket for below-knee amputations provides a new solution for sensitive stumps where weight-bearing has been or may be uncomfortable. In constructing the Soft Socket Limb, a special socket is made which incorporates a layer of a new nitrogen-filled cellular rubber. This produces a slight but tangible degree of softness and resiliency in the socket, with the result that the sudden pressure on the stump caused by the first impact of weight-bearing is greatly reduced. Hanger Research—by testing new ideas, methods and materials—is constantly seeking the better way to make even better prostheses that will bring greater happiness to amputees.

Hanger PROSTHESIS

1529-33 N. ILLINOIS ST., INDIANAPOLIS 2, IND.
3108 BURNET AVENUE, CINCINNATI 29, OHIO
FAIRFIELD AT PONTIAC, FORT WAYNE, IND.
418 N. MAIN ST., EVANSVILLE, IND.

TB Meeting to Include 3 Days of Scientific Programs

Three days of scientific sessions are planned for the annual meeting of the National Tuberculosis Association next May in Los Angeles, Calif. They will be sponsored by the NTA's medical section, the American Trudeau Society, May 16-18, 1960.

ATS meetings will be held in conjunction with the annual meeting of the NTA, May 16-19. Public health sessions will be held concurrently with the medical sessions. Scientific exhibits will be on display throughout the meeting. The Statler-Hilton and the Biltmore will be headquarters hotels.

In addition to sessions at which papers will be presented, the committee has planned five panel discussions and seven luncheon seminars. Panels will include the following topics: Childhood Tuberculosis, Tissue Culture Technics and Mycobacterial Research, Steroids in Nontuberculous Pulmonary Diseases, Adenoviruses in Respiratory Diseases, and the Treatment of the Chemotherapy Failure. Seminar topics will be: Practical Pulmonary Function Testing, Treatment of Bone and Joint Tuberculosis, Compulsory Isolation of the Recalcitrant Patient, Air Pollution and Pulmonary Diseases, Indications for Lung Collapse, Surgery of Lung Cancer, and Treatment of Empyema.

16 Hoosier Surgeons Named Fellows at Recent Congress

Sixteen Indiana surgeons were among 1015 physicians inducted as new Fellows of the American College of Surgeons at a recent Clinical Congress in Atlantic City.

Hoosiers receiving the distinction were Seymour W. Shapiro, East Chicago; Edward G. Dovey, Elkhart; Theodore V. Beutler and John Rousseau, Fort Wayne; Daniel J. Schlessinger, Hammond; John A. Hetherington, Robert E. Lempke, David Lozow, John T. Luros and Loren F. Schmidt, Indianapolis; John F. Kerrigan and Myer Stumer, Michigan City; William H. Garner, Jr., New Albany; Charles Baran, South Bend; Walter R. Vaughn, Vincennes, and Henry R. Schroeder, Jr., Washington.

———

When the debts of businessmen or individuals equal their assets they go into bankruptcy. When the same thing happens to government, it raises the debt limit.—*W. L. Hudson, Quote.*

Burney Elected Vice-President of Military Surgeons' Association

The Association of Military Surgeons at its 66th Annual Convention in Washington November 9-11, elected Dr. Leroy E. Burney, Surgeon General of the Public Health Service, as first vice-president.

Dr. Robert E. Bitner, retired colonel of the Army medical service, and a graduate of Indiana University School of Medicine, has been secretary-editor of the association for the past several years and was re-elected to this position.

Medical Clinics Association Names Two Hoosier Medics as Officers

The American Association of Medical Clinics held its 10th annual meeting at the Sheraton-Blackstone in Chicago September 24-26. Dr. Russell V. Lee of the Palo Alto Medical Clinic in California took office as president. Dr. Joseph B. Davis, Marion, Ind., was the secretary-treasurer of the organization and Dr. Harold D. Caylor of Bluffton, Ind. is one of the trustees.

You've reached old age when you are more interested in pension than passion.—*Anna Herbert, Quote.*

A New Year's Reminder!

don't forget the new

Journal deadline for

all copy and/or changes.

5th day of month

PRECEDING MONTH OF ISSUE

Booklet Deals with Immunization for International Travelers

A revised edition of the booklet "Immunization Information for International Travel" has been published by the Public Health Service. The new edition supersedes all other editions. It may be obtained at a price of 30 cents per copy by writing the Epidemiology and Immunization Branch, Public Health Service, Washington 25. ◄

PEACE OF MIND FROM OFFICE AND BUSINESS WORRIES

OUR SERVICES COVER:

Tax Returns
Bookkeeping
Office Planning
Instructing Personnel
Fees
Partnerships—Clinics
Counselling—Investments
Insurance
Personnel Placement Service

DELINQUENT ACCOUNTS

Individually typed letter to EACH delinquent account EVERY month
No Commission

ASSOCIATES:

Clayton L. Scroggins
John R. Lesick
Richard D. Shelley
Hugh G. Stiffler
Richard J. Conklin
Robert C. Welti
William A. Ogg
Robert O. Holland
Marvin T. Burkett

Member—Society of Professional Business Consultants

Available

PROFESSIONAL BUSINESS MANAGEMENT

FOR DOCTORS ONLY

CLAYTON L. SCROGGINS ASSOCIATES

ESTABLISHED: 1945
WOodburn 1-1010

141 West McMillan Street
Cincinnati 19, Ohio

I would like to talk with one of your representatives.

Name.....

Address.....

.....Telephone.....

All Services Completely Confidential

Add 1

The Signs We Must Live By; Move Over Wyatt, My Eyes Hurt

by corki



When a society of peoples is formed, it must necessarily make a few rules and laws of behavior for protection of the group as a whole and to sort of keep a semblence of order.

Some of these are formal and written into laws (if the society uses a written language), others the unwritten protocol, behavior patterns exacted by the majority (even if the majority don't always adhere!).

It all began with the latter, the unwritten rules as with so-called primitive tribes of today, and developed as the society developed. Which makes it stand to reason that as the society develops, so their laws and patterns become more complicated!

Complicated Lives

In no other society have the lives of individuals and the mass become as complicated as in modern America today (at least, I've read of none to equal us!).

Of the written laws—and behavior patterns—we can see reflections in the signs we live by, and, if we watch and think about them, can spot a perceptible increase in the complications.

For instance, back in the horseback riding era, transportation-wise, I doubt if a rider was confronted by more than a sign designating the town he was entering, if even that! If things had become a little rough, as in the "wild" West, he might have found a sign telling him to "park yore guns here" before he got soused. And when he had had his redeye, if he could read, he might have seen a legend depicting the "Sheriff's Office."

Trotting Limits

Can you imagine his indignation—plain disbelief—had he seen "Trotting limit, 5 mph," or "Use Gee Lane for Turning!" Maybe horses weren't to be tethered at certain populous spots, I don't know, but what would our horsey friend have thought of "Deposit Silver Dollar for 1-hour Tethering"? Well, now.

Time has marched on and strange as it may seem that we somehow have retained the right to carry a hand gun as long as it isn't hidden (with certain other modifications), that's about all we can do without following signs. (Come to think of it, I must wonder what the man in blue would do if I strapped a .22 on my hip and wandered down the street—get a straight-jacket maybe!)

Think of an average day of an average Hoosier following his signs of the times.

He first hops in his car and heads for work, his eyes constantly picking up street signs that buzz little warnings to his hands and feet for action, immediate action—Stop, Slow, Go, Right Turn Only, Speed Limit 30 mph, Begin 25 mph, No Parking, 10-minute Parking, Tow Away Zone, Loading and Unloading Only, Bus Zone, Give Right of Way, One Way Only, Do Not Enter, Straight Ahead Only, etc.





And On-and-off Arrows

There are street signs and road signs and flickering signs and arrow signs and on-and-off arrows and stop-then-go signs. (The one that really takes the cake and a mastermind to interpret is down on South East nearing Raymond in Nap Town . . . I still haven't figured it out, so simply avoid it when possible . . . this after years of driving on supposedly complicated California freeways. Which reminds me, only missed one question when I first applied for a California drivers license. It concerned the time limits on various colored curbs. There are red curbs, green curbs, yellow curbs, various stripped curbs—and, heck, I *never did* get them straightened out!)

But back to our Hoosier arriving at work. Maybe he pulls out a time card and punches the clock (or the boss maybe?) and probably sees a sign "Do not punch after 8:01 a.m." I've seen 'em!

Shades of Carrie Nation!

There's probably a few signs around on the office walls to keep him in line such as "No talking' or "No smoking" (the latter usually referring to women only, shades of Carrie Nation!) to "Don't forget to turn off the lights" and "You're *on the job* until the bell rings!"

So he goes to lunch at the bell and again he follows the traffic signs as referring to pedestrians (spending a good deal of his time "Waiting" for the "Walk" sign), and also following little white "pedestrian" lines—outside of which lines is "Off limits" to the guy hoofing it on a cold winter day.

But that's OK. Don't get me wrong. As with all these complicated laws of action and rules, they are for *his protection.* It says so in fine print. Honest. I read that once.

A Goof is a Goof is a Goof

An Open Letter:

I, Corki Wilson, am hereby relegated to the boondocks. I was way out in left field, as the current generation of hipsters might say. Last month . . .

But my humble apologies first—to Champion Paper and Fiber Company which so generously loaned us the 4-color plates for our delightful Christmas cover picture last month. Somehow the December JOURNAL got to press before anyone remembered the credit for that bright and shining picture.

(signed)
corki

Roast Beef 60c

So he goes into a local hash house (a colloquial expression of our society designating the only joint near enuf to get a fast sandwich and beer and get back at the desk by the bell). There he has a field day reading signs—Roast Beef 60c, Baked Beans 25c, Milk 15c, etc. (or if it is of a higher caliber where there actually *is* roast beef between the bread slices, quoted prices will show slightly higher).

The only sign he misses is the one that says, "No tipping. Our help is adequately paid." It isn't there because the help usually isn't!

He goes back to work by his signs and reads the office signs some more (if he didn't skip the beefless roast beef and make it up in beer).

Well, this can go on and on.

Watch yourself one day as you live by your signs of the times!

Of course, I keep wondering how they will change as our society gets more complicated (it really *is* possible, even probable, you know!).

Pedestrian Hop, Too!

I was reading about the air car the other day. It jets out an air cushion upon which it rides and can hedge hop, house hop, drive over water or probably go over a pedestrian out of his lane without mutilating him too much.

Now think of signs to govern this type of travel—No Hopping Over the State House, Keep Within 12 Inches of Street in Downtown Areas (car needs altimeter!), No Pig-a-back Driving, No Leap-frogging on Main Highways,



IT ALL ADDS UP!

+ Friendly and well trained personnel

+ 33 Modern Laboratories

+ Blue Ribbon Rx Service

+ Finest optical supplies

+ Guaranteed satisfaction

It's easy to do business with White-Haines

The WHITE-HAINES OPTICAL COMPANY
Blue Ribbon Rx Quality for Over Half a Century
INDIANAPOLIS, SOUTH BEND and TERRE HAUTE
GENERAL OFFICES: COLUMBUS 16, OHIO

The Norbury Sanatorium

Established 1901 — Incorporated
Licensed — Jacksonville, Illinois

FRANK GARM NORBURY, A.M., M.D., Medical Director
HENRY A. DOLLEAR, M.D., Superintendent
FRANK B. NORBURY, M.D., Physician

Operating

Maplecrest—

Restful, congenial homelike surroundings are combined with the most modern diagnostic and therapeutic equipment.

Maplewood—

Most comfortable home for individuals requiring rest, scientific diagnosis and treatment. Fireproof construction.

Add 1

Continued

Right of Air-way—Keep Away (someone might even erect an "invisible shield" and post a sign to that effect).

And what will the television people dream up when air cars start hopping thru their TV beams?

My main question is: How will they suspend signs up and away from lowly ground cars to direct air car lanes? (Or, would anyone care for a dissertation on space travel signs?)

Move over Wyatt! I'll gladly park my guns for the quiet and the simple. My ophthalmologist is "Out to Lunch!"

Abstract

"Synopsis of Treatment of Anorectal Diseases"
Stuart T. Ross, M. D. Pp 235
Price $6.50 The C. V. Mosby Co.
St. Louis, Mo.

An excellent manual of diagnostic and therapeutic facts without the usual unessential frills. Its 27 chapters leave little to be desired in the care of anorectal diseases by the G. P. Chapter 15 on Pruritus Ani is in itself worth the price of the manual. Etiology, symptoms and treatment is the basis for each chapter discussion and makes a concise and easily readable digest of important facts. The volume is small enough to carry in a coat pocket, and makes ideal reading material for study of anorectal diseases during slack moments.

W. L. Portteus, M.D.,
Franklin

A Chinese philosopher once said that parents who are afraid to "put their foot down" usually have children who step on toes. Because of strong parental influence in the right direction, delinquency is almost unheard of in our Chinese-American communities.—*Sunshine Magazine.*

———

We heard of a man who was having trouble with his car. He had bought a carburetor advertised to save 30% on his gasoline, a transmission guaranteed to save 50%, and new spark plugs that would save 40%.

"Well, what's the trouble?" a friend asked.

"Just that when I drive 10 miles, the gas tank overflows!"
—*Griff Niblack, Indianapolis News.*

———

The installment collector came around to remind Joe he was seven payments behind on his piano. "Well," replied Joe, "the company advertises 'pay as you play'—and I play very poorly!"—*Service for Company Publications.*

A HAPPY

New Year

to you all

The Journal Staff

Deaths . . .

Roxford D. Arford, M.D.

Dr. Roxford D. Arford, physician in the Middletown, Ind. area for 46 years, died Nov. 6 at Anderson. He was 73.

A senior ISMA member, Dr. Arford was a graduate of Loyola University School of Medicine, and was a member of the Masonic lodge, Indianapolis Scottish Rite and the American Legion. He served as a medical corps member during World War I.

Lowery H. Bear, M.D.

Dr. Lowery H. Bear, 91-year-old Vevay, Ind. physician, died Nov. 26 in his home.

A graduate of the Medical College of Indiana in 1892, Dr. Bear was a senior and 50-Year Club ISMA member. He practiced medicine for 63 years.

Dr. Clarence E. Briscoe, M.D.

A New Albany, Ind. physician for 52 years, Dr. Clarence E. Briscoe, died November 25 at Peewee Valley, Ky., at the age of 83.

Dr. Briscoe was a former Floyd County coroner, and a senior and 50-Year Club ISMA member. He had served as president of the Floyd County Medical Society, and was a 50-year member of the Masonic Lodge and the American Legion, having served in World War I. Dr. Briscoe was a 1903 graduate of the Kentucky School of Medicine.

Jessie C. Calvin, M.D.

A 91-year old retired Fort Wayne physician, Dr. Jessie C. Calvin, died Nov. 22 in a Fort Wayne Hospital.

Dr. Calvin, who was instrumental in organizing the Allen County Medical Auxiliary, was a 50-Year Club and senior ISMA member having practiced 62 years. She was recipient of a distinguished service award of the American Society for the Control of Cancer, and had helped to establish the visiting nurse league service in Fort Wayne in 1897. She and her husband, the late Dr. Warren Calvin, began practice in Fort Wayne in 1897.

Minor Miller, M.D.

Dr. Minor Miller, head of the Evansville-Vanderburg County Health Department since 1951, died Nov. 17 at Evansville. He was 72.

Dr. Miller graduated from the Indiana University School of Medicine in 1912.

District, County News

Thirteenth District

Dr. Leroy E. Burney, Surgeon General of the United States Public Health Service, gave the Giordano Memorial Lecture at the Nov. 18 meeting of the Thirteenth District Medical Society.

Also on the program for the afternoon sessions were Dr. Earl W. Mericle, Indianapolis, ISMA President, Dr. Thomas G. Ward, professor of virology, University of Notre Dame, Dr. Helmut A. Gordon, Lobund Laboratory, University of Notre Dame.

Allen

Ninety-four members of the Allen County Medical Society met Dec. 1 for afternoon and evening scientific sessions. Speakers included Dr. Alex J. Steigman, on "Histoplasmosis in Childhood" and "Chronic Chest Diseases in Children," and Dr. Richard B. Smith on "Clinical Value of Pulmonary Function Test" and "Obstructive Pulmonary Emphysema."

At the November 17 meeting on socialized medicine, the keynote speaker was Dr. Rueben Dalbec, of AMA, on "Socialized Medicine and Forand Bill Legislation." Also on the program were Dr. Earl Mericle, Indianapolis, ISMA president, Dr. Guy A. Owsley, Hartford City, ISMA president-elect and Dr. Maurice Glock, Fort Wayne, ISMA Council chairman.

Boone

Dr. John Hetherington, Indianapolis, spoke on "Vascular Lesions Involving the Brain" at the Nov. 3 meeting of the Boone County Medical Society at Lebanon. Thirteen members attended.

Clay

Nine members of the Clay County Medical Society met at Brazil Nov. 17 for a discussion of the proposed Forand Bill legislation.

Fayette-Franklin

A representative from the Indiana State Police spoke on "Highway Safety with Seat Belts" at the Nov. 10 meeting of the Fayette-Franklin Medical Society at Connersivlle. Fourteen members attended.

Floyd

Dr. Robert Dyer spoke on "Anticoagulants" at the Nov. 13 meeting of the Floyd County Medical Society at New Albany. There were 30 members present.

County News

Continued

Fountain-Warren

Members of the Fountain-Warren Medical Society met Nov. 5 at Attica to discuss proceedings of the 110th annual ISMA convention. Seven doctors attended.

Hamilton

Dr. John Lein spoke on "The Incompetent Cervical Os Syndrome" at the Nov. 10 meeting of the Hamilton County Medical Society. Twenty-two members attended.

Lake

Dr. Leonard Lovshin, associate professor of medicine at Bunts Institute, Cleveland Clinic Foundation, spoke on the "Tired Mother Syndrome" at the Nov. 18 meeting of the Lake County Medical Society at Gary. Ninety members attended.

In October, the society was a co-sponsor, with the Hammond Area Community Council, for a Health Fair.

LaPorte

"Cancer of the Breast" was the topic of the scientific paper given by Dr. Joseph T. Gault, associate professor of clinical surgery, Chicago Medical School, at the Nov. 17 meeting of the LaPorte County Medical Society.

Marion

Members of the Marion County Medical Society and their wives heard Donald Dunham, medical writer for the Cleveland Press, discuss "Headlines and Headaches" at their Nov. 24 meeting. Following the program, they attended an open house at the society's new headquarters.

Montgomery

Dr. Phillip White spoke on "Epilepsy" at the Nov. 19 meeting of the Montgomery County Medical Society at Crawfordsville. Twenty-six members attended.

Parke-Vermillion

Dr. Donn R. Gossom spoke on "The Colon" at the Nov. 18 meeting of the Parke-Vermillion Medical Society at Clinton. Ten members were present.

Owen-Monroe

Dr. James Gosman, Indianapolis, spoke on "Recent Advances in the Practice of Dermatology" at the Nov. 19 meeting of the Owen-Monroe Medical Society. Thirty-three members attended.

Perry

Seven members of the Perry County Medical Society heard Dr. N. L. Neifert speak on "Do's and Don'ts of Initial Hospital Care" at their Oct. 6 meeting.

Putnam

Dr. Pat Flanagan spoke on "Advances in Anesthesia" at the Nov. 13 meeting of the Putnam County Medical Society at Greencastle.

Rush

"Common Skin Disorders" was the subject of a talk given by Dr. James Gosman, Indianapolis, at the Nov. 12 meeting of the Rush County Medical Society.

The group met on Nov. 19 with the Rush County Nurses Association to see a film entitled "On Call to a Nation."

Wayne-Union

Forty-four members of the Wayne - Union Medical Society met Nov. 10 at Richmond to hear Grimsely Hobbs, Ph.D., Associate Professor of Philosophy at Earlham College, speak on "Philosophy of Medical Ethics."

Wells

Members of the Wells County Medical Society met Nov. 16 to view the AMA film strip "Aging —A Community Responsibility."

Whitley

Fourteen members of the Whitley County Medical Society and their wives met Nov. 10 to hear Dr. Otto Lehmberg talk and show movies on a recent Alaskan Trip.

It wasn't so bad when the law firm of Henderson, Wakefield, Nelson, O'Brien, Garver and Harper merged with Jaffe, Tierman, Davies, Weiner, Erba and Sobol. But when this combination joined forces with the firm of Fagin, Stevens, Hoffman, Ross, Bussman and Bayne, their PBX operator gave up and now answers the telephone by saying, "Good morning—this is We the People!"—*Telephone Magazine.*

"I am beginning to suspect," said the bridegroom, "that your mother has a low opinion of me."

"Whatever makes you think that?" asked the bride.

Replied the groom, "These towels she gave us are marked 'Hers' and 'It'"—*Patuxent River Tester.*

Association Reports

EXECUTIVE COMMITTEE

November 11, 1959

Roll call showed the following present: Don E. Wood, M. D., chairman; Wendell E. Covalt, M. D.; Earl W. Mericle, M. D.; Guy A. Owsley, M. D.; Maurice E. Glock, M. D.; Okla W. Sicks, M. D.

Frank B. Ramsey, M. D., editor of *The Journal;* Robert Hollowell, attorney, and James A. Waggener, executive secretary.

Guests: Richard J. Bennett, M. D., and Percy E. Hopkins, M. D., both of Chicago.

Membership Report

Number of members as of October 31, 1958 ---- 4,166

1959 members as of October 31, 1959:

Full dues paying	3,547
Interns	39
Residents	173
Council remitted	39
Senior	396
Military	43
Honorary	1

Total 1959 members as of October 31, 1959	4,238
Gain over last year	72
Number of members December 31, 1958	4,201
Delinquent members as of October 31, 1959	6
Number of AMA members as of October 31, 1958	4,029
1959 AMA members:	
Dues paying	3,376
Exempt, but active	732
Total 1959 AMA members as of October 31, 1959	4,108
Gain over last year	79
Number of AMA members as of December 31, 1958	4,052
Delinquent AMA members as of October 31, 1959 (The above paid 1958 AMA dues but not 1959)	13
Number who have paid state dues but not AMA dues in 1959	117
	130

Headquarters Office

The secretary reported on the activities of the field men, contacting the county medical societies and, if authorized by the society, visiting physicians who were not members of the local society or the American Medical Association, and from reports indications are that some additional members will be gained for both the state association and the AMA in the year 1960.

Treasurer's Office

The treasurer reported on the financial condition of the Association, and the report was approved by consent.

The purchase of a $25,000.00 blanket bond covering all employees and officers of the Association, and a $25,000.00 forgery bond was approved on motion of Drs. Mericle and Owsley.

Legislative Matters

National

Forand Bill. Dr. Wood reported upon the St. Louis meeting regarding the Forand Bill and the proposed plans of the Commission on Legislation to implement activity in the state of Indiana on this issue.

McNamara Hearings. Dr. Wood also reported on the McNamara hearing which had been held in Boston, West Virginia and Pittsburgh, and the forthcoming meeting in Miami. In a discussion which followed concerning the extension of social security, it was pointed out that physicians are being harassed by persons wanting examinations as potential applicants for disability under social security.

It was suggested that many of these people would not be eligible, and in visiting a Social Security office, a person merely handed them a blank instead of first discussing with them whether or not they would be eligible if they were found to be disabled.

It was the consensus of opinion that the Social Security office should do a preliminary screening job with these applicants before putting them to the trouble and expense of visiting a doctor for a physical examination. By consent, it was agreed that the Commission on Governmental Medical Services should be asked to study this problem and to see if some arrangement could be made with the Social Security Administration for a change in its administrative procedures for handling applicants under the disability freeze program.

1959 Annual Convention Indianapolis, October 6 to 9, 1959

The secretary read the report of the Medical Exhibitors' Association regarding the 1959 convention.

Organization Matters

The request of the Medical Assistants Association for approval of recommended bylaws changes was approved on motion of Drs. Mericle and Covalt, after the proposed changes have been reviewed by Mr. Hollowell.

The secretary presented a resolution adopted by the Commission on Voluntary Health Agencies which was proposed to be distributed to the component county medical societies. The resolution and distribution were approved on motion of Drs. Owsley and Covalt.

The secretary also reported that the Commission on Voluntary Health Agencies had made plans to call in the heads of the voluntary health agencies of the state of Indiana for a meeting with the Commission.

The request of the Indiana Health Foundation that the State Association designate a Medical Advisory Committee to advise the foundation as to the disposition of funds for medical research was discussed, and on motion of Drs. Mericle and Sicks the executive secretary will assume this role.

The resolutions to be presented to the interim ses-

Executive Committee

Continued

sion of the American Medical Association at Dallas were reviewed and the resolutions on intern training and re-evaluation of acceditation requirements, as approved by the House of Delegates, were ordered introduced.

A resolution requesting the AMA to study the need and the feasibility of establishing a home for aged physicians and those who have retired from active practice was discussed and upon motion of Drs. Mericle and Glock this resolution was to be given to the delegates for introduction if they deem it wise.

A letter from Dr. John K. Kingsbury, addressed to Dr. Kenneth L. Olson, was read to the committee at the request of Dr. Olson, in which Dr. Kingsbury pointed out his gratitude for the honor bestowed upon him by the Indiana State Medical Association in naming him the "Physician of the Year."

The secretary read the correspondence he had had with the Governor regarding the appointment of representatives from the State of Indiana to the 1961 White Conference on Aging. Quite a discussion was held on this matter and the Committee recommended that the Commission on Public Health work very closely with Dr. George Davis of Purdue University in order to have medicine adequately represented at this conference.

Corporate membership in the Indiana Public Health Association was approved by consent.

Membership in the Indiana State Chamber of Commerce in the amount of $1,000.00 was approved on motion of Drs. Glock and Mericle.

Commission on Forensic Sciences. A letter from Dr. Edward B. Smith, on behalf of the Commission on Forensic Sciences of the State of Indiana, was read, in which Dr. Smith stated the Legislature gave the commission no funds with which to operate and they were hopeful of procuring money from private sources to get the work of the commission under way, and in which he requested a gift of $5,000.00 from the Indiana State Medical Association. By consent it was agreed that the Association should not make a contribution to this cause. The secretary was instructed to write Dr. Smith a letter explaining the reasons.

New Business

Subscription campaign. Dr. Owsley suggested that the Association should undertake a subscription campaign among the physicians of the State of Indiana in an effort to raise additional funds to be used in the construction and the equipping of the new building, in the hope that this might offset the necessity of using the Association's reserve funds. By consent the Executive Committee agreed that this should be done, and this recommendation is to be passed on to the Building Committee when it is appointed.

Dr. Owsley reported on his recent visit with Dr. F. J. L. Blasingame and their discussion of unification of physicians, and a tape report of the action taken in Texas in 1954 was presented to the Committee.

Following discussion of this, upon motion of Drs. Glock and Mericle, the Executive Committee is to direct the Commission on Convention Arrangements to invite all of the presidents and secretaries of the specialty groups to meet with the Commission and the Executive Committee at 6:00 p.m. on December 16, 1959, at the Student Union Building for a discussion of ways of unifying physicians, and the expense of this meeting is to be borne by the Indiana State Medical Association.

Attorney. The question of another attorney for the Indiana State Medical Association was dicussed and Mr. Hollowell offered the services of Judge Ralph Hamill. This offer was accepted upon motion of Drs. Owsley and Mericle.

Dr. Owsley discussed the request for a liaison group to work with a similar committee of the Indiana Hospital Licensing Council to discuss patient care. This request was approved by consent and assigned to the appropriate commission.

The secretary reported on a call from Dr. W. B. Challman expressing the opinion that the Association should prepare a news release condemning Mr. Arthur S. Flemming, head of the Health, Education and Welfare Department, for his statement regarding cranberries. By consent it was agreed that the Association should not enter into this controversy.

The formation of a Health League was discussed. Upon motion of Drs. Mericle and Covalt, Dr. Wood was requested to take this matter to his Commission on Legislation and to come back to the Committee with their recommendations.

The Journal

The editor reported on the recent State Medical Advertising Bureau conference in Chicago and the fact that the Indiana Journal was rated among the top seven journals in the country.

Notice of increase in publication prices from C. E. Pauley and Company was read in which it was pointed out that there would a 5% across the board increase effective November 1, 1959, and another increase of the same amount on Nov. 1, 1960.

The purchase of a typewriter for *The Journal* was approved on motion of Drs. Owsley and Mericle.

Medical Defense

Illinois Medical Witness Plan. Dr. Richard J. Bennett and Dr. Percy E. Hopkins of Chicago were introduced and they discussed the recent activities in the State of Illinois with the federal judges in establishing a medical witness plan. It was explained that they were appearing before the Indiana State Medical Association at the request of two of the federal judges in the northern part of the state who had been meeting with the federal judges in Illinois and Wisconsin for the discussion of a medical witness program, and these judges had requested the representatives from the Illinois State Medical Association to explain this plan to the Indiana State Medical

Association in the hopes that Indiana would adopt a similar plan of cooperation with the federal courts.

After a very comprehensive review of the work undertaken by the Illinois State Medical Association and the federal judges was presented, many questions were asked of the Illinois representatives and upon motion of Drs. Mericle and Owsley it was agreed that the question should be referred to the Commission on Legislation for study.

Future Meetings

The AMA Interim Session in Dallas, Dec. 1-4, 1959, was called to the attention of the committee.

Mental Health Conference, Chicago, Nov. 20-21, 1959. Dr. Mericle reported that Dr. Howard A. Stellner of Fort Wayne will represent the Association at this meeting.

There being no further business the meeting adjourned. The Committee will meet again at 4:00 p. m., Wednesday, Dec. 16, 1959. ◄

A State of Otherness

A great proportion of the thoughts with which we live are not thought out by us with the evidence in hand. With some shame we recognize that the greater part of the things we say we do not understand very well; and if we ask ourselves why we say them, we will observe that we say them only for this reason: that we have heard them said, that other people say them. . . .

We have abandoned ourselves to other people and we live in a state of otherness, constantly deceiving and defrauding ourselves. We are afraid of our own life, which is synonymous with solitude, and we flee from it, from its genuine reality, from the effort it demands; we hide our own selves behind the selves of other people, we disguise ourselves behind society.

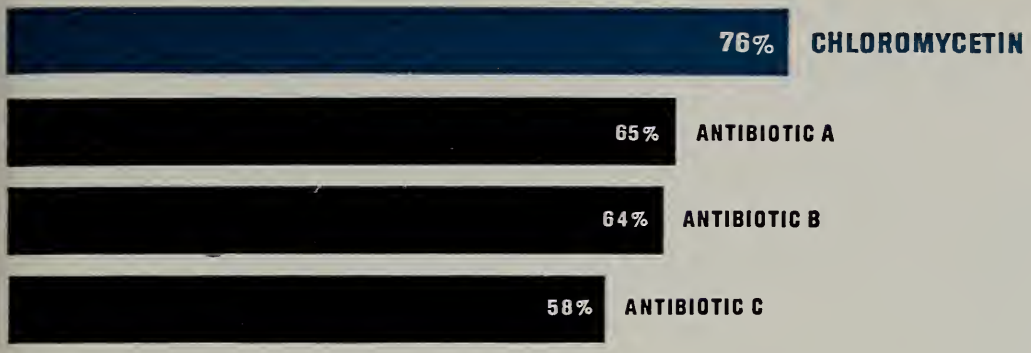
Jose Ortega Y Gasset
Man and Crisis

Acute Isomorphy

America suffers from a new and baffling social disease: acute isomorphy. Whether we like it or not, we are growing more and more alike, not simply in terms of the superficial features of living—our clothing, our automobiles, or houses, our tastes—but, more troublingly, in the bedrock conceptions we have of life: what it is all about, what we are in the world for, and what we are supposed to be doing with our precious three-score and ten.

Dr. Van Cleve Morris
Professor of Education
Douglas College, Rutgers Univ.
"Conformity, Rebellion, and the Authentic Life"
Teachers College Record
Oct. 1959

IN VITRO SENSITIVITY OF GRAM-POSITIVE COCCI FROM 5,600 CONSECUTIVE CULTURES TO CHLOROMYCETIN AND TO THREE OTHER BROAD-SPECTRUM ANTIBIOTICS*

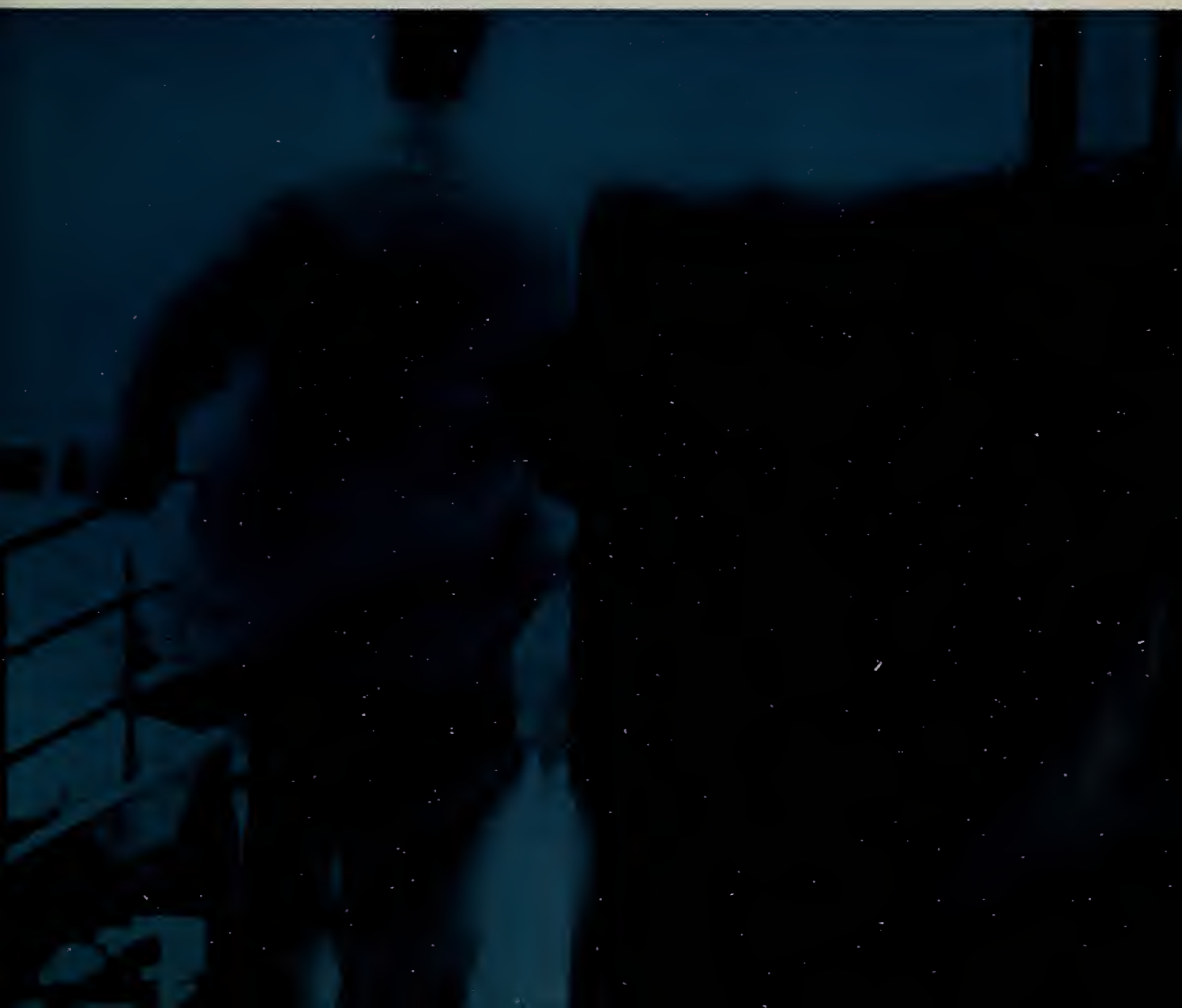


REFERENCES: (1) Leming, B. H., Jr., & Flanigan, C., Jr., in Welch, H., & Marti-Ibañez, F.: Antibiotics Annual 1958-1959, New York, Medical Encyclopedia, Inc., 1959, p. 414. (2) Goslings, W. R. O., & Buchli, K.: *Arch. Int. Med.* **102**:691, 1958. (3) Suter, L. S., & Ulrich, E. W.: *Antibiotics & Chemother.* **9**:38, 1959. (4) Metzger, W. I., in Welch, H., & Marti-Ibañez, F.: Antibiotics Annual 1958-1959, New York, Medical Encyclopedia, Inc., 1959, p. 966. (5) Fischer, H. G.: *Deutsche med. Wchnschr.* **84**:257, 1959. (6) Borchardt, K. A.: *Antibiotics & Chemother.* **8**:564, 1958. (7) Schneierson, S. S.: *J. Mt. Sinai Hosp. New York* **25**:52, 1958. (8) Waisbren, B. A.: *Wisconsin M. J.* **57**:89, 1958.

*Adapted from Leming & Flanigan.[1]

PARKE, DAVIS & COMPANY • DETROIT 32, MICHIGAN

09060



The Journal

February 1960

of the INDIANA STATE MEDICAL ASSOCIATION

Office of Publication:
1019 Hume Mansur Building, Indianapolis, Indiana

$1.00 per copy
except Yearbook
$5.00 per year

Contents

SCIENTIFIC

Cardiology at General Hospital, Kenneth G. Kohlstaedt, M.D., Indianapolis 253
Robert M. Moore Heart Clinic, a pictorial view 254
Employment of Cardiacs, Charles Fisch, M.D., Indianapolis 255
Effect of Digitalis on the Master Exercise Test, Edward Steinmetz, M.D., Indianapolis 259
Electrocardiographic Diagnosis and Clinical Implications of Ventricular Premature Systoles, Robert B. Chevalier, M.D., Charles Fisch, M.D., Indianapolis 263
Metastatic Tumors of the Pericardium, Pasquale D. Genovese, M.D., Dallas B. Fouts Sr., M.D., Indianapolis 267
Schematic drawing of of cover art (with explanation) 278-79
Diagnosis of Patent Ductus Arteriosus with Pulmonary Hypertension Without Reversed Flow, Ward Laramore, M.D., Indianapolis 280
'Silent' Myocardial Infarction, Wendell A. Shullenberger, M.D., Indianapolis 285
'Non-Cardiac' Congestive Heart Failure, Dean A. Miller, M.D., Indianapolis 290
Lipoma of the Heart: Report of Two Cases, Emmett C. Pierce, M.D., Robert E. Bakemeier, M.D., Indianapolis 294
Ventricular Aneurysm with Characteristic EKG Changes, Report of a Case, Howard M. Rice, M.D., Charles Fisch, M.D., Everett L. Hays, M.D., Indianapolis 297

EDITORIALS

Fat Metabolism and Cholesterol 301
Accidental Poisonings Are Preventable 302
Drug Prices 303
AMEF Shows Steady But Vigorous Growth 303
From New York: **Why Blame Blue Cross?** 304
From American Red Cross: **Fifty Years of Conserving Human Life** 305

SPECIAL FEATURES

'I Was in Prison and You Came to Me' 240
St. John's Wort, Miki Wilson (beginning a series on herbs in medical history) 316
School Phobia: Psychiatric First Aid, Gordon T. Brown, M.D., Indianapolis 320
Contributions of the Pharmaceutical Industry to Medical Science, John E. McKeen, president, Charles Pfizer & Company, Inc. 328

REGULAR FEATURES

Month in Washington 226
Abstracts 229
Fourth Estate 230
Why You Should Support Blue Shield (12th in a series) 236
President's Page 306
Woman's Auxiliary Reports 307
Medical Panorama, A. W. Cavins, M.D., Terre Haute 308
AMEF Needs Your Support 347
News Notes: 351
Help Given Mother Needing Medical Care, Aid for Children 351
Reduce Lung Cancer Risk by Elimination of Smoking: Burney 355
Hoosiers in Dallas: AMA Meeting Photos 359
Journal Essay Contest 376
Add 1, by corki 361
Deaths 368
Lighter Vein 375
Advertisers' Index 386

BUSINESS

County News 369
Association News: Executive Committee, Dec. 16, 1959 372

EDITORIAL AND ADVERTISING INFORMATION

All articles must be typewritten, double-spaced with margins of one inch.

Photographs should be printed on glossy paper. Negatives cannot be used.

Illustrations are desirable. Selection of illustrations submitted at discretion of editor and editorial board members. Cost of color illustrations must be shared by the author.

Contributors are responsible for all statements made in their articles. The editors and editorial board members may not be in agreement with all views expressed by authors, but it is desired to give all authors as great latitude as possible. However, the right is reserved to reduce in length or reject any article.

Articles are accepted for publication with the understanding that they are submitted for exclusive publication in THE JOURNAL of the Indiana State Medical Association.

Communications dealing with editorial matter should be sent to Frank B. Ramsey, M.D., Editor, 1802 North Illinois Street, Indianapolis 2, Indiana. All other communications should be sent to THE JOURNAL of the Indiana State Medical Association, 1019 Hume Mansur Building, Indianapolis 4, Indiana.

Advertising rates will be furnished on request. Copy must be received by the 5th of the month preceding month of issue. (Scientific manuscripts must be received at least two weeks earlier if geared for a specific issue.)

Entered as second class matter January 25, 1933, at the Postoffice at Indianapolis, Indiana. Copyright, 1960, by the Indiana State Medical Association. Published monthly at 1019 Hume Mansur Bldg., Indianapolis 4, Indiana.

Abstracts:

THE CARE OF MINOR HAND INJURIES

Adrian E. Flatt, M.A., M.D., F.R.C.S. Pp. 257, price $9.50. C. V. Mosby Co., St. Louis, 1959

While the title of this book may be a bit misleading, its contents certainly are not minor. Divided into Part I, General Principles of Care, and Part II, The Care of Specific Injuries, the book gives a ready reference for the busy physician in caring for hand injuries. Even a so-called minor injury to the hand can be quite disabling and patients often remark, "I did not realize how important my finger was until it was injured and I could not use it."

Mechanization on the farm, increasing "do it yourself addicts," and increasing gadgets in the home make hand injuries more commonplace. Chapter IX covers crush injuries, a frequent injury among children as seen by the general practitioner. The volume is well illustrated; follows an easily readable outline, and recommends equipment the author has found to be effective.

Attention to the chapters on tendon, joint and bone injuries will aid the practitioner in restoring function to as near normal as is compatable with tissue loss. I can sincerely recommend this book to any student, resident or practitioner as a valuable addition to his library.

Walter L. Portteus, M.D.,
Franklin

SYNOPSIS OF GYNECOLOGY

R. J. Crossen, M.D., D. W. Beacham, M.D. and W. D. Beacham, M.D. $6.50. The Mosby Co., St. Louis, 1959.

The senior author of this book is an outstanding gynecologist and medical author. Four previous editions were an abridgment of his comprehensive text "Diseases of Women," but this work is a departure from the former editions. It presents an up-to-date panoramic view of the principles of gynecology, without operative technic. The first chapter, dealing with anatomy and physiology, is especially interesting and informative; in a concise fashion it covers the vast field of rapidly changing concepts of reproductive physiology and endocrinology. To this edition has been added chapters on the complications of pregnancy, functional disturbances and the legal aspects of gynecology. The reproductions and tables are abundant and the text is exceptionally readable. Following each chapter is a copious list of selected references.

The preparation of this book is so well done that it makes it exceptionally valuable, especially for students and interns. It is also an excellent quick reference for the general practitioneer, internist or general surgeon.

The authors deserve commendation for the painstaking preparation of this synopsis. The reviewer recommends it very highly.

David Bickel, M.D.
South Bend

immortals of chinese mythology:



Ho Hsien-Ku

This gentle maiden became an immortal by her unique diet of moonbeams and mother-of-pearl

TODAY...

this steroid of unsurpassed safety and effectiveness holds an enduring place in the medical armamentarium

METICORTEN

METICORTEN,® brand of prednisone, 5 mg. tablets.

SCHERING CORPORATION • BLOOMFIELD, NEW JERSEY

You will soon receive in your mail a handmade, four-color three-dimensional figure of this Chinese Immortal, mounted and suitable for framing.

5-346B

Schering

The Fourth Estate Looks at Medicine

Here's A County Milestone

At last there is a reduction in prospect for the budget of the Marion County department of public welfare. The county's welfare spending has risen each year, and substantially, since 1954. But the budget for 1960 will be slightly lower than the one for 1959.

We are glad to see, for one thing, abandonment of a plan to put medical care for welfare recipients on a new basis which would have made the county eligible for Federal aid for this care. At present welfare patients go to General Hospital, except when they require special facilities not available there, and the welfare department is not billed for their treatment. Under the proposed new plan, welfare patients would have made their own choices of hospital and doctor, and the welfare department would simply have paid the bills. The elimination of this proposal produced one of the savings which makes a budget reduction for next year possible.

Most of the credit for the achievement of a reduced budget must go to the County Council for swinging the ax hard on the budget proposed by the welfare department. The department's original proposal was for a whopping budget. almost a million and a half higher than the 1959 budget. This would have been more increase in one year than has occurred in the last five years.

When the shocked County Council got through with this budget it was $135,000 smaller than this year's budget.

It is a tribute to the care with which the Council did its work that most of its cuts were upheld in the review by State Tax Board examiners.

The welfare department itself then came forward and made a contribution to the reduction by voluntarily agreeing to give up the new medical plan.

Of course, neither the welfare department nor County Council can make welfare costs smaller just by wishing them to be so. We trust that these costs are dictated by necessity. The population of the county is growing, and there may be some reasonableness in expecting the number of welfare recipients to grow also. But the trend, in both the number of persons on the dole and the average of the county's share of the annual support for each one, is responsive to the policies by which eligibility is established and maintenance standards determined. It is good for the county to grow, but not much contribution to this good is made by illegitimate births or by persons who come here simply to join the welfare rolls. Whether this happens is influenced by the policies of proving eligibility. The amount of effort made by recipients to become self-supporting is also likely to be governed by the policies as to maintaining eligibility and measuring need.

The department's policies should aim at every proper means of reducing the number of publicly supported families and increasing the proportions of the self-supporting in the county's population.

Indianapolis Star
Dec. 9, 1959

Family Doctor Holds His Own

The family doctor holds a high and honorable place in American history and tradition.

The very phrase brings up pictures of a dedicated physician, fighting his way through storm and darkness in a horse and buggy or a primitive car.

Yet, some years ago there was a feeling that the family doctor was on the way out, and that medical knowledge had become so vast and treatment so complex that only specialists could meet the need. And, for a time, the statistics bore this idea out.

In 1940, only one medical student in 10 planned on entering general practice. But a dramatic change has taken place. Today, six medical students out of 10 will go into general practice.

There are good reasons for this.

The general practitioner of today is far more competent, far more knowledgeable than his predecessors. Postgraduate work, reading, medical meetings and other factors see to it that he keeps up with medical progress.

And there is more to the matter than just the question of competence.

The family doctor fills a niche that no one else can fill. He knows his patients—and they know him, as a friend as well as a medical man. He is on call when needed. He brings with him confidence and peace of mind—psychological medicines, so to speak, which are important to building and regaining health. He knows when a specialist should be summoned, and what kind.

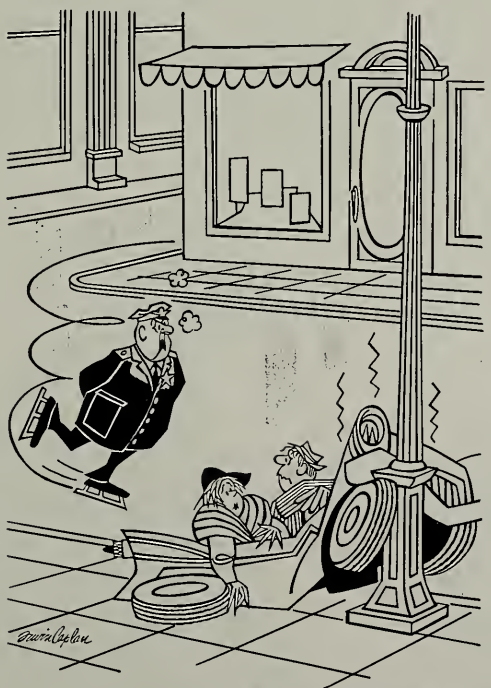
The American scene wouldn't be the same without the family doctor. It's good to know that he is holding his important place in the great canvas of American medicine.

Princeton (Ind.) Democrat
Dec. 8, 1959

It meant traveling thousands of miles, but I wanted to be married at home while on leave from my Naval aviation squadron. Even tho time was limited, the many necessary arrangements went off without a hitch—all except one, that is.

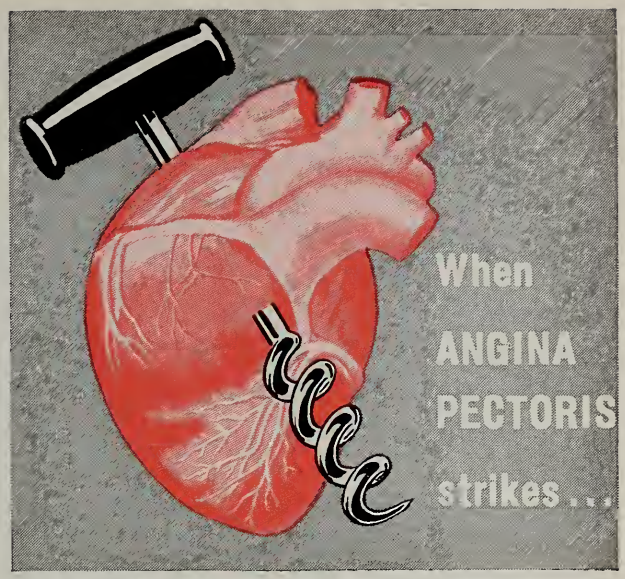
Our wedding bands had been engarved in a rush, and when my mother-in-law-to-be looked at them, she gasped and nearly fainted. My wife's wedding band was correctly lettered: "ACE TO HAS 6-7-'52." The engraver hadn't finished mine and it simply read "HAS TO."—*Lt. A. C. Eastman, True.*

An efficiency expert is a man who spends all day getting out of an hour's work.—*Dan Bennett, Quote.*



Courtesy National Safety Council

"You can't say I didn't warn you folks the roads were in icy condition!"



prescribe

NIPHYLLINE

the unique specific

This exclusive development is neutral in action, and ***specific in prophylaxis and treatment of angina pectoris.*** It is effective orally in about thirty minutes, for periods of 7 to 8 hours . . . and, even when given routinely, does not cause nausea or gastric upset. Niphylline is an efficient vasodilator and diuretic combining the effectiveness of Neothylline (soluble, neutral, stable derivative of theophylline) and pentaerythritol tetranitrate, substantially more effective than mannitol hexanitrate. Thus, the patient receives the benefits of both drugs without any annoying side effects.

Niphylline is safe, and well tolerated . . . exerts strengthening effect on heart muscles, and acts synergistically, remarkably reducing severity and frequency of cardiac attacks.

Indications: Relief and control of angina pectoris, cardiovascular symptoms, asthenia, coronary spasm with myocardial pain, prophylaxis and treatment of left ventricular insufficiency, cardiac dyspnea and oliguresis.

Dosage: One or two tablets, 3 or 4 times daily, or as directed by physician.

Supplied: Bottles of 100 and 1000 tablets.

Each tablet contains: Pentaerythritol tetranitrate, 10 mg., and Neothylline (dihydroxypropyl theophylline), 100 mg.

PM **PAUL MANEY**
LABORATORIES, INC.
Cedar Rapids, Iowa

The first synthetic penicillin available for general clinical use

FOR YOUR NEXT PATIENT WHERE PENICILLIN IS INDICATED.

SYNCILLIN

BLOOD LEVELS TWICE AS HIGH AS WITH POTASSIUM PENICILLIN V

ORAL ROUTE PROVIDES HIGHER BLOOD LEVELS THAN INTRAMUSCULAR PENICILLIN G

IMPROVED ANTIBIOTIC ACTION FROM ISOMERIC COMPLEMENTARITY





performance



genitourinary infection. Roberts, M. S.; Seneca, H., and Lattimer, J. K.,[1] New York, N. Y.—Ninety-one per cent of the Gram-positive and 27 per cent of the Gram-negative, among 66 organisms cultured from genitourinary infection, responded to DECLOMYCIN. Serum antibiotic activity was found three times greater than with tetracycline.

toleration. Boger, W. P., and Gavin, J. J.,[2] Norristown, Pennsylvania—Side effects with DECLOMYCIN were minimal. When dosage was 0.5 to 1 Gm. daily in divided doses, only two of 82 patients exhibited nausea.

activity level sustentation. Kunin, C. M.; Dornbush, A. C., and Finland, M.,[3] Boston, Massachusetts—Of the four tetracycline analogues, DECLOMYCIN Demethylchlortetracycline showed the longest sustained activity levels in the blood.

gonococcal infection. Marmell, M., and Prigot, A.,[4] New York, N. Y.—Of 63 cases of gonorrhea, 61 promptly responded after short courses of DECLOMYCIN. Therapeutic effect was found equal to that of intramuscular penicillin.

bronchopulmonary infection. Perry, D. M.; Hall, G. A., and Kirby, W. M. M.,[5] Seattle, Washington—Of 30 cases of acute bacterial pneumonia, all were afebrile following two to 10 days of treatment with DECLOMYCIN. Results were good in 21.... All of six patients with acute bronchitis responded promptly.

pediatric infection. Fujii, R.; Ichihashi, H.; Minamitani, M.; Konno, M., and Ishibashi, T.,[6] Tokyo, Japan—In 309 pediatric patients with various infections, DECLOMYCIN was effective in 75 per cent.

urogenital infection. Vineyard, J. P.; Hogan, J., and Sanford, J. P.,[7] Dallas, Texas—Clinical response in pyelonephritis correlated well with results of *in vitro* sensitivity tests, which showed some strains of *A. aerogenes*, Proteus and Pseudomonas more susceptible to DECLOMYCIN Demethylchlortetracycline than to its analogues.

pneumonia. Duke, C. J.; Katz, S., and Donohoe, R. F.,[8] Washington, D. C.—Results were satisfactory in all but two of 32 cases of acute bacterial pneumonia, of which only 11 were uncomplicated. No side effects were observed.

brucellosis. Chávez Max G.,[9] Mexico, D. F., Mexico—All of nine patients with *Br. melitensis* infection were afebrile after five days on DECLOMYCIN. Blood cultures were negative in all cases on the 20th day. Side effects were limited to slight temperature increases which abated in four days.

pustular dermatosis. Blau, S., and Kanof, N. B.,[10] New York, N. Y.—Results with DECLOMYCIN were excellent in both of two cases of impetigo, one of two cases of folliculitis, six of nine cases of furunculosis, all of three cases of acne rosacea and 26 of 45 cases of acne vulgaris. Overall, results were excellent or good in 85 per cent.

antibacterial spectrum. Finland, M.; Hirsch, H. A., and Kunin, C. M.,[11] Boston, Massachusetts—DECLOMYCIN Demethylchlortetracycline was found the most effective of the tetracycline analogues against two-thirds of 680 normally sensitive strains of 15 separate species.

the over-all picture. Combined results reported by 210 clinical investigators[12]—DECLOMYCIN produced a favorable response (cured or improved) in 87 per cent of 1,904 patients. Two-thirds of the patients received one capsule every six hours. Treatment was continued for as long as 180 days, but was between three and eight days in most. Side effects were seen in 9.9 per cent, but necessitated discontinuance of treatment in only 1.8 per cent.

LEDERLE LABORATORIES, a Division of AMERICAN CYANAMID COMPANY, Pearl River, New York

Lederle

'. . . I Was in Prison and You Came to Me'

THE FIVE Americans in Communist Chinese prisons may have never heard of Joseph Carniglia of Plainfield, N. J. But this 35-year-old American Red Cross field director could be considered one of their best friends.

Every month Carniglia flies to Hong Kong from his post at Clark Air Force Base in the Philippines to deliver food parcels destined for his fellow countrymen serving sentences ranging to life imprisonment.

The five Americans are John Downey, New Britain, Conn.; Richard Fecteau, Lynn, Mass.; Robert McCann, Altadena, Calif.; Hugh Redmond, Yonkers, N. Y., and the Most Rev. Bishop James E. Walsh, a Catholic missionary from Cumberland, Md.

The men receive two kinds of food parcels. The standard 11-pound Red Cross parcels contain such items, purchased and packaged in Japan, as meat, soup, cheese, powdered coffee and cream, juice, fruit, sugar, peanut butter, crackers, cookies, vitamins, candy, gum, plastic spoons, cigarettes, matches, a can opener and a cake of soap. In addition, the men receive parcels packed by their families in the United States.

The family parcels are sent to the Red Cross at Travis Air Force Base in California and then flown to Japan by the Military Air Transport Service. From Japan, these and the Red Cross parcels are flown by the Air Force in "Red Cross Mercy Flights" to Hong Kong, where they are stored for Carniglia's arrival.

DBI



trademark, brand of Phenformin HCl

the "full-range" oral hypoglycemic agent
. . . safely lowers blood sugar in mild, moderate
and severe diabetes, in children and adults

start
low

Carniglia picks up the food parcels in Hong Kong, contacts the American consul general and the British Red Cross Society, and obtains from British authorities the special permit needed to enter the no-man's-land separating British territory and the Chinese mainland. Accompanied by a member of the Hong Kong Special Police and, usually, a representative of the British Red Cross, Carniglia goes to Lowu Bridge, the border checkpoint, and turns over the parcels to an agent of the Red Cross Society of China.

The American Red Cross began this delivery of food parcels to Americans imprisoned in China in May 1955. At that time, 44 American airmen and civilians, including missionaries and priests, were officially listed as detained. Since that date, more than a thousand parcels have been turned over to the Chinese and delivered to the imprisoned men.

The men have called the parcels "lifesavers." An American priest, since released, wrote to the American Red Cross from his Chinese prison:

"Having no material way to express my gratitude, I would rather quote:

"'I was hungry and you gave to eat; I was thirsty and you gave me to drink . . . I was in prison and you came to me.'

"These words, which you are fulfilling many times over, and which were inspired by our Heavenly Father, carry with them a blessing and a promise to those who do them. May that blessing of God, then, be with you; and may His promises be realized in you." *(Released by the American Red Cross)* ◄

The **"Start Low! Go Slow!"** dosage pattern with DBI enables a maximum number of diabetics to enjoy the convenience, comfort and satisfactory regulation of oral therapy in:

stable adult diabetes
unstable (brittle) diabetes
juvenile diabetes
sulfonylurea resistant diabetes

"Start Low! Go Slow" means low initial dosage (25 mg., or 50 mg. in divided doses, per day) with small dosage increments (25 mg.) every 3rd or 4th day until blood sugar levels are adequately controlled. Injected insulin is reduced gradually with each increase in DBI dosage. Satisfactory regulation of mild stable diabetes is usually achieved with DBI alone.*

On **"Start Low! Go Slow!"** dosage, DBI is relatively well tolerated.

Over 3000 diabetics have been carefully studied on DBI daily for varying periods up to three years. No histologic or functional changes in liver, blood, kidneys, heart or other organs were seen.

DBI (N^1-β-phenethylbiguanide) is available as white, scored tablets of 25 mg. each, bottles of 100.

*Send for brochure with complete dosage instructions for each class of diabetes, and other pertinent information.

go slow

an original development from the research laboratories of

u. s. vitamin & pharmaceutical corporation

Arlington-Funk Laboratories, division • 250 East 43rd Street, New York 17, N. Y.

Indiana State Board of Health

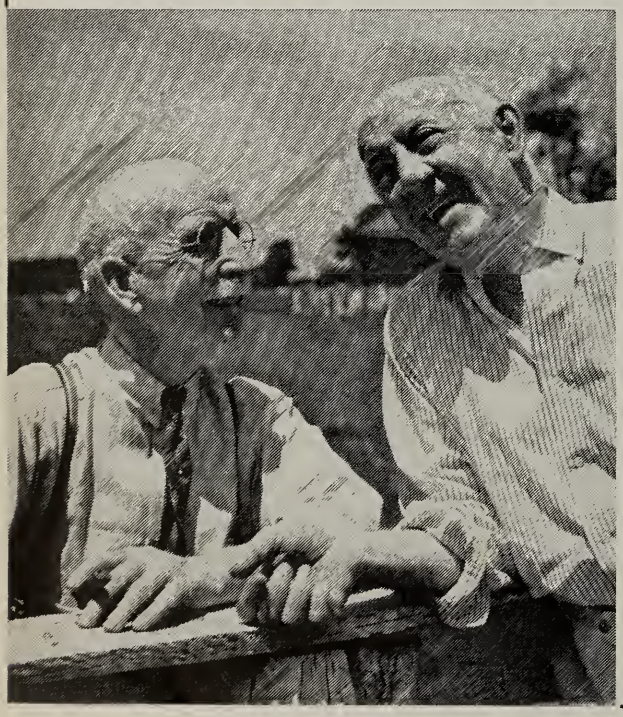
DIVISION OF COMMUNICABLE DISEASE CONTROL

MONTHLY REPORT - December, 1959

Disease	Dec. 1959	Nov. 1959	Oct. 1959	Sept. 1959	Dec. 1958	Dec. 1957
Animal Bites	246	239	435	601	227	76
Chickenpox	592	180	40	36	606	308
Conjunctivitis	68	24	38	91	61	26
Diphtheria	1	0	0	1	0	2
Dystentery, Unspecified	40	23	16	14	29	5
Impetigo	97	72	112	302	77	29
Infectious Hepatitis	38	39	18	12	56	15
Infectious Mononucleosis	20	10	12	5	12	1
Influenza	1114	583	411	375	616	1024
Measles (Rubeola-Rubella)	280	95	35	79	456	188
Meningitis, Meningococcal	4	2	1	1	5	7
Meningitis, Other	49	17	23	49	10	10
Mumps	178	89	41	40	127	218
Pertussis	95	29	40	81	61	30
Pneumonia	259	98	76	112	163	112
Poliomyelitis	4	13	20	55	8	9
Streptococcal Infections	492	229	135	182	292	217
Tinea Capitis	16	5	7	1	4	2

PSYCHIC ENERGIZER

For Your Geriatric Patients



Metalex®

Pentylenetetrazol w/ Nicotinic Acid

METALEX is a vasodilator, a respiratory and central nervous system stimulant. It helps overcome the hypoxia frequently present in athero-arteriosclerosis of old age, its analeptic action increases nerve impulse transmission.

"TONIC" EFFECT—Ameliorates mood, paranoid delusions, loss of memory, confusion, depression, anxiety, apathy, vertigo, insomnia, headache and anorexia due to athero-arteriosclerosis.

IN TINNITUS—When cerebral function and oxygen supply can be improved, visual and auditory improvement is often noticeable.

SUPPLIED: Tablets—bottles of 100.
Elixir—pint bottles.

Composition: Each tablet and each 5 cc. elixir contains 100 mg. Pentylenetetrazol, and 50 mg. Nicotinic Acid.

Send for samples and literature.

STORCK **Pharmaceuticals,** 2326 Hampton Blvd., St. Louis 10, Mo.

The Journal of the INDIANA STATE MEDICAL ASSOCIATION

Supervised by THE COUNCIL

Volume 53 — February 1960 — Number 2

Cardiology at General Hospital

KENNETH G. KOHLSTAEDT, M.D.*

Indianapolis

THE DEDICATION of the Krannert Diagnostic Laboratory at the Marion County General Hospital in February of 1959 was an important milestone in the development of the Department of Cardiology at this institution. The facilities were augmented by the installation, in December, 1959, of an image intensifier with cine attachment for angiocardiography. Although the Krannert Laboratory is intended primarily to aid in the treatment of heart disease, it has enhanced the opportunities for medical education in this community. Not only are medical students and house officers participating in the program of the Department of Cardiology, but we hope practicing physicians will also take advantage of the facilities for graduate education.

A diagnostic conference is held each Wednesday, beginning at 1 p.m., in the Lilly auditorium on the 4th floor of the out-patient building, and ward walks begin each Saturday at 9 a.m. on ward A-2, Marion County General Hospital.

Upon completition of a year as Krannert Fellow, Dr. E. F. Steinmetz is continuing as a full time cardiologist at General Hospital. Dr. Robert Chevalier is the Krannert Fellow for 1959-1960. The residents in the Department of Medicine at the General Hospital may also elect to serve in the Department of Cardiology.

During 1959, Dr. Alfred Fasola, former Krannert Fellow, because of his special training in pulmonary physiology, played a major role in establishing and equiping the cardiopulmonary laboratory.

In this issue of the *Journal* will be found pictures of the Krannert Laboratory and some of the scientific papers report work done by the staff.

Facilities for investigators requiring the use of experimental animals are provided by the Lilly Research Unit at the Marion County General Hospital.

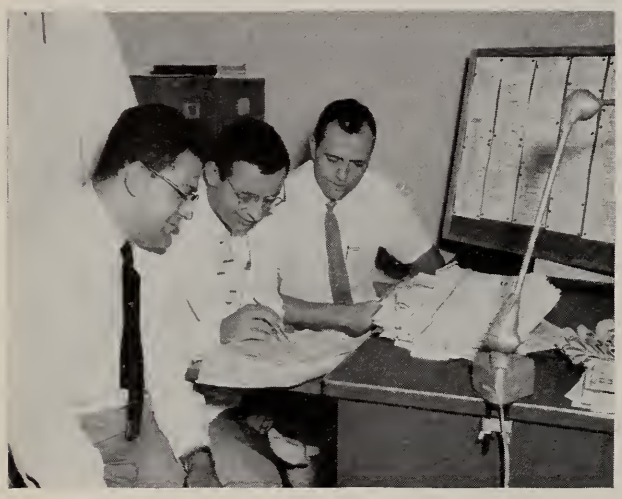
Each year the Robert Moore Heart Clinic has increased its efficiency and expanded its services. This has occurred primarily because of the ability and untiring effort of Dr. Charles Fisch.

We wish to express appreciation for the financial support we have continued to receive from Mr. and Mrs. Herman C. Krannert and from the Indiana State Board of Health, as

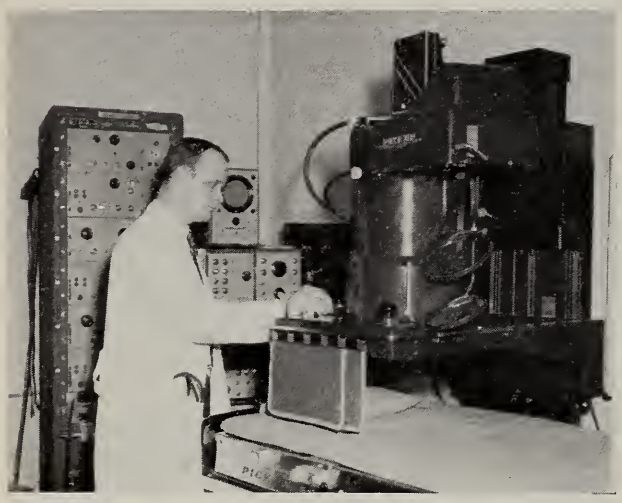
* Director, Clinical Research Division, Eli Lilly and Company; professor of medicine, Indiana University School of Medicine; chief, Department of Cardiology, Marion County General Hospital.

well as for the fine cooperation from the administration of the Marion County General Hospital, the Health and Hospital Corporation of Marion County, from the Department of Medicine, Indiana University School of Medicine, and from Eli Lilly and Company.

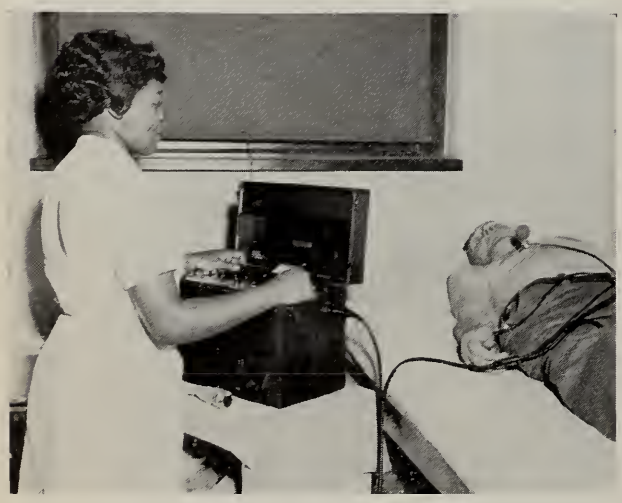
An invitation is hereby extended to all physicians to visit the Robert Moore Heart Clinic and the Krannert Diagnostic Clinic, which are located on the ground floor of the Flower Mission Unit of the Marion County General Hospital in Indianapolis. ◄

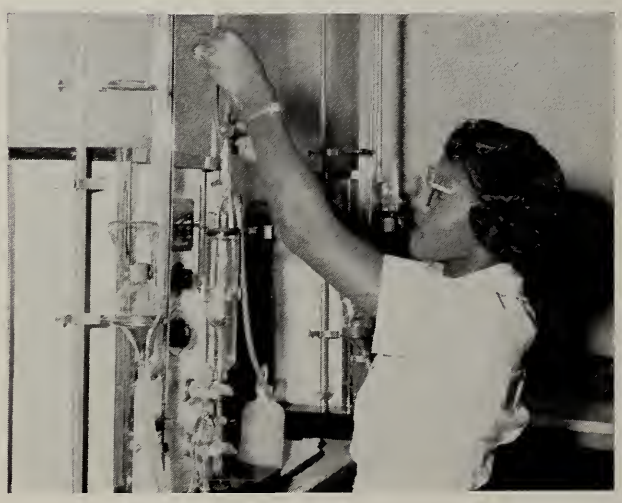












Robert M. Moore Heart Clinic

Employment of Cardiacs

Jobs may be classified according to the energy output required. Cardiac patients may be classified according to the energy they may deliver safely — a patient who is matched to a job within his work tolerance may be gainfully employed.

*CHARLES FISCH, M.D.**

Indianapolis

THE PROBLEMS of employment faced by individuals with heart disease are many. The most obvious ones are: (1) the ever expanding labor force, (2) the average cardiac falling into an age group in which even healthy individuals have some difficulty in finding a job, and (3) the appearance in certain medical and non-medical circles of a philosophy that work contributes to heart disease. It is with the latter, and especially as it applies to individuals with coronary disease, that we will concern ourselves in this paper.

During the past 25-30 years there appeared a rather peculiar philosophy, totally lacking scientific support, which suggests that work is harmful. This idea is particularly pernicious because some have gone one step further and assumed that work is not only "harmful" but is a cause and furthermore aggravates, activates and accelerates disease. No attempt is made by some of the more vocal proponents of this philosophy to separate the natural course of the disease from complications brought on by measurable and, for the given individual, unusual exertion.

A classical example of detrimental effect of sudden exertion is the development of anginal pain in the course of undue effort. If death of a patient suffering with angina follows unusual and strenous exertion then it is possible, at this state of our knowledge, to incriminate the effort in question as the precipitating cause of myocardial ischemia and probably a terminal arrhythmia.

However, cases with known angina are not the major problem facing the industrial physician. These patients can be protected from peak loads by proper job placement. The problem that needs early solution is posed by the individual who dies suddenly and unexpectedly, either as a result of coronary thrombosis or myocardial ischemia, while performing his daily work and without any evidence of unusual effort.

A Strange Philosophy

Unfortunately there has been an increasing trend to judge such accidents compensible, apparently in keeping with the strange philosophy of harmful effect of work, but at the same time to detriment of the cardiacs in general.[1,2,3] Garnett,[4] referring to those who accept this

From the Robert M. Moore Heart Clinic, Marion County General Hospital, and the Department of Medicine, Indiana University School of Medicine, Indianapolis.

Supported by the Herman C. Krannert Fund of the Indiana Heart Association and the Indiana State Board of Health, Indianapolis.

Presented as part of a Symposium on Rehabilitation of Cardiacs before the Marion County Medical Society, Nov. 10, 1959.

* Director Robert M. Moore Heart Clinic

peculiar notion, stated: "They seem to labor under the delusion that, were they financially endowed from the cradle, there would be no grave." Commenting on this purported cause and effect between work and disease and its effect on employability of the cardiac, Ungerleider[5] wrote that "the real crux of the problem of heart disease in industry is the question of liability and compensation and that there the fears of the employer have a substantial basis . . . Unwise legislation enacted without the benefit of sound medical knowledge has resulted in disservice to industry and employee alike."

Against this background an estimated 400,000 persons with coronary disease are added each year to the ever expanding labor forces. If the philosophy of detrimental effect of work on the heart continues to gain, the cardiac will ultimately be faced with one of two alternatives, neither one very promising. He may either accept the purported cause and effect of work and coronary disease and solve his dilemma by retiring to the wheel chair. On the other hand he may wish to follow the suggestion of most physicians and physiologists, and elect to return to work, only to find that industry, fearful of compensation and liability laws, has closed its doors to cardiacs.

Trend Can Be Reversed

This trend to implicate work as a cause of heart disease can and should be reversed, until the solution of the problem can be evolved from laboratories and critically conducted clinical studies. As matters stand now the vast majority of physicians engaged in the study of coronary disease have every reason to and do doubt that work has any bearing on the cause or course of atherosclerosis.

An exception to this generally accepted feeling is a handful of psychosomatically oriented physicians who, as Sprague[6] put it would "like to bring the atherosclerosis camel into the spiritual tent. . . ." Commenting further on the dangers of psychosomatic concept of coronary disease, Sprague states, "it is an easy way out because it almost precluded scientific investigation. No one can prove that our age is more troubled than many before it. No one can measure emotional stress, since it has no meaning except in relation to him who is stressed. Furthermore, it creates the belief that emotional stress is a bad thing. Therefore, not only are pain, anxiety, grief, fear, anger and frustration undesirable, but so also must be joy, pride. success, striving and love.

"It seems likely that emotional tension results in compulsive eating, drinking and smoking in many individuals as compensation for anxiety, and I believe that it is through this indirect mechanism that stress has its influence on coronary disease.

"The danger of attributing cardiovascular disease to emotional tension is that it makes everyone fearful lest he find himself in a situation of anxiety, and it fosters a belief that struggle and achievement are lethal, whereas they are probably healthy. It plays into the hands of those who would have us believe that work causes heart disease. Authoritative opinion denies this."

Example of Bias

As an example of bias with which some data is treated, a well respected worker, in an attempt to support the role of emotions in heart disease, points to the coroners' data which indicate that the majority of deaths during and immediately after intercourse follow illicit rather than marital relationship. Even an uninitiated investigator would see the fallacy of such a study and ask the obvious:

1. How often is a death at ones home a coroner's case?

2. How often would the family volunteer the information as to the activities immediately preceding death?

3. Is not a study of men who die in strange beds extremely biased with a statistically predictable answer?

There is an even smaller group that could be described as believing that every day events, or living per se, causes atherosclerosis. In a recent study Sigler[7] concluded, "the observations suggest that there is a multiplicity of factors associated with industrialization which contribute to the etiology of arteriosclerotic and hypertensive heart disease. Some of the factors may be the smog-filled, poisonous air which we inhale in industrial areas; confined, indoor life; insufficient fresh, open-air recreation; pent-up emotions associated with monotony of automatic activity of the worker in this machine age;

the rapid speed of work and travel in this restless age, and the extreme tensions under which we live."

A detailed discussion of evidence for or against such philosophies is beyond the scope of this paper. To those, however, who subscribe very strongly to the effect of emotions on atherosclerosis, I wish to point out that the segment of population that we consider to be under "undue" stress is the same in that it is well to do, well fed and is sheltered, by choice or necessity, from physical effort and exercise.

Cardiac Can Be Rehabilitated

With the ever improving prognosis for many patients with coronary disease, huge amounts of data have been accumulated, both by industrial and union physicians, to show that a cardiac can be rehabilitated and that his work performance with proper planning is as good as that of the healthy employee.[8-14] That such individuals should be reemployed is extremely desirable from the medical standpoint, from the standpoint of family economics, stability of the society and finally because of immense benefits to the industry. It was pointed out by Franko[15] that the individual who suffers with myocardial infarction has been with the company for about 25 years and represents an unassessable financial investment by the industry. Such an individual is as a rule difficult to replace and the cost of replacement is high.

Evidence available at this time not only does not support the concept that everyday work is a cause of atherosclerosis, or that it contributes to coronary thrombosis, but, to the contrary, the data suggests that it is actually beneficial, perhaps because it stimulates development of collateral circulation. Such conclusions are supported by studies of: (1) the activities preceding the acute illness, (2) the effects of employment on coronary disease and (3) the anatomical physiologic investigations. This phase of the problem was reviewed recently in this *Journal*.[16-32]

For proper placement of individuals, the physician must be familiar with the patient's physical tolerance and the energy requirements for both steady and peak loads of the various jobs for which the individual in question is being considered.

Fixed Energy Costs

The functional classification as defined by the New York Heart Association is very useful. Its value, however, could be greatly enhanced by ascribing certain fixed energy costs to each class, rather than to use vague descriptive terms. Briefly the four classes are: Class I—heart disease without symptoms; Class II—symptoms with unusual exertion only; Class III—symptoms with usual exertion and Class IV—symptoms at rest. In evaluating a patient the physician can test the maximum activity an individual can do for five minutes and, knowing the energy cost of such an activity, he may safely prescribe any activity within this cost range. Knowing for example that energy costs of walking at 2.5 miles per hour is 3.6 Cal. per minute, one can choose any job within this cost range, provided naturally that the activity is punctuated by rest periods.

Utilizing the relation of O_2 consumption in cc/min. to energy expenditure in Cal/min. and to cardiac output in L/min. (increase of O_2 by 1000 cc/min. raises energy expenditure by 5 Cal/min. and C.O. by 6-7.0 L/min.). Many investigators have defined numerous jobs in terms of energy costs.

The average energy cost of jobs classified as light, moderate, heavy, very heavy and extraordinarily heavy has been defined as 2.6-4.9, 5.0-7.5, 7.6-10.0, 10.1-12.5 and 12.5 and up calories per minute.[34] These figures represent peak loads rather than a steady expenditure of energy. It has been calculated that for a continuous energy expenditure, without rest periods, 5 Cal/min. is probably the maximum an individual could tolerate (this amount of energy is expended by workers in steel industry tending an open hearth furnace).[14] The limits suggested by the League of Nations, assuming a steady energy expenditure, for light, moderate, hard and very hard work are up to 2.6, 2.7-3.8, 3.9-6.3 and 6.4 up calories per minute respectively.[33] With such data available to the family as well as an industrial physician, the problem of proper job placement can be put on a sound basis.

The field of rehabilitation of patients with heart disease is in its infancy and it behooves us not to hamper its much delayed development by unscientific, wholly unsubstantiated and harmful concepts.

Summary

1. An attempt has been made to summarize the problems facing the worker with heart disease.
2. Data indicating that continous employment is not only feasible but beneficial to the health and welfare of the worker and industry alike, were presented.
3. Attention was drawn to the ever increasing data of energy costs of various jobs and that such data allow for a better work prescription.

REFERENCES

1. Small, B. F.: The Heart Problem in Workmen's Compensation is Settled—Until the Next One, *J. Ind. State Med. Assn.*, 52:236, 1959.
2. Edwards, J. D.: The Insatiable Heart. A Lawyer's View-point of Compensation Problems of the Cardiac, *Am. J. Card.*, 1:357, 1958.
3. Sprague, H. B.: Perils of Employment, *J. Ind. State Med. Assoc.*, 52:229, 1958.
4. Garnett, W. G.: Coronary Artery Disease in Industry, *Indust. Med.* 23:59, 1954.
5. Ungerleider, H. E.: Can the Cardiac Work? Insurance Aspect, *New York J. Med.*, 56:1433, 1956.
6. Sprague, H. B.: Emotional Stress and Etiology of Coronary Artery Disease, *Circ.*, 17:1, 1958.
7. Sigler, H. L.: The Mortality from Arteriosclerotic and Hypertensive Heart Disease in the United States: II. Possible Relation to Industry, *Am. J. Card.*, 3:605, 1959.
8. Price, L.: The Occurrence of Heart Disease Among Industrial Workers, *Am. J. Card.*, 1:351, 1958.
9. Thorpe, J. J.: Continued Employment of Individuals Partially Disabled by Heart Disease, *Am. J. Card.*, 1:348, 1958.
10. Crain, R. B., Missal, M. E., Wilson, K. W.: The Industrial Employee with Myocardial Infarction, *Arch. Ind. Hygiene and Occup. Med.*, 1:525, 1950.
11. Thorpe, J. J.: The Optimum Time for Return to Work Following Major Cardio-vascular Disability, *Industrial Med. and Surg.*, 25:329, 1956.
12. Rosenbaum, F. F. and Belknap, E. L.: Work and the Heart, Transactions of the First Wisconsin Conference on Work and the Heart. Paul B. Hoeber.
13. Ford, A. B. and Hellerstein, H. K.: Work and Heart Disease: I. A Physiologic Study in the Factory, *Circ.*, 18:823, 1958.
14. Ford, A. B. and Hellerstein, H. K.: Work and Heart Disease: II. A Physiologic Study in a Steel Mill, *Circ.*, 20:537, 1959.
15. Franko, C. S.: The Cardiac Can Work, *Ind. Med. & Surg.*, 23:315, 1954.
16. Fisch, C.: Stress, Coronary Thrombosis and Myocardial Infarction, *J. Ind. State Med. Assoc.*, 51:177, 1958.
17. Luten, D.: Contributory Factors in Coronary Occlusion, *Am. Heart J.*, 7:36, 1931.
18. Fitzhugh, G., and Hamilton, B.: Coronary Occlusion and Fatal Angina Pectoris, *J.A.M.A.*, 100:475, 1933.
19. Phipps, C.: Contributory Causes of Coronary Thrombosis, *J.A.M.A.*, 106:761, 1936.
20. Cooksey, W. B.: Exertion and Coronary Thrombosis. Letter to the Editor, *J.A.M.A.*, 113:351, 1939.
21. Master, A. M., Dack, S., and Jaffe, H. L.: Factors and Events Associated with Onset of Coronary Artery Thrombosis, *J.A.M.A.*, 109:546, 1937.
22. Master, A. M.: Acute Coronary Artery Disease and Efforts, *Indust. Med. Surg.*, 19:512, 1950.
23. Spain, D. M., Bradess, V. A.: Sudden Death from Coronary Atherosclerosis, *Arch. Int. Med.* 100:228, 1957.
24. Blumgart, H. L.: The Relation of Effort to Attack of Acute Myocardial Infarction, *J.A.M.A.*, 128:775, 1945.
25. French, A. J. and Dock, Wm.: Fatal Coronary Arteriosclerosis in Young Soldiers, *J.A.M.A.*, 124:1233, 1944.
26. Yater, W. M., Traum, A. H., Brown, W. G., Fitzgerald, P. R., Geisler, M. A., and Wilcox, B. B.: Coronary Disease in Men 18 to 39 Years of Age, *Am. Heart J.*. 36:33, 1948.
27. Morris, J. N., Heady, J. A., Raffle, P. A. B., Roberts, C. G., Parks, J. W.: *Lancet,* 265:1053, 111, 1953.
28. Zoll, P. M., Wessler, S., Schlessinger, M. J.: Interarterial Coronary Anastomosis in Human Heart with Particular Reference to Anemia and Relative Cardiac Anoxia, *Circ.* 4:797, 1951.
29. Baroldi, G., Mantero, O., Schomazzoni, G.: The Collaterals of the Coronary Arteries in Normal and Pathological Hearts, *Cir. Research,* 4:223, 1956.
30. Eckstein, R. N.: Effect of Exercise and Coronary Narrowing on Coronary Collateral Circulation, *Cir. Research,* 5:230, 1957.
31. Patterson, J. C.: Capillary Rupture with Intimal Hemorrhage as a Causative Factor in Coronary Thrombosis, *Arch. Path.* 25:474, 1938.
32. Patterson, J. C.: Relation of Physical Exertion and Emotion to Precipitation of Coronary Thrombi, *J.A.M.A.*, 112:895, 1939.
33. Gordon, E. E.: Energy Costs of Activities in Health and Disease, *Arch. Int. Med.*, 101:702, 1958.
34. Christensen, E. H.: Physiological Valuation of Work in Nykroppa Iron Works, presented at the ergonomics society symposium on fatigue, *Leeds,* London 1953, quoted by Gordan.[33]

From a preliminary study, it would appear that digitalis will, on occasion, give a false positive Master two step and that patients should be off digitalis for 3 weeks or more before the test is performed.

Effect of Digitalis on the Master Exercise Test

*EDWARD F. STEINMETZ, M.D.**

Indianapolis

SINCE the introduction of a standardized exercise test using the electrocardiogram in evaluation of coronary artery insufficiency,[1] numerous investigators have tried to modify the test; devising new technics such as the step test,[2] the use of treadmill[3] and the use of hypoxia.[4] Others have evaluated the test and modified Master's original criteria.[5] From the practical standpoint the Master two step is the most useful to the practicing physician. Consequently all possible pitfalls attending this test should be thoroughly investigated. It has been suggested that digitalis will give a false positive test. It is with the latter that this report will concern itself.

Method Used

In the initial study, eight male medical students ranging in age from 24 to 28 years, clinically free of heart disease and normotensive, performed a double Master's two step test. The technic of the test was performed as set forth by Master except the students had eaten a light breakfast and the test was performed at least two hours later. Tracings of lead I, II, III, V4 were taken with a control, 1 min., 3 min. and 10 min. after exercise. After performing the control exercise test the subjects were given 0.8 mgm of crystodigin. In six hours another 0.4 mgm was given and the students returned the next morning to repeat the test. None of the students had subjective symptoms of digitalis toxicity.

Results

In evaluating our results we adhered to Master's criteria of 0.5 mm depression of ST in any of the four leads recorded. Of the eight subjects, one digitalized subject shows 1 mm depression immediately after exercise and 0.5 mm depression at 3 min. after exercise as compared to his normal control (Figure I). One other subject showed normal control and 0.5 mm depression immediately after exercise but this was absent at 3 min. One other subject showed biphasic T waves after digitalization without significant change following exercise.

Discussion

As a rule, in a patient on digitalis an exercise test would not be indicated. Occasionally, however, both the diagnosis of heart disease and the necessity for digitalis are not clearly defined and an effort test may be valuable.

From the Robert M. Moore Heart Clinic, Marion County General Hospital and the Department of Medicine, Indiana University School of Medicine, Indianapolis.

Supported by the Herman C. Krannert Fund of the Indiana Heart Association and the Indiana State Board of Health, Indianapolis.

* Krannert Fellow and Trainee, National Heart Institute, Marion County General Hospital.

Master's criteria for a positive test have been criticized as being too liberal.[5,6] Thus Thomas[7] found that in 263 medical students, 16% showed a positive test by Master's standards. In other studies of young adults or mixed populations false positive results have ranged from 16 to 30%.[8] Even in studies of known coronary artery disease the incidence of false negatives have been reported as high as 50%.[9] Master,[10] in defending his criteria, studied 250 cases of known coronary artery disease and found that ⅔ had a negative single two step but only 3% had a false negative after a double two step test. Because of these variations, attempts have been made to modify Master's criteria in a mixed population. Some have felt that the use of 1 mm depression would eliminate the number of false positives.[3]

Due to almost simultaneous depolarization and repolarization of auricles and the ventricles, under certain circumstances ST depressions may occur in the absence of coronary insufficiency. Scherf[11] and Lepeschkin[5] have described technics to overcome this problem. Figure II is partially reproduced from Lepeschkin. With slow rates the reference base line is the P-R segment. In the presence of fast heart rates and inability to identify this segment, the reference point is the onset of the QRS. In those tracings where a P wave is superimposed on the T wave or an abnormally large U wave so that the PR segment has a downward slope, special corrections are made for ST depressions. This is based on the fact that depressions of the J junction or early ST segment may be due to auricular repolarization. To correct for this, the downward slope is projected across the QRS. ST depression is then measured along a vertical line, distance OJ (see Figure II). In the presence of a short PR interval due to early depolarization so that a PR segment is not seen, a line connecting the onset of the P and its termination is projected across the QRS and ST depression is measured as above.

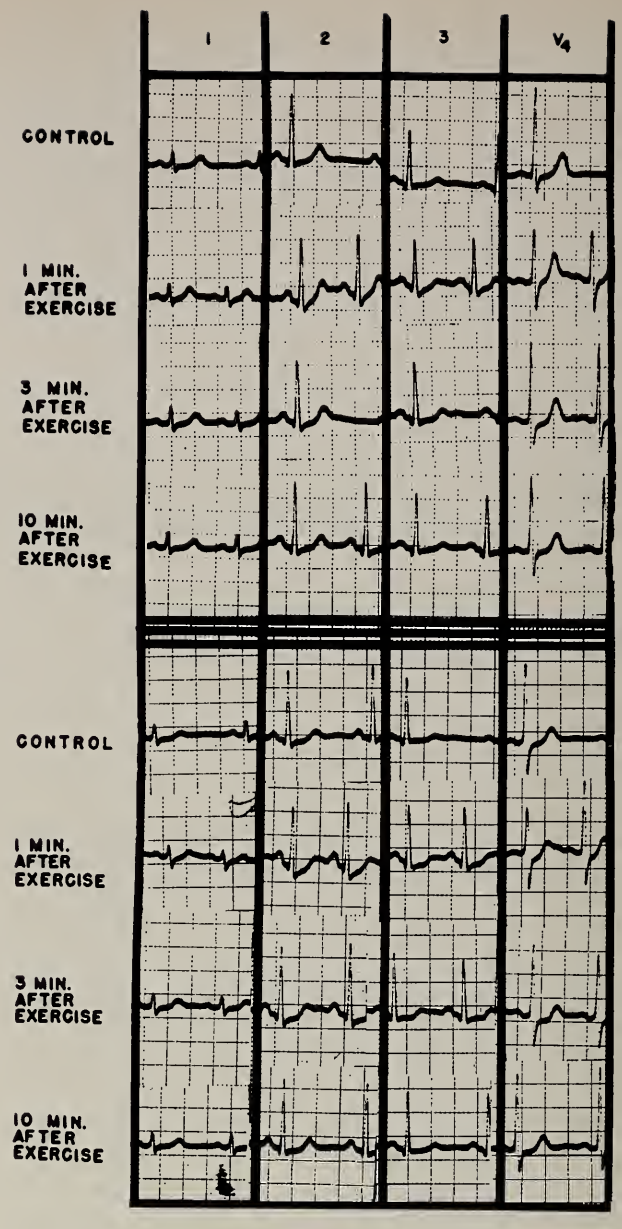


Figure I

TRACINGS above triple line taken before digitalis and below the lines after digitalis in the same subject. Note the ST depression in 2, 3, V4 after exercise and 3 minutes.

Other EKG Changes

The occurrence of other electrocardiographic changes during the exercise test are generally not diagnostic. Thus, Mattingly[11] found no really significant correlation between T wave changes alone and the future development of coronary artery disease. Master[10] feels that minimal T wave changes are of no aid, but that deeply inverted T waves are abnormal. The latter author

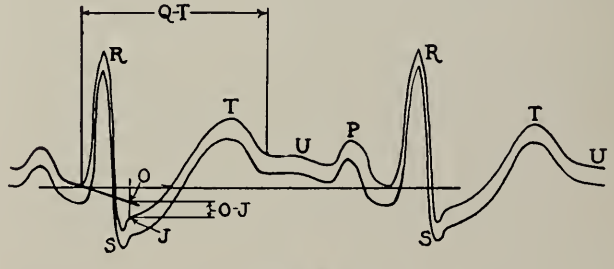


Figure II

PARTIALLY reproduced from Lepeschkin.[5] See text.

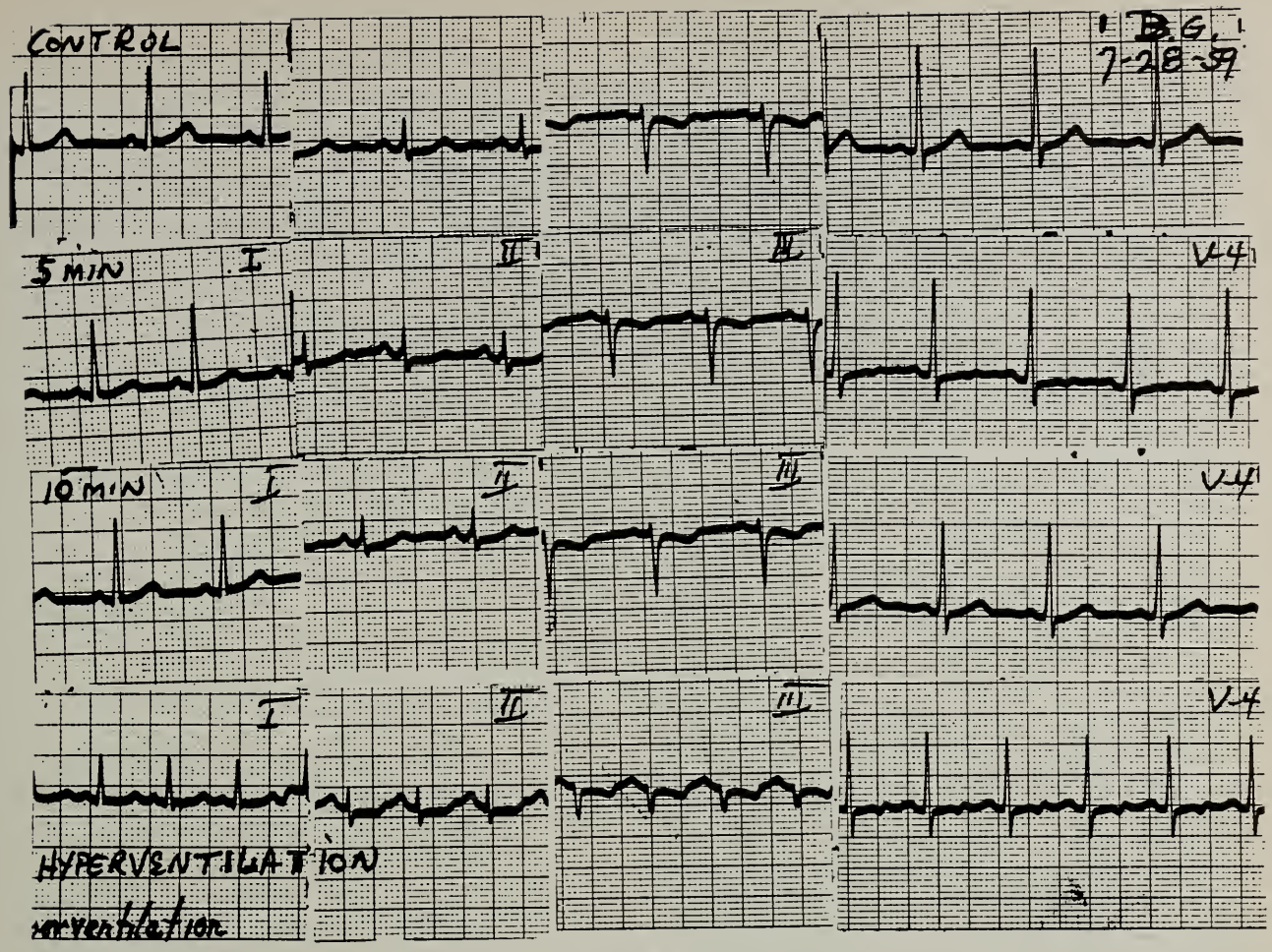


Figure III

LEADS I, II, III, V4 from left to right. The top three strips represent a Master double two step test. The bottom strips are after hyperventilation while lying flat.

also states that the occurrence of arrhythmias or conduction defects such as bundle branch block alone in no way aids in the diagnosis of coronary artery disease. Other workers feel that these changes, especially T wave changes, are significant.[12]

Hyperventilation has occasionaly produced non-specific T wave changes.[13] Figure III represents a standardized double step test in a 41-year-old white male with a vague history of left chest pain. The bottom strip was taken immediately after hyperventilation while lying flat. The patient experienced no chest pain during either of these tests. It can be seen that the T wave changes are more marked after hyperventilation than after exercise. These may represent artefact due to a low upright T and U waves.

In order to increase the accuracy of the test a combination of electrocardiographic measurements has been suggested. The persistence of ST depression after return of heart rate to normal is significant. Figure IV represents a true positive double Master's test and in this instance the depression persists for 10 minutes.

Another criterion is the duration of depressed ST in relation to the QT interval.[14] Lepeschkin has tried to quantitate the length of the Q-ST to the QT and suggests that in coronary disease the former is more than 50% of the latter after exercise. However, in a series of normals,[5] the author found that 3.5% had all three of the following: ST depression greater than 0.5 mm, lasting longer than two minutes with return of the ST segment to the isoelectric line in the second half of the QT interval. In a series of 30 known coronary artery disease, all but two had all three of the above findings. The author also suggests frank inversion of the U wave following exercise is indicative of coronary insufficiency, but also points out the difficulty in separating a U wave from biphasic T waves. These combinations will have to be applied to larger populations before their significance is ascertained.

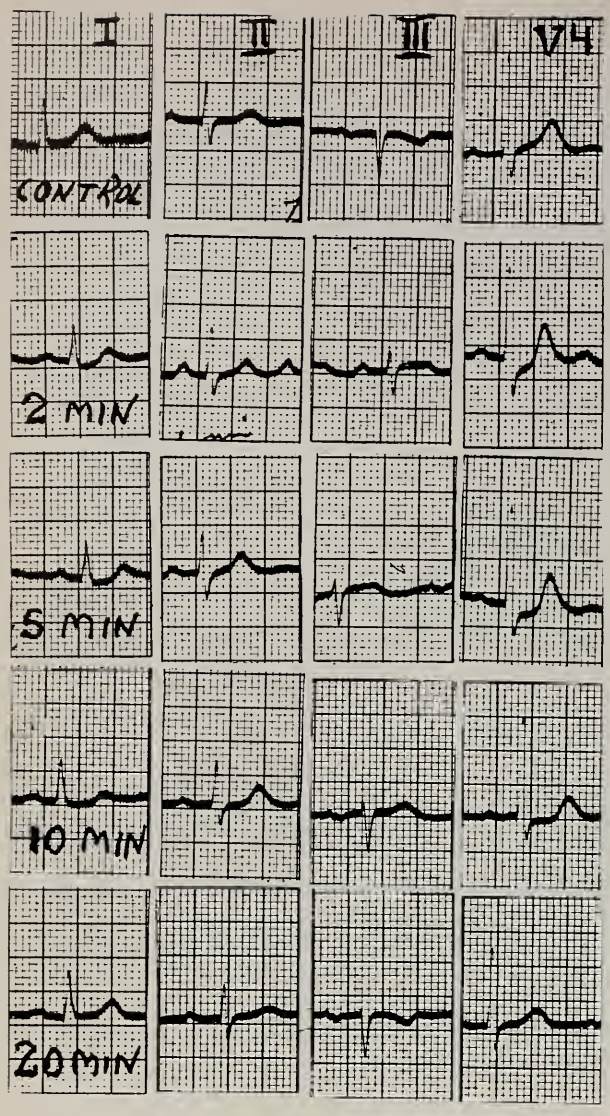


Figure IV

A POSITIVE exercise test. Note the ST depression in V4 which persists for 10 minutes, and the flatness of the depressed segment.

REFERENCES

1. Master, A. M., Friedman, R., Dack, S.: The Electrocardiogram after Standard Exercise as a Functional Test of the Heart, *Am. Heart J.*, 24:777, 1942.
2. Brauha, L., Graybiel, A., Heath, C. W.: The Step Test, a Simple Method of Measuring Physical Fitness for Hard Muscular Work in Adult Man, *Rev. Canad. Biol.*, 2:86, 1943.
3. Graybiel, A., Newton, A. W.: The Work Electrocardiogram, *Am. J. Card.*, 3:430, 1959.
4. Levy, R. L., Williams, N. E., Bruenn, H. G., Carr, H. W.: Anoxemia Test in Diagnosis of Coronary Insufficiency, *Am. Heart J.*, 21:643, 1941.
5. Lepeschkin, E., Surawiez, B.: Characteristics of True-Positive and False-Positive Results of Electrocardiographic Master Two-step Exercise Tests, *New England M.J.*, 258:511, 1958.
6. Cosby, R. S., Mayo, Mary: The Value of the Master Two-step Test in Coronary Artery Disease, *Am. J. Card.*, 3:444, 1959.
7. Thomas, C. B.: The Cardiovascular Response of Normal Young Adults to Exercise as Determined by the Double Master Two-step Test, *Bull. Johns Hopkins Hosp.*, 89:181, 1951.
8. Leeds, M. F., Kroopf, S. S.: The Exercise Test in Electrocardiography, *Calif. Med.*, 79:36, 1953.
9. Davis, F. W., Jr., Scarborough, W. R., Mason, R. E., Singewald, M. L., Baker, B. M., Jr.: *Am. Heart J.*, 46:529, 1953.
10. Master, A. M., Field, L. E., Donoso, E.: Coronary Artery Disease and the "Two-step Exercise Test," *New York State J. Med.*, 57:1051, 1957.
11. Mattingly, T. W., Fancher, P. S., Bauer, F. L., Robb, G. P.: Army Medical Service Graduate School, Research report, 21-54, Sept. 1954, Washington, D. C., Walter Reed Army Medical Center.
12. Gubner, R. S., Ungerleider, M. D.: Long-term Prognosis and Insurability in Coronary Heart Disease, *Am. Ht. Journal*, 58:436, 1959.
13. Wasserburger, R. H., Siebecker, K. L., Lewis, M. D.: The Effect of Hyperventilation on Normal Adult Electrocardiogram, *Circ.* 13:850, 1956.
14. Scherf, D., Schaffer, A. I.: The Electrocardiographic Exercise Test, *Am. Heart J.*, 43:927, 1952. ◄

Tension

Tension is not a severe illness, and those who suffer from tension are well enough to feel and suffer from the cramping self-centeredness imposed upon them by their psychosomatic disorder. They are like those lost souls whose punishment is, in the words of the great Catholic poet, Gerard Manley Hopkins, "to be their sweating selves, but worse."—Aldous Huxley: The History of Tension (editorial). —*The New Physician*, May, 1959.

Electrocardiographic Diagnosis And Clinical Implications Of Ventricular Premature Systoles

Various types of ventricular premature systoles are described and their significance in clinical medicine is briefly discussed.

*ROBERT B. CHEVALIER, M.D.**
CHARLES FISCH, M.D.
Indianapolis

THE VAST majority of ventricular premature systoles (VPS) can be grouped as follows:

1. Fixed Coupling
   a. Identical appearance of QRS (single focus)
   b. Multiple foci with each focus having its own fixed relation to preceding sinus beat
   c. Different appearance of QRS (single focus)
2. Parasystole
3. Unifocal VPS without fixed coupling
4. Multifocal

By definition a VPS is a beat that originates in the ventricle and is bizarre in configuration electrocardiographically with a duration of 0.12 sec. or more. VPS originating in the septum, the bundle of His and in the homolateral ventricle in the presence of bundle branch block may be normal or slightly bizarre in appearance. They are not usually preceded by a P wave and nearly always show a full compensatory pause.

A discussion of the concepts of the etiology of VPS is beyond the scope of this paper. Basically it is felt that they are due to: (1) sporadic ventricular activity, (2) supernormal phase of excitability of the ventricle, (3) re-entry phenomenon, and (4) parasystole. These concepts are covered in texts by Katz and Pick[1] and Scherf and Schott.[2]

It is the purpose of this paper to describe the morphology (EKG) and clinical implication of each of the different types of VPS.

Fixed Coupling with Identical Appearance of the QRS

In this type of VPS, the interval between the R of the beat conducted from the atrium and that of the VPS is constant. The configuration

From the Robert M. Moore Heart Clinic, Marion County General Hospital and the Department of Medicine, Indiana University School of Medicine, Indianapolis.

Supported by the Herman C. Krannert Fund of the Indiana Heart Association and the Indiana State Board of Health, Indianapolis.

* Krannert Fellow and Trainee of the National Heart Institute.

configuration is explained by varying exit. In other words, although they all arise from the same focus in the myocardium they are able to spread throughout the ventricles in different directions. They must be differentiated from multifocal VPS. This can be done by noting the absence of a fixed R-R interval in multifocal VPS.

Clinically this sort of VPS is probably never seen with a normal heart and is frequently due to digitalis.

Parasystole

Figure 2 (A) illustrates parasystole. This type of VPS is postulated when four criteria are met.

1. The configuration of the VPS is constant, but there is no fixed relationship to the preceding QRS.
2. The R-R interval of the parasystolic beats is a simple mathematical multiple of the shortest paraystolic R-R interval.
3. There are occasional episodes of fusion beats when a parasystolic beat occurs simultaneously with ventricular beat conducted from the atrium.
4. Their failure to register when expected must be accounted for by refractoriness of the ventricle.

The parasystolic focus, if rapid, represents ventricular tachycardia. A bigeminy with a fixed R-R interval in the absence of sinus arrhythmias could conceivably meet the first two criteria, but not the third. Multifocal VPS lack a fixed relationship to each other.

Clinically, parasystole is significant in that it indicates heart disease.

Unifocal VPS without Fixed Coupling

This type of VPS is shown in Figure 2 (B). These VPS are identical to each other in appearance, but do not show fixed coupling or a constant relationship to one another as manifested by parasystole.

Clinically, their significance is not known.

Multifocal

Figure 2 (C) is representative of multifocal VPS. They are not related to the normally conducted beat or to each other. They may be considered an example of "chaotic" heart action. Figure 2 (D) illustrates the potential hazard of these sort of VPS in that they can produce ventricular tachycardia.

Clinically, these sort of VPS usually indicate severe heart disease and often represent a prefibrillatory state. Digitalis in toxic doses can produce this picture.

REFERENCES

1. Katz, L. M., Pick, A.: *Clinical Electrocardiography, the Arrhythmias,* Philadelphia, 1956, Lea and Febiger,
2. Scherf, D., Schott, A.: *Extrasystoles and Allied Arrhythmias,* London, 1953, William Heinemann, Medical Books, Ltd. ◄

98% of Blue Shield Plans Consider Aged

A study conducted by the national Blue Shield association shows that 32 of the plans, representing more than 50% of total enrollment, have made available nongroup programs for persons over the age of 65. Three plans, with about 15% of total Blue Shield membership, have programs already approved and ready to be offered as soon as the mechanics of administration are completed. Also, 23 additional plans, covering 30% of total enrollment, have senior citizen programs in various stages of development and these plans report that they expect their programs to be in force early in 1960.

Thus, about 98% of the total United States Blue Shield enrollment is in areas where special aged programs are already being offered or are in stages of development, all within a one-year period following passage of the AMA resolution. —*Blue Shield Newsletter,* December, 1959.

Malignant tumors of the pericardium are susceptible of diagnosis. Although they are eventually fatal, palliative treatment is useful and important.

Metastatic Tumors of the Pericardium

PASQUALE D. GENOVESE, M.D. **
*DALLAS B. FOUTS, SR., M.D.**
Indianapolis

THE DIAGNOSTIC and therapeutic advancements in the past two decades have permitted one to recognize many previously undiagnosed syndromes associated with neoplastic disease. This is also true of metastatic involvement of the heart and pericardium. In this particular group the diagnosis is frequently a difficult one, and the syndrome associated with it quite varied. Previous reviews by Cohen,[1] Bisel,[2] Prichard,[3] Pollia[4] and others[5,6,7] confirm the varied patterns that are associated with neoplastic invasion of the myocardium or pericardium.

In this paper, some of the more common patterns associated with neoplastic involvement of the heart and pericardium are reviewed. Seven cases are reported, and in a few, the pattern simulated the clinical pictures previously described by other authors. In others, the mode of onset, and not infrequently the course, was unusual and for this reason the authors believe that these should be reported.

From the Robert M. Moore Heart Clinic and the Department of Medicine, V.A. Hospital and Indiana University School of Medicine, Indianapolis.

* Senior resident in medicine, Indiana University School of Medicine.

** Assistant professor in medicine, Indiana University School of Medicine.

Frequency and Nature of Cardiac Metastases

The incidence of cardiac metastasis has been reported to be 0.24% to 6.45% of all autopsies by various observers,[4,5,6,7] as compared to an incidence of 0.0017% for primary tumors of the heart. However, the incidence of cardiac metastases in autopsies based on the total number of malignant tumors has been reported to be 5% to 11% by Friedberg[8] and from 2% to 21% by others.[2,4,5,6,7]

The explanation for this wide range of incidence is not entirely satisfactory but may reflect several factors. In some centers there is a preponderance of certain types of tumors in which cardiac metastases are more frequent. With the advent of new chemotherapeutic agents, life has been prolonged and there has been a greater opportunity for metastases to develop. A discrepancy in the range of incidence may also reflect the care with which autopsies are performed, the findings recorded, and coded for reference, as suggested by Cohen.[1]

Metastases to the heart and pericardium may arise from a malignant neoplasm in almost any organ. However, bronchogenic carcinoma, carcinoma of the breast, malignant lymphoma and malignant melanoma constitute the most frequent

primary lesions. In Scott's series, carcinoma of the bronchus and breast accounted for 48% of all cases. Metastases to the heart were found in about ⅓ of all tumors of these two organs. Cohen's reported incidence of 54% compares favorably with Scott's figure.

Metastases Routes

Cardiac metastases occur by three routes: by direct extension from neighboring intrathoracic organs, by embolization from the primary tumor and by retrograde lymphatic extension. These are listed in the order of relative frequency. Pericardial metastases are more common than myocardial metastases, and endocardial metastases are rare.

In myocardial involvement the right side of the heart has been noted to be involved more frequently than the left.[3] In an attempt to explain this phenomenon, it has been observed that 75% of the coronary arterial flow returns to the right chambers of the heart, passing through the thebesian veins and the coronary veins. Thus, the opportunity for right sided invasion is greater than the left.

Endocardial metastases are presumably due to surface implantation. Valvular implants occur but are rare. This is believed to be associated with the relative avascularity of the valves.[3] Some authors believe that pre-existant valvular damage is a prerequisite for tumor implantation.[13]

There are apparently several factors which operate to keep the incidence of cardiac metastases low: (1) the strong kneading action of the heart, (2) the metabolic peculiarities of the myocardium, (3) rapid blood flow and (4) restricted lymphatic connections.[2,3]

Neoplastic disease may occur in any age group, and a natural corollary is that metastatic invasion of the heart and pericardium may occur in any age group. However, the majority of cases reported in one series were in the fifth, sixth and seventh decades of life. The range in ages was 20 to 84 years.[1]

Diagnosis of Cardiac Metastasis

The antemortem diagnosis of neoplastic invasion of the heart and pericardium may be extremely difficult. Prichard in 1951 reported an antemortem diagnosis in 21 cases from some 500 autopsy proved cases. In many of these, cardiac metastasis produced no evidence of disturbance in cardiac function, and death was the result of either the primary lesion or of metastasis to other organs. In others sudden death occured in the absence of prior evidence of heart disease. Congestive failure, developing without apparent cause, particularly in a patient with a known malignant lesion, seems to be the most important finding indicative of cardiac metastasis. Abnormalities of cardiac rhythm or evidence of pericardial disease are only suggestive signs.

Electrocardiographic changes depend primarily on the location and extent of cardiac metastases and, therefore, no specific diagnostic patterns can be described. Premature auricular contractions, auricular flutter and auricular fibrillation have been noted to be the predominant arrhythmias. Scott and Garvin, and Siegel and Young[14] found tumor involvement of the atrium in all but one case at autopsy in which arrhythmias had been noted. Electrocardiograms taken at frequent intervals may reveal changes not ascribable to any other form of heart disease, and a presumptive diagnosis of metastatic disease can be entertained.

Certain syndromes may suggest involvement of the pericardium, or great veins. Signs of cardiac tamponade, a rigid, nonpulsating cardiac border on fluoroscopy, or electrocardiographic evidence of pericarditis suggest infiltration of the pericardium or possibly the right atrium.[15] A persistent or rapidly reforming pericardial effusion, especially if serosanguineous or frankly hemorrhagic constitutes strong presumptive evidence of neoplastic involvement of the pericardium. An unexplained tachycardia, friction rub or gallop rhythm, associated with electrocardiographic abnormalities, may be considered to be evidence of neoplastic involvement of the pericardium, especially in patients with a known malignant lesion.

Important Method

A more important method of establishing the diagnosis of metastatic disease is the demonstration of tumor cells in the pericardial fluid, when this is present, by either the Papanicolaou technic or by section of the sediment. A dry pericardial tap, however, does not exclude the diagnosis. An adhesive pericarditis may be present either as a result of disease or previous roentgen therapy.

Myocardial metastasis is most often heralded by unexplained heart failure, which may be sudden in onset and intractable in nature. Unexplained arrhythmias, sinus tachcardia, premature auricular or ventricular contractions, auricular flutter or fibrillation, bundle branch block, or complete heart block with Stokes-Adams syndrome, are considered by some to be the second most frequent manifestation of myocardial involvement. However, "T" wave abnormalities were noted by Bisel to be the most common electrocardiographic abnormality in his series.

Disturbances of rhythm or conduction are usually encountered in cases with invasion of the atria, particularly the right atrium. If a coronary artery is encroached upon, angina may be present. Irregularity of the cardiac silhouette may be noted on x-ray in myocardial involvement.

Ancillary Measures

If the diagnosis is difficult, ancillary measures such as angiocardiography, fluoroscopy and kymography may differentiate tumor from aneurysms, since tumors do not fill with radiopaque material and pulsations are absent or only poorly transmitted. Artificial pneumopericardiography has been utilized to outline the heart, prior to confirmation of the diagnosis of neoplastic involvement by the identification of neoplastic cells from pericardial fluid.

No significant correlation was noted between the clinical, roentgenographic, and electrocardiographic findings and the size and degree of cardiac metastases in the series reported by Bisel.[2]

Case Reports

Illustrative examples have been chosen from the files of the VA Hospital and the Indiana University Medical Center, Indianapolis, in which the diagnosis of metastatic disease was established antemortem.

CASE I

A 69-year-old white male was admitted to the hospital Nov. 2, 1947 with the complaints of anorexia, dyspnea, weakness, cough and abdominal pain of 18 months duration.

Physical examination revealed a chronically ill, cyanotic male, BP 100/60. Periorbital edema, venous distention, glossitis, decreased breath sounds and dullness in the bases were present. No cardiac enlargement, thrills or murmurs were noted. A 5 x 6 cm. mass in the left upper quadrant was palpable, and there was enlargement of the liver.

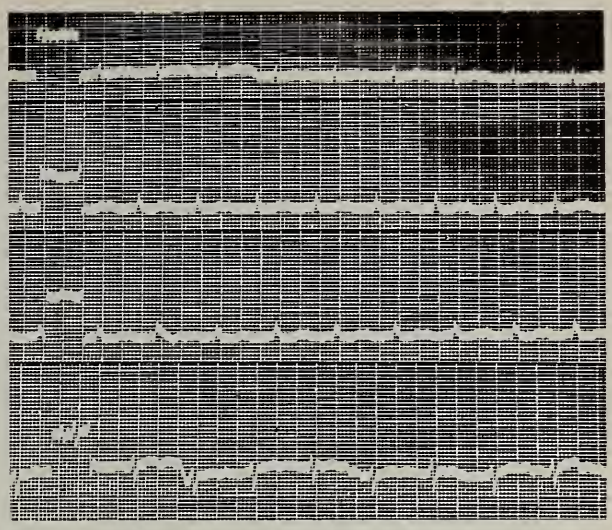


Figure 1

LOW VOLTAGE QRS complexes with long P-R interval.

PA chest film and fluoroscopy revealed a nonpulsating mass along the right cardiac border. Initial ECG revealed a first degree A-V block (P-R interval 0.30 seconds), and a low voltage (Figure 1). A second ECG revealed decreased voltage and complete A-V block.

The course was rapidly downhill with the development of a pulsus paradoxus. Pericardiocentesis was performed and 50 ml of serosanguinous fluid removed. Cytologic examination revealed malignant cells. Following repeated pericardial aspirations the patient improved temporarily, but finally died on Nov. 19, 1947.

Autopsy revealed a large retroperitoneal mass. The histology revealed a malignant lymphoma of the reticulum cell sarcoma variety. There was extensive metastases to the pericardium and the wall of the right heart.

Comment

The incidence of cardiac involvement in malignant lymphomas and the leukemias is quite high. Bisel reports an overall incidence of cardiac metastasis in 33% of 188 cases.[2]

CASE II

A 49-year-old white male was admitted to the hospital Aug. 20, 1955 with the complaints of recent anterior chest pain, dyspnea and a chronic cough of one year duration. In April, 1955 a course of roentgen therapy to the right hemithorax was given for bronchogenic carcinoma with clinical improvement.

Physical examination revealed a critically ill, unresponsive, cyanotic male, BP 90/60. An inspiratory lag was present on the right, with dullness to percussion, decreased breath sounds and moist rales in this same area. There was cardiac dullness to the anterior axillary line. Heart tones were very distant and a pulsus paradoxus was evident. Hepatomegaly was noted.

Chest x-ray revealed marked cardiac enlargement and a lesion in the right upper lung field. Electrocardiogram revealed electrical alternans and ST-t changes consistent with pericarditis (Figure 2).

The patient improved slightly on supportive therapy. Five hundred ml of serosanguinous fluid was obtained from the pericardium. Cytological examination revealed malignant cells of the squamous cell variety. Despite all efforts the patient expired three days after admission.

Autopsy revealed bronchogenic carcinoma of the right upper lobe with metastatic involvement of the pericardium.

CASE III

A 64-year-old white male was admitted May 24, 1957 with the complaints of anterior chest pain, a "cold" and cough. Symptoms began in early May and progressed. Physical findings and x-ray studies were suggestive of pneumonitis and the patient was referred to this hospital.

Physical revealed a well developed, well nourished male in pain, BP 120/80. There was dullness and decreased breath sounds at the right base. An aortic systolic murmur was noted. There was clubbing of the fingers and toes.

Laboratory studies were negative except for an alkaline phosphatase of 13.4 Bodansky units. Chest x-ray revealed cardiomegaly and a right pleural effusion. ECG revealed multiple auricular premature systoles, blocked auricular premature systoles and a run of auricular tachycardia with 2:1 conduction.

Shortly after admission, repeat chest x-ray revealed a marked increase in cardiac size. A pericardial friction rub developed. A pericardiocentesis was done on May 31, and 4 ml of bloody fluid obtained. Cytological examination revealed malignant cells. The patient expired suddenly on June 2, 1957.

Autopsy revealed bronchogenic carcinoma with metastatic involvement of the pericardium, and a generalized fibrinous pericarditis with 1000 ml of serosanguinous fluid in the pericardial space (Figure 3).

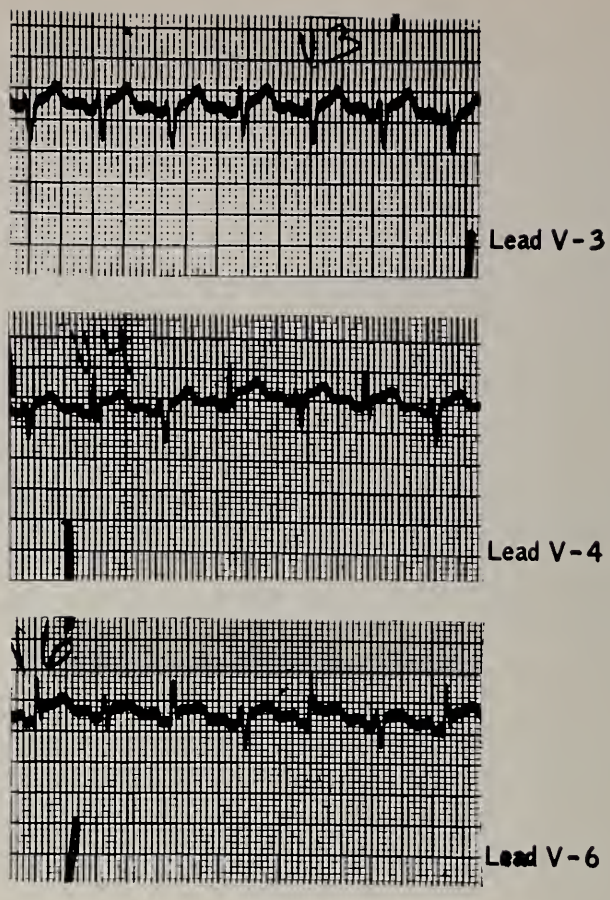


Figure 2

ELECTROCARDIOGRAM revealing electrical alternans.

Comment

Malignancy arising in the respiratory system serves as the primary focus for metastatic lesions of the pericardium and heart in 11% to 35% of all instances of cardiac involvement, and is the leading source in most series.[2,3,5] Direct invasion of the pericardium by tumor from the surrounding hilar structures is the usual route of spread in bronchogenic carcinoma.

In Case III, the patient presented himself as a problem of acute pericardial effusion, and thus a problem in differential diagnosis of acute pericardial effusions. Occasionally, therefore, bronchogenic carcinoma may invade the pericardium early, and early diagnosis is essential to properly determine the therapeutic program.

CASE IV

A 53-year-old white housewife was admitted June 7, 1957 for evaluation of congestive failure which had begun in May of 1957. Usual cardiac measures had been unsuccessful in controlling symptoms.

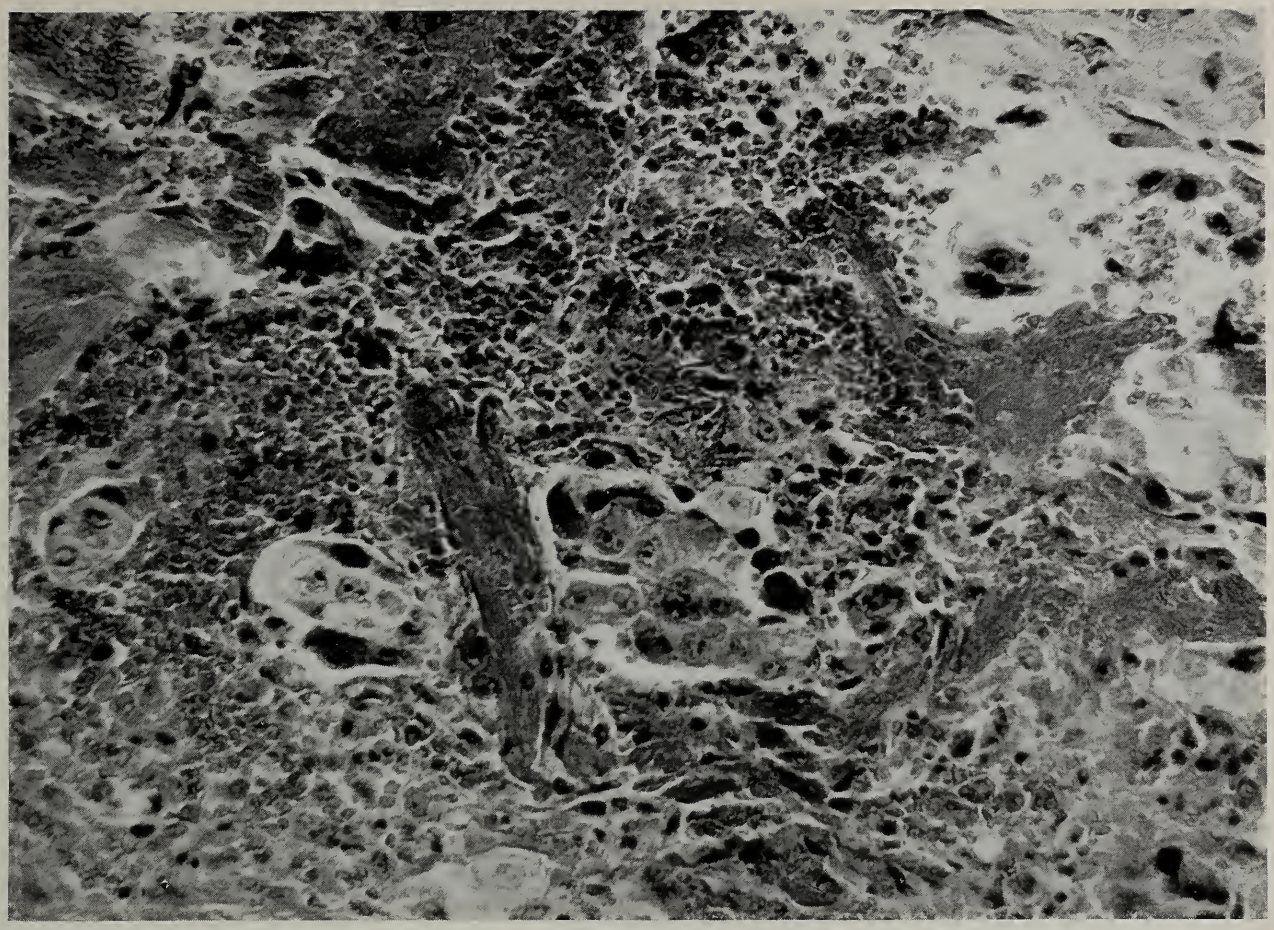


Figure 3

METASTATIC involvement of pericardium by squamous cell carcinoma.

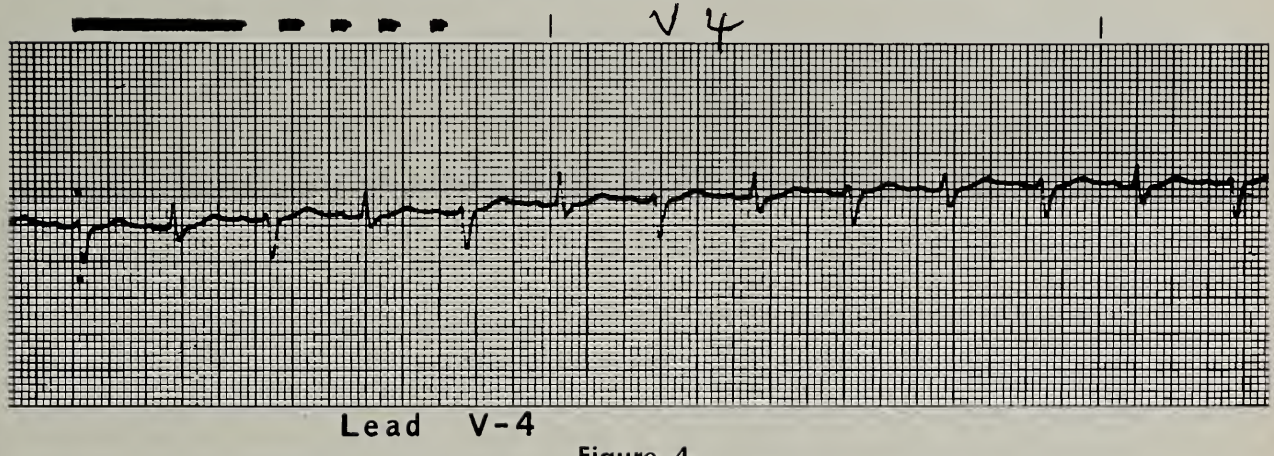


Figure 4

ELECTROCARDIOGRAM demonstrating electrical alternans of QRS complexes.

Physical revealed an acutely ill, dyspneic, cyanotic white female. BP 104/80, P-120, R-30 T 101 (R). There was dullness below D-6 on the left and D-8 on the right and absent tactile fremitus in this area. Diminished breath sounds and course rales were present in the remainder of the lung fields. Cardiomegaly to the A.A.L. with decreased heart tones was noted. There was marked jugular distention with a pulsus paradoxus. A 10 cm hard irregular mass was palpable in the right breast. Marked hepatomegaly and pedal edema were also observed.

Chest x-ray revealed a left pleural effusion and a marked cardiomegaly. ECG revealed a sinus tachycardia with electrical alternans (Figure 4). Pericardiocentesis was performed and 600 ml of serosanguinous fluid removed with resultant clinical improvement. Cytology revealed malignant cells.

Nitrogen mustard (20 mg) was instilled into

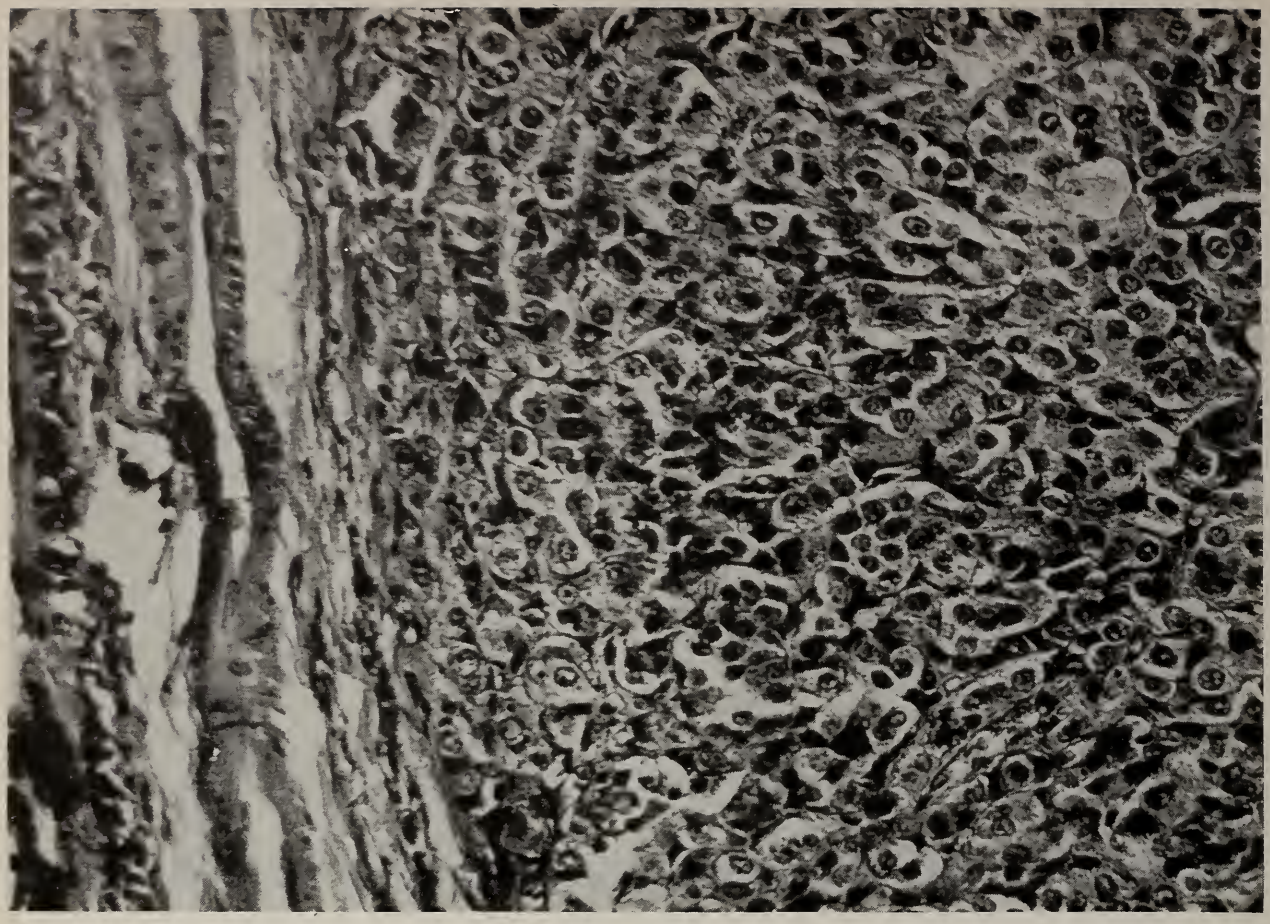


Figure 5

ADENOCARCINOMA of breast invading a lymph node.

the pericardial space on 7-12-57 and 7-23-57. The effusion gradually subsided; simultaneously there was improvement in the cardiac status. Breast biopsy was refused. The patient was discharged from the hospital on 8-18-57.

Rehospitalization in February 1958, for cough and chest pain was necessary. Marked cervical adenopathy was present, and biopsy of a node revealed metastatic adenocarcinoma. There was marked improvement on methyl testosterone therapy, 10 mg sublingually four times a day, and the patient was discharged from the hospital.

She was readmitted in April, 1959, because of G.I. symptoms. Marked hirsutism was present at this time. Testosterone was discontinued and a course of triethylene melamine (T.E.M.) given with a good response.

She was rehospitalized on 9-2-59 with severe frontal headaches. Another course of T.E.M. was given with improvement, but this was short lived and there was a rapid downhill course. Death occurred in December of 1959. Autopsy revealed adenocarcinoma of the breast with wide spread metastases including the pericardium (Figure 5).

Comment

Malignant lesions of the breast have been associated with 14% to 35% of metastatic disease of the heart or pericardium.[1,5] Carcinoma of the breast occurs in about 4% af all adult women, and this site is involved by cancer almost twice as frenquently as any other location.[18] Lymphatic channels may carry malignant cells from the primary lesion in the breast to the prepericardial lymph nodes where tumor may then extend to involve the pericardium. Direct extention through the chest wall may also involve the pericardium. Hormonal therapy has been quite beneficial in many cases of carcinoma of the breast, and may be of material benefit even after involvement of the pericardium has taken place, as illustrated by this case.

Metastatic disease to the pericardium was apparently well-controlled until the time of death, in this case, by instillation of nitrogen mustard into the pericardial space. At no time during the



Figure 6

CYTOLOGY of pericardial fluid revealing malignant cells.

course of the illness, following nitrogen mustard therapy, was pericardial effusion ever a problem.

CASE V

A 42-year-old white female office worker was admitted April 20, 1956 with the complaints of cough and chest pain which began in March of 1956 and were progressive. Symptoms were unimproved on symptomatic therapy. Laboratory studies including x-rays and ECG's were interpreted as suggestive of myocardial infarction and she was referred to this hospital. She had been treated for carcinoma of the cervix in 1952 with x-ray and radium therapy and a panhysterectomy had been performed in 1954.

Physical revealed an acutely ill white female, BP 120/80 T-101, P-120. There was dullness to percussion below D-8 on the right. There was decreased fremitus and decreased breath sounds in this area. The border of cardiac dullness was in the anterior axillary line. Heart tones were distant and a soft apical systolic murmur was present. A pulsus paradoxus was noted. There was hepatomegaly.

Initial laboratory studies were negative. Serum electrolytes were abnormal, chloride 58 meq, sodium 118 meq, and potassium 4.7 meq.

X-rays revealed marked cardiomegaly and a bilateral pleural effusion. Fluoroscopy revealed decreased cardiac pulsations. ECG revealed ST-T changes suggestive of pericarditis or ischemia.

Cardiac management was instituted and on April 25 a pericardiocentesis was performed and 50 ml of grossly bloody fluid obtained. Cytological studies of the fluid were negative. On repeat pericardiocentesis 400 ml of fluid was obtained. Cytology at this time revealed malignant cells (Figure 6). A course of roentgen therapy (4000R) to the right hilar area was given, and on May 10, 70 ml of radioactive gold (AU 198) was instilled into the pericardial space.

The course was steadily downhill. Marked electrolyte abnormalities and mild hypotension were noted on May 18, and adrenal insufficiency was considered. However, there was no response to the administration of steriods and the patient expired on May 28, 1956.

Permission for autopsy was not obtained.

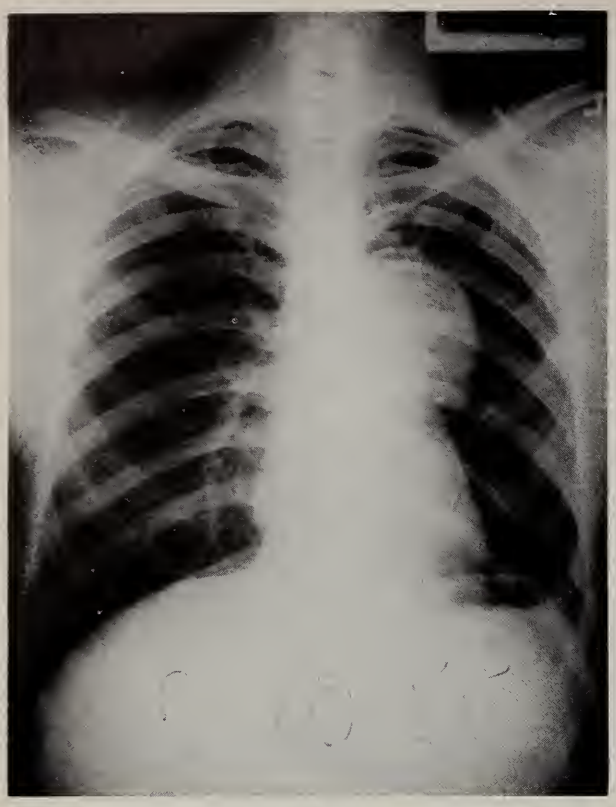


Figure 7a

EWING'S sarcoma, metastatic to the lung: 1955.

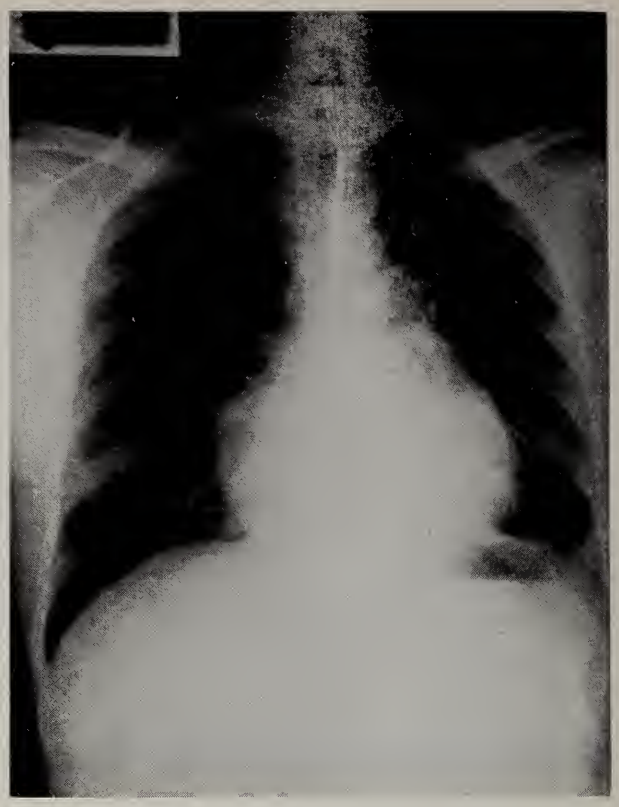


Figure 7b

CARDIOMEGALY at time of pericardial biopsy, November, 1958.

Comment

Metastasis to the heart and pericardium from the cervix is a relatively rare occurrence, but has been reported in some series to be 1.6% to 4.1% of all cases.[1,3,5] The usual sites for metastasis from the cervix are to the parametria. Metastasis to remote organs is rare.[9]

CASE VI

A 33-year-old white male was admitted Nov. 3, 1958 for evaluation of cardiomegaly noted initially in October of 1957. No cardiovascular complaints were elicited.

Past history revealed that a mid-thigh amputation had been performed in January of 1948 in Fitzsimmons Army Hospital for Ewing's sarcoma. In December of 1950, a nodule was noted in the left upper lobe. A thoracotomy was performed in September of 1951 and a metastatic lesion (Ewing's sarcoma) excised. In September of 1955, at Richmond, Va., a left hilar mass was noted and treated with x-ray therapy (17,150 R-air) via the grid technic (Figure 7). A dramatic response was obtained and the patient remained asymptomatic until his admission in November, 1958.

Physical revealed a well developed, well nourished male, BP 126/80. The PMI was 1 cm outside the MCL. A grade II systolic murmur was heard over the precordium. A scratchy, diastolic murmer was heard in the recumbent position. A right mid-thigh amputation was noted.

Laboratory studies were negative.

X-rays revealed an elevated L. diaphragm and blunted left C.P. angle. The cardiac silhouette was moderately enlarged.

ECG revealed ST-T changes suggestive of pericarditis.

Cardiac catheterization revealed an end diastolic pressure of 13 mm of mercury in the right ventricle. There was an end diastolic plateau on the pressure curve, which was compatible with, but not diagnostic of cardiac constriction (or compression) as seen in constrictive pericarditis or pericardial effusion. The resting cardiac output was decreased, and there was little response to exercise. In addition, there was a marked increase in the A-V difference in oxygen saturation with exercise.

On November 24, a pericardial biopsy was performed. The pericardium was thickened and 350 ml of straw colored, clear fluid was removed. Cytology revealed no malignant cells in the pericardial fluid and histological sections of the peri-



Figure 7c

NO EVIDENCE of recurrence of malignancy, November, 1959.

cardium revealed only chronic pericarditis with mesothelial cell proliferation. The postoperative course was benign and the patient discharged Dec. 5, 1958.

He was readmitted Dec. 10, 1958, with fever and precordial pain. A pleuropericardial friction rub was heard. The symptoms improved gradually and he was discharged Dec. 19, 1958. He has remained essentially asymptomatic.

Comment

In this instance metastatic disease to the pericardium was not demonstrated histologically. However, after intensive radiation therapy it may be most difficult to demonstrate malignant cells. Radiation pericarditis must also be considered as a possibility in this instance.

This case of probable Ewing's sarcoma is remarkable because of the long term survival. The usual prognosis as to life is considered to be three years,[10] although Lichtenstein has reported a 20-year survival after amputation of a lower extremity.[11] Regardless of the exact nature of this tumor, this particular patient demonstrates that at times continued treatment of metastatic lesions is worthwhile. Bisel reported one case of Ewing's sarcoma, in his series, with metastasis to the pericardium. However, the length of survival was not stated.

We are aware of the difficulties frequently encountered in establishing the diagnosis of Ewing's sarcoma histologically. The histologic sections, both of the primary and the metastatic lesion, are no longer available. This is regrettable since no photomicrographs could be obtained for publication. However, the sections were reviewed by four qualified pathologists who independently arrived at the same conclusion, namely that of Ewing's sarcoma. In addition, the sections have been reviewed by the Armed Forces Institute of Pathology and again the diagnosis was confirmed.

CASE VII

A 61-year-old white male was admitted on May 26, 1959 with the complaints of weakness, dyspnea, abdominal pain and pedal edema. There was a "flu" like illness in December of 1958 from which he never completely recovered. In March, 1959, exertional dyspnea developed, followed by orthopnea and paroxysmal nocturnal dyspnea. Symptoms progressed and he was hospitalized elsewhere and studied. Therapy consisted of cardiac management and blood transfusions. A pleural effusion on the left was noted and thoracentesis performed. Studies on this fluid were negative. Symptoms progressed and he was referred to the VA Hospital. Past history revealed only diabetes mellitus of 28 years duration, controlled by diet and insulin.

Physical revealed a chronically ill white male. BP 100/70, P-70, T-98. There was dullness with absent breath sounds and decreased tactile fremitus in both bases. Cardiomegaly, venous distention and a pulsus paradoxus were present. There was 4 pedal edema.

Chest x-ray revealed marked cardiomegaly, a right pleural effusion and partial collapse of the right middle lobe. ECG revealed low voltage, digitalis effect and electrical alternans.

Cardiac and diabetic management was continued. Hemoptysis developed and the pulsus paradoxus became more pronounced. A pericardiocentesis was performed the day following admission and 600 ml of serosanguinous fluid removed. Cytological examination revealed malignant cells. Nitrogen mustard (40 mg) was instilled into the pericardial space on May 28. Following this, signs of pericardial fluid were less prominent. There was a rapid downhill course, however, and the patient expired on July 12, 1959.

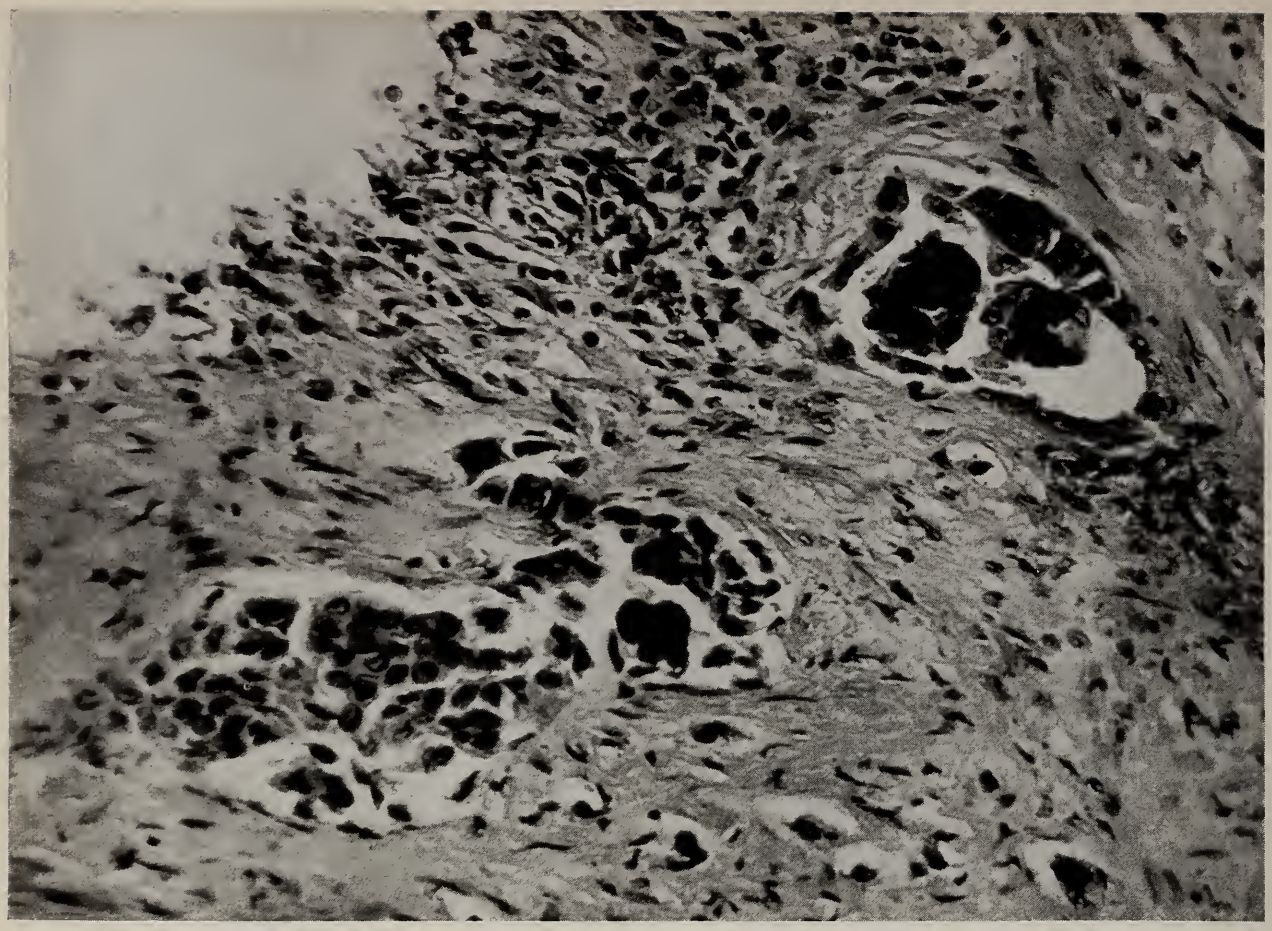


Figure 8

PERICARDIUM revealing metastatic lesions with psammoma bodies.

Autopsy revealed carcinoma of the thyroid with pericardial metastasis (Figure 8).

Comment

Pericardial metastases from carcinoma of the thyroid is a rare occurrence. Bisel reported 15 cases of carcinoma of the thyroid in 304 autopsies in which a malignancy was present. In two of the 15 cases, pericardial metastases were found for a 5.4% incidence. In other series the incidence was lower.

Electrocardiographic Changes

Three of our cases presented with electrical alternans in addition to other ECG changes. The association of electrical alternans and pericardial effusion has been previously reported by McGregor and Baskind.[12] They suggested that the association between electrical alternans and pericardial effusion is more than fortuitous, and that there are some unique features of the alternans found in cases of effusion.

Electrical alternans, of the QRS complex, has been divided into three types: (1) alternans associated with rapid heart rates, (2) associated with intraventricular conduction defects, and (3) alternation of apparently normal complexes at normal or moderately increased rates. It is this third group which is sometimes associated with pericardial effusion.

In alternans of pericardial effusion, there may be simultaneous alternation of the P wave. Alternation of the heart sounds in the absence of alternation of the pulse has been reported also. The alternans persists despite complete respiratory arrest.[12]

Numerous theories of the mechanism of alternation have been offered for this phenomenon. The most recent theory is that in a pericardial effusion there is free movement of the heart in the pericardial sac. It is felt that the periodic fluctuation in the tension of the great vessels, which are in a spiral arrangement as they leave the heart, could produce a rotatory effect on the "floating" heart. This would adequately explain: (1) the association between pericardial effusion and electrical alternans, (2) the fluctuation in voltage, other than true alternans, found in some cases with pericardial effusion, (3) synchronous

alternation of auricular and ventricular complexes, and (4) alternation of intensity of heart sounds.

It is obvious this explanation applies only to the alternans associated with pericardial effusion. In other situations, the other theories of explanations are quite applicable.

Treatment

The effectiveness of cytolytic, hormonal, roentgen and radioisotope therapy in malignancy has been demonstrated in many instances. Nevertheless, the earlier the diagnosis, the sooner therapy is instituted, the better the prognosis.

A high index of suspicion is imperative if the antemortem diagnosis of pericardial metastasis is to be made. Whenever possible, the primary lesion should be determined in order that the most effective therapeutic program may be chosen for the specific type of neoplasm.

Instillation of nitrogen mustard into the pericardial space may prove more effective in one situation, whereas instillation of a radioisotope or roentgen therapy may be more advantageous in another.

The development of pericardial metastasis, while a very serious complication of neoplastic disease and a poor prognostic sign, is not an utterly hopeless situation. The careful and intelligent utilization of the present therapeutic tools may provide temporary clinical improvement and prolongnation of life, as illustrated by cases 4 and 6.

Summary

1. Some of the more common patterns associated with neoplastic involvement of the heart and pericardium have been reviewed.
2. Seven cases have been reported, some of which simulated the common patterns previously described, and others which presented in an unusual manner.
3. Metastatic involvement of the heart and pericardium originates from tumors of the bronchus, breast, malignant melanoma, and the lymphoma group in approximately 75% of all cases.
4. Congestive heart failure, cardiac arrhythmias or cardiac tamponade (or compression) should suggest the diagnosis of neoplastic involvement of the heart or pericardium, especially in patients with a known malignancy.
5. The prognosis, while very guarded, is better than in the past since the advent of newer therapeutic tools.

ACKNOWLEDGMENT

The authors wish to acknowledge the assistance of Edward Graham, M.D., Department of Pathology, and George Cave, Department of Illustration, VA Hospital, Indianapolis.

BIBLIOGRAPHY

1. Cohen, G. U., Peery, T. M., Evans, J. M.: Neoplastic Invasion of the Heart and Pericardium, *Ann. Int. Med.* 42:1238-1245, 1955.
2. Bisel, H. F., Wroblewski, F., LaDue, J. S.: Incidence and Clinical Manifestations of Cardiac Metastasis, *J.A.M.A.* 153:712-715, 1953.
3. Prichard, R. W.: Tumors of the Heart; Review of the Subject and Report of 150 Cases, *Arch. Path.* 51:1, 98-128, 1951.
4. Pollia, J. A., Gogol, L. J.: Some Notes on Malignancy of the Heart, *Am. J. Cancer* 27:329-333, 1936.
5. Scott, R. W., Garvin, C. F.: Tumors of the Heart and Pericardium, *Am. Heart J.* 17:431-436, 1939.
6. Dimmette, R. M.: The Antemortem Diagnosis of Secondary Tumors of the Heart; Report of 4 Cases, *U. S. Armed Forces M. J.* 1:750-758, 1950.
7. DeLoach, J. F., Haynes, J. W.: Secondary Tumors of the Heart and Pericardium, *Arch. Int. Med.* 91:224-249, 1953.
8. Friedberg, C. K.: *Diseases of the Heart,* 2nd edit., W. B. Saunders Co., Philadelphia, 1956.
9. Anderson, W. A. D.: *Pathology,* 1948, C. V. Mosby Co., N. Y., p. 1135.
10. Jaffe, H. L.: *Tumors and Tumorous Conditions of the Bone and Joints,* 1958, Lea and Febiger, Philadelphia, pp. 350-367.
11. Lichtenstein, L.: *Bone Tumors,* 2nd edit., 1959, C. V. Mosby Co., St. Louis, Mo., p. 249.
12. McGregor, M., Baskind, E.: Electric Alternans in Pericardial Effusion, *Circ.* 11:837-843, 1955.
13. Coller, F. C., Inkley, J. J., Moragues, V.: Neoplastic Endocardial Implants; Report of a Case, *Am. J. Clin. Path.* 20:159-164, 1950.
14. Siegel, M. L., Young, A. M.: Electrocardiographic Findings in Tumors of the Heart with Report of a Case, *Am. Heart J.* 8: 682-690, 1933.
15. Ravid, J. M., Sachs, J.: Tumors of the Heart with a Report of a Primary Fibromyxosarcoma of the Left Auricle and the Pulmonary Vein Associated with Multiple Tumors of the Mesentary and Alimentary Tract, *Am. Heart J.* 26:385-397, 1943.
16. McCandless, F. D., Faloon, W. W.: The Diagnosis of Metastatic Tumor by Cytological Examination of the Pericardial Fluid; Report of a Case Using Shorr's Stain, *Ann. Med.* 29:1157-1168, 1948.
17. Leichtling, M., Reibstein, H. B., Stein, M. H., Bass, H. E.: Carcinoma Diagnosed by Examination of Pericardial Fluid, *New Eng. J. Med.* 247:884-885, 1952.
18. Anson, B. J., Maddock, W. G.: *Callander's Surgical Anatomy,* 1952, W. B. Saunders Co., Philadelphia, pp. 262-264.

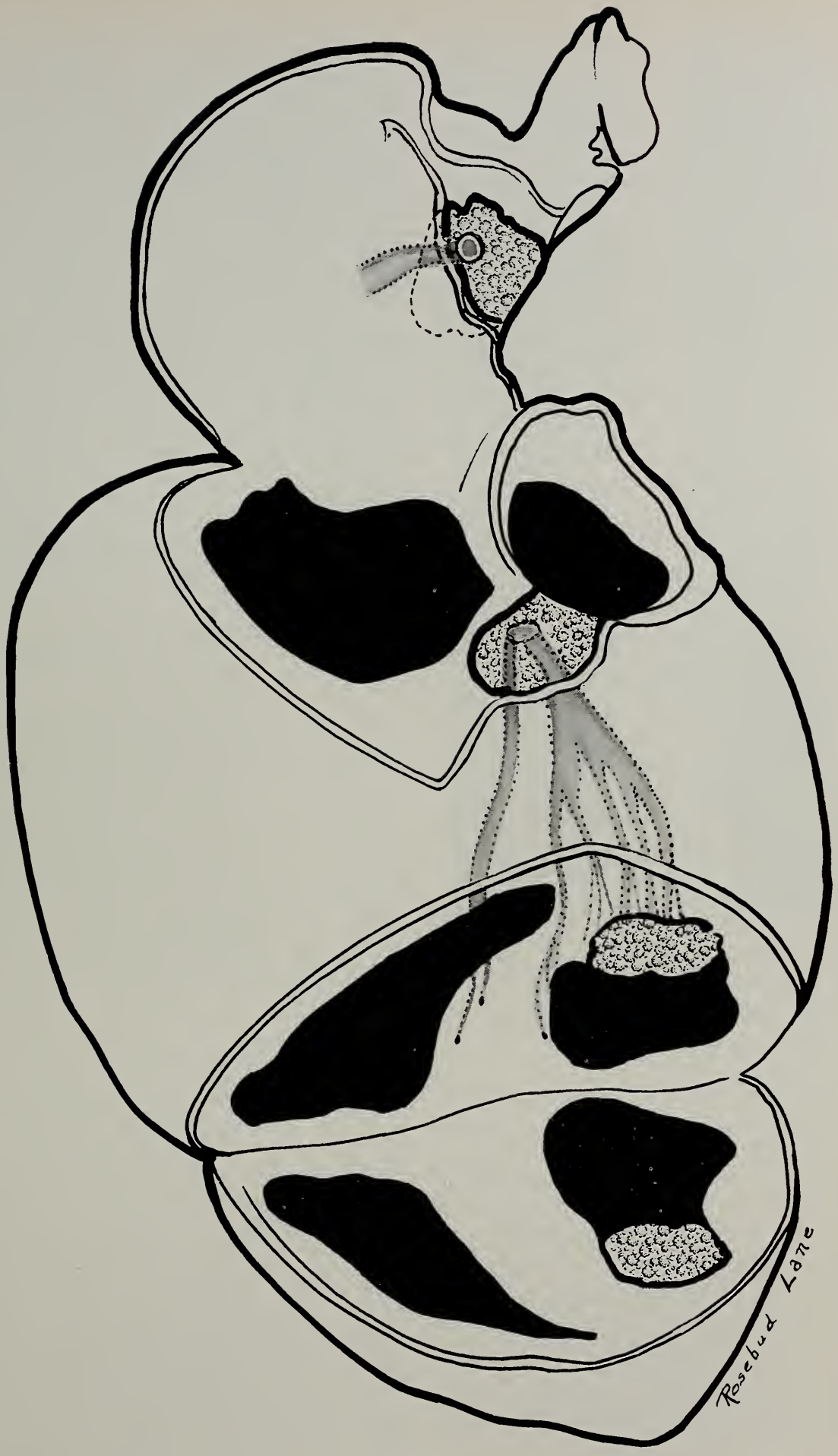
Our Cover Story

"Synoviomata are not only highly malignant tumors but are comparatively rare. A single and only metastasis to the heart is likewise rare. The combination encountered in this heart is, therefore, probably unique. Cardiac metastases are difficult to diagnose since they are often clinically 'silent,' or, as in this case, associated with a multiplicity of arrhythmias.

"The color rendition shows the tumor. Black and white schematic drawing (at right) shows its precise relationship to the conducting system.

"For details of this case see Cupp, Woolvin and Inmon, AMERICAN HEART JOURNAL, 1958, 56, 695-700."

Artwork and explanation are by Rosebud Lane Preddy, medical illustrator at Letterman Army Hospital, San Francisco. Other of Mrs. Preddy's work has been featured in the *Journal* (cover art for Nov. 1958, Feb. 1959 and Aug. 1959) as well as in other publications. Her work also appeared last year in an exhibit of medical illustrations by Bay Area, Calif., medical artists and photographers.


Rosebud Lane

Discussion of a non-operative diagnosis of a major congenital defect.

Diagnosis of Patent Ductus Arteriosus with Pulmonary Hypertension Without Reversed Flow

WARD LARAMORE, M.D.

Indianapolis

SINCE the advent of cardiac catheterization and more advanced surgery for congenital cardiac anomalies, correlation of clinical findings with operative findings has made possible more accurate diagnosis without recourse to the more advanced technical procedures. This was recently re-emphasized at the Robert Moore Heart Clinic by the following case.

The patient was a 19-year-old white female referred to the clinic for a definitive cardiac diagnosis. She stated that she had been told that she was a "blue baby" at birth but was not informed as to the duration of the cyanosis or as to the presence of any heart murmur. At the age of two she allegedly was seriously ill with pneumonia, measles and whooping cough concurrently with uneventfuly recovery. Subsequently she had "asthma" until the age of 12.

At the age of eight she was kept at bed rest for one week with an illness, the symptoms of which she could not recall. There was no history of dependent edema, orthopnea, vertigo, syncope, hemoptysis, chest pain or palpitation. She stated that she was able to participate in the usual physical activities with her companions without symptoms; however, on running hard or skating vigorously she became dyspneic and found it necessary to rest more than the average child. She was unaware of ever becoming cyanotic at these times. Two siblings were alive and well and without known cardiac abnormality, the rest of the family history was also negative.

Physical examination revealed a well developed, well nourished white girl who was in no acute distress. Her temperature was 98.6°; her pulse was regular at 98; her blood pressure was 118/60-50 in the right arm. The neck veins were collapsed in the recumbent position. The carotid arteries were markedly pulsatile and the peripheral pulses were all very active. There was no cyanosis of the feet or elsewhere. There was no clubbing of the toes or fingers. No edema or hepatomegaly was noted.

Examination of the chest revealed some increase in the anterior-posterior diameter; this was more marked on the left. The excursions were equal in both hemithoraces. The lungs were clear to ausculation and percussion. Examination of the heart revealed a precordial heave at the apex which was located in the sixth interspace at the mid-clavicular line. A systolic thrill was palpated at the level of the fourth interspace between the left sternal border and the apex. The first heart sound appeared normal. The second sound was single on inspiration and split on expiration and the pulmonary component was louder

From the Robert M. Moore Heart Clinic, Marion County General Hospital and the Department of Medicine, Indiana University School of Medicine, Indianapolis.

Supported by the Herman C. Krannert Fund of the Indiana Heart Association and the Indiana State Board of Health, Indianapolis.



Figure 1

PLEASE NOTE the generalized cardiac enlargement, the enlarged pulmonary arteries, and full peripheral lung fields.

than the aortic component. There was an ejection click heard at the fourth interspace at the left sternal border. This was followed by a grade III blowing systolic murmer. There was also a grade II short mid-diastolic murmer at the apex.

The hemoglobin was 11.5 gm, an average level at this institution. The chest x-ray (Figure 1) revealed cardiomegaly with markedly enlarged and engorged pulmonary arteries. The electrocardiogram (Figure 2) revealed a pattern consistent with both right and left ventricular hypertrophy.

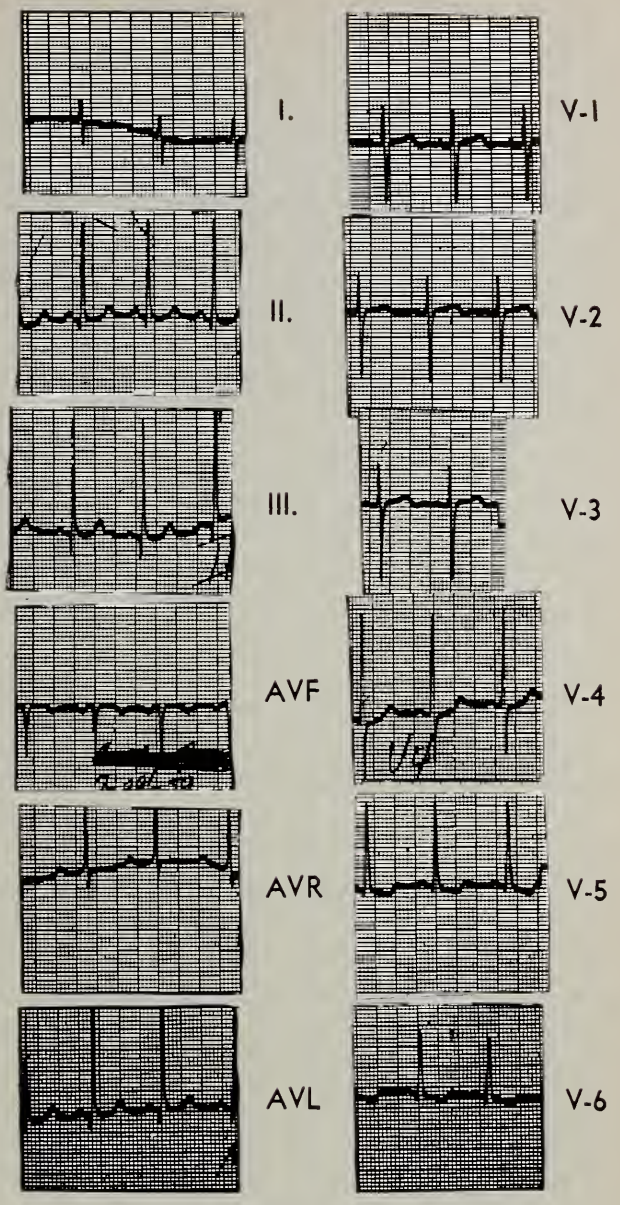


Figure 2

PLEASE NOTE the large R over the right percordial leads and the large R and inverted T over the left precordial leads consistent with right and left ventricular hypertrophy.

Catheterization Performed

At this point, the clinical diagnosis was felt to be a ventricular septal defect with a marked degree of left to right shunt. Later discussion will direct attention to the findings which suggested the correct diagnosis prior to catheterization. Cardiac catheterization was performed on Sept. 22, 1959 (Figure 3). During the procedure, there was noted to be marked movement of the catheter when it was in the main pulmonary artery. With further manipulation, it curved medially toward the vertebral column and then directly downward.

At this point, blood samples revealed arterial blood (oxygen content 14.83, oxygen saturation 93%) and verified the fact that the catheter was in the aorta. The course that the catheter took suggested that the catheter had passed through a patent ductus arteriosus rather than through an aorto-pulmonary window.

Discussion

A patent ductus arteriosus is one of more frequent congenital cardiovascular lesions.[1,2,3] The ductus arteriosus is a vital part of the circulatory structure of the fetus. Normally it ceases to function as a shunt soon after birth. Eldridge, Hultgren and Wignor[4] found the ductus to be a functional venoarterial shunt in most new-born infants for the first three hours of life. In a

significant number of cases the shunt persisted up to three days. R. R. Wilson,[5] in a postmortem study of stillborn and newborn infants, noted contraction of this vessel in most infants that lived for a few days and lack of contraction in stillbirths suggesting active vasoconstrictive at the onset of respiration. The exact mechanism initiating and effecting closure of the ductus is not known. Those that fail to close present three different and recognizable overlapping clinical patterns which are correlated with the pulmonary arterial pressure.

Typical Uncomplicated Ductus

The typical uncomplicated ductus has only slight elevation of the pulmonary artery pressure; and because of the higher pressure in the systemic circuit, there is a constant shunting of blood during both systole and diastole from the aorta into the pulmonary circuit. This hemodynamic relationship produces a well recognized diagnostic clinical picture as follows.[2,3] The continuous shunting of blood produces a typical continuous murmer which grows louder in late systole and early diastole, often obscuring the second heart sound. The murmer is located anatomically over the pulmonary artery at the second left interspace and usually is associated with a thrill in this area.

Because of the additional blood shunted into the pulmonary circuit and the corresponding decrease in volume in the systemic circuit, there is a plethora of blood in the pulmonary arteries and a collapsing peripheral pulse, the pulmonary arteries often are very pulsatile and there is an increased work load on the left ventricle which may give rise to evidence of left ventricular hypertrophy radiographically and electrocardiographically. These findings are present in about 90% of the cases of patent ductus arteriosus and are sufficiently diagnostic of the lesion present to make additional studies unnecessary in the management of the case.

At the other end of the spectrum of patent ductus arteriosus are those cases with so marked an elevation of the pulmonary arterial pressure that it exceeds the systemic pressure and gives rise to a characteristic clinical picture noted in patent ductus arteriosus with reversed shunt.[3,6-10] In this situation unoxygenated blood is shunted from the pulmonary artery into the aorta and distributed to systemic areas distal to the site of the junction of the ductus and aorta. This results

Cardiac Catheterization

	Pressure MM of HG	Van Slyke Content	Van Slyke Saturation	Oximeter
Superior Vena Cava				
Inferior Vena Cava				49%
Right Atrium, High				59%
Right Atrium, Mid	Normal	9.93	62%	51%
Right Atrium, Low				60%
Right Ventricle	75/0	10.41	65%	51%
Right Ventricle Outflow				
Main Pulmonary Artery	75/48-56	12.97	81%	83%
Right Pulmonary Artery	80/50-56	13.69	86%	81%
Left Pulmonary Artery				
Pulmonary Wedge				
Subclavian Vein				
Hepatic Vein				
Hepatic Wedge	10			
Left Atrium				
Left Ventricle				
Aorta	100/50-60	14.83	93%	93.5%
Radial				
Saturation after 100% O_2		14.85	93%	98.5%
O_2 Capacity, HGB. 11.50 gm x 1.34—	15.41	15.85		
O_2 Consumption	169 cc/min.			

Cardiac Output
Systemic Aorta/RA
3.45 L/min.
Pulmonic Aorta/MPA
9.08 L/min.
Shunt 5.63
Resistance—$\frac{5.6\text{-}10}{9.08}$ = 5 units

Figure 3

PLEASE NOTE the left to right shunt as indicated by a rise in O_2 saturation from 65% in right ventricle to 86% in right pulmonary artery. The passage of the catheter into the aorta was signified by a rise of O_2 saturation to 93%. The pressure in the right pulmonary artery is significantly elevated (80/50-56 mm Hg).

in a differential cyanosis of the parts supplied by the aorta distal to the ductus. Polycythemia and clubbing of the digits receiving the unoxygenated blood usually occurs. In these cases, the shunt is large and the velocity of blood flow is slow so that there is no continuous murmur; in fact, there may be a systolic murmur with or without a diastolic murmur or no murmur at all.

The second heart sound is usually closely split

and has an accentuated pulmonic component. The pulmonary artery is prominent radiographically but the peripheral lung fields are clear as there is a reduced blood flow through the peripheral lung fields. The work load of the right ventricle is greatly increased while that of the left ventricle is reduced; correlatively, there is right ventricular hypertrophy radiographically and electrocardiographically without left ventricular hypertrophy.

A Third Small Group

Between those cases of typical patent ductus arteriosus and those cases of patent ductus arteriosus with pulmonary hypertension with reversed flow lies a third small group of cases of patent ductus arteriosus. In this group the patent ductus arteriosus is associated with an elevated pulmonary pressure which approaches rather than exceeds the systemic arterial pressure resulting in a balanced shunt or a left to right shunt only in the systolic phase of the cardiac cycle.

These cases have less dramatic but still highly suggestive findings which point to the correct diagnosis.[2,11-13] In these cases there is no continuous murmur, as there is no continuous shunting of blood during the cardiac cycle. There often is only a systolic murmur corresponding to the systolic shunt. Occasionally an early diastolic murmur due to rapid ventricular filling may be heard over the apex of the heart.

There is a large left to right shunt in these cases resulting in pulsatile, enlarged, and engorged pulmonary arteries throughout the lung fields and a collapsing peripheral pulse. The work load of both ventricles is increased, the right ventricular work load is increased because of the pulmonary hypertension, and the left ventricular work load is increased because of the large left to right shunt. As a result, there is both right and left ventricular hypertrophy radiographically and electrocardiographically.

Second Heart Sound

Another feature, upon which emphasis should be placed, is the character of the second heart sound in this entity. There is a reversed or paradoxical splitting of the second heart sound. In this situation, the pulmonary valve closes before the aortic valve closes; during inspiration the pulmonary closure is normally delayed and the split of the second sound is narrowed at a time when normally it should be widest. Leatham[13] noted a paradoxical splitting of the second sound only in cases with complete left bundle branch block, aortic stenosis, some cases of systemic hypertension, and patent ductus arteriosus with large left to right shunts which produce a markedly increased stroke volume of the left ventricle.

In retrospect, this patient exhibited the typical findings of a patent ductus arteriosus with pulmonary hypertension without reversed flow. There was a non-continuous murmur, both left and right ventricular hypertrophy, engorged pulmonary arteries, large peripheral arterial pulsations, and parodoxical splitting of the second heart sound. This lesion can be distinguished from a typical patent ductus arteriosus by the lack of a diagnostic continuous murmur[14] and by the presence of right ventricular hypertrophy. It differs from a patent ductus arteriosus with pulmonary hypertension and reversed flow by the absence of differential cyanosis and clubbing and by the presence of left ventricular hypertrophy and paradoxical splitting of the second sound.

A large ventricular septal defect may present many of the features present in this case, but usually is associated with a small peripheral pulse and a normally or closely split second heart sound.

An atrial septal defect also presents many of the same features but usually is associated with a small pulse, a fixed widely split second heart sound, and right ventricular hypertrophy without any left ventricular hypertrophy. The lesion is indistinguishable from an aorta-pulmonary window on examination because the two lesions are physiologically exactly alike. During cardiac catheterization, the course of the catheter as it passes into and down the aorta indicates which is present. When the catheter passes through a patent ductus into the aorta, it enters the aorta below the level of the arch and descends directly downward; after the catheter passes through an aorto-septal window, it passes upward and follows the arch of the aorta.

Proper Management

Although the prime purpose of this presentation is to emphasize the fact that a patent ductus arteriosus with pulmonary hypertension and without reversed flow can be diagnosed on non-operative (catheterization or surgery) grounds, a word as to the proper management would not be amiss. It is accepted generally that a typical uncomplicated ductus arteriosus should be treated

surgically, as the operation mortality is very low and the complication of subacute bacterial endarteritis is prevented thereby.[2,3,6] Also, it is accepted generally that surgical closure of a patent ductus arteriosus with reversal of flow is contraindicated.[2,10,15-17] In the hemodynamic situation present in this case in which there is a large left to right shunt, surgical closure of the ductus is indicated.[2,19] Clelland[17] reported that surgical closure in these cases was extremely beneficial and produced an immediate decrease in pulmonary arterial pressure and a rise in aortic pressure. Consequently, surgery has been advised for this patient.

In conclusion, a case of patent ductus arteriosus with pulmonary hypertension without reversal of flow was presented. The features and related hemodynamics which permit diagnosis without resort to operative technics were discussed.

REFERENCES

1. Taussig, H. B.: *Congenital Malformations of the Heart.* The Commonwealth Fund.
2. Wood, P.: *Diseases of the Heart and Circulation.* 2nd Edition, J. P. Lippincott Co.
3. Friedberg, C. K.: *Diseases of the Heart.* W. B. Saunders Company.
4. Eldridge, F. L., Hultgren, H. N., Wignor, M. E.: The Physiological Closure of the Ductus Arteriosus in Newborn Infants: A Preliminary Report, *Science,* 119, 731, 1954.
5. Wilson, R. R.: Post-Mortem Observations of Contraction of the Human Ductus Arteriosus, *British M. J.,* 1, 810, 1958.
6. Neill, C., Mounsey, P.: Auscultation in Patent Ductus Arteriosus, *British Heart J.* 20, 61, 1958.
7. Whitaker, W., Heath, D., Brown, J. W.: Patent Ductus Arteriosus with Pulmonary Hypertension, *British Heart J.,* 17, 121, 1955.
8. Gordon, A. J., Donosa, E., Kuhn, L. A., Ravitch, M. M., Himmelstein, A.: Patent Ductus Arteriosus with Reversal of Flow, *New England J. of Med.,* 251, 923, 1954.
9. Campbell, M., Hudson, R.: Patent Ductus with Reversed Shunt Due to Pulmonary Hypertension, *Guy's Hospital Reports,* 100, 26, 1951.
10. Genovese, P. D., Khoo, E. C.: Patent Ductus Arteriosus with Pulmonary Hypertension and Reversed Flow, *J.I.S.M.A.,* 52, 217, 1959.
11. Damman, J. F., Jr., Sell, C. G.: Patent Ductus Arteriosus in the Absence of a Continuous Murmur. *Circ.,* 6, 110, 1952.
12. Gonzalez-Curna, J. L., Lillehei, C. W.: Patent Ductus Arteriosus with Pulmonary Hypertension Simulating Ventricular Septal Defect, *Circ.,* 18, 877, 1958.
13. Leatham, A.: Auscultation of the Heart, *Lancet,* 2, 703 and 757, 1958.
14. Haring, O. M., Luisada, A. A., Gasul, B. M.: Phonocardiography in Patent Ductus Arteriosus, *Circ.,* 10, 501, 1954.
15. Smith, G.: Patent Ductus Arteriosus with Pulmonary Hypertension and Reversed Shunt, *British Heart J.,* 16, 233, 1954.
16. Evans, W., Shark, D. S.: Pulmonary Hypertension and Congenital Heart Disease, *British Heart J.,* 20, 529, 1958.
17. Clelland, W. P.: Symposium on Congenital Heart Disease, *British Heart J.,* 20, 277, 1958. ◄

Parents Warned

Blood supplied by Red Cross recently helped save the lives of three Washington, D. C., infants who had swallowed a large number of aspirin tablets. In addition to pumping out the contents of the children's stomachs, doctors drained and replaced their entire blood supply to prevent the poison from reaching body tissues. Dr. Sanford L. Leikin, hematologist at Children's Hospital, said that in each instance a bottle of aspirin tablets had been left within easy reach. He urged all parents to make aspirin and all other potentially dangerous substances *inaccessible* to younger children.—*The Red Cross Newsletter,* December, 1959.

Severe coronary artery disease may exist without ECG findings. Severe disease may also exist without characteristic symptoms.

'Silent' Myocardial Infarction

*WENDELL A. SHULLENBERGER, M.D.**

Indianapolis

THE TWO electrocardiograms illustrating this article are not of themselves particularly remarkable. Both exemplify serious myocardial injury, the one, no doubt, rather late, the other rather acute. They are remarkable and, perhaps, disturbing because in neither case was the patient aware that he had threatening heart disease. The case histories follow.

A male, 63 years of age, had been a chronic complainer, with "sinus trouble" and vague gastro-intestinal complaints. He had undergone laparotomy because of a perforated duodenal ulcer in 1951, approximately three years prior to the time in which we are interested in him, and was seen at intervals of a few weeks thereafter with his usual complaints. He was examined during a routine office call on Jan. 29, 1954 and, aside from a post-nasal discharge, was found to be negative as to his upper respiratory tract, chest, heart, abdomen, rectum and prostate gland. Blood pressure was 174/90, which was about his usual level.

He was not seen again until Nov. 20, 1954 when he came in complaining of a raw throat. He said that he had been smoking a package of cigarets a day, drinking a lot of milk and having no trouble with his stomach. His temperature was normal, pulse 80 beats per minute and regular, blood pressure 134/70. The first heart tone at the apex was bifid and was followed by a grade 2 systolic blowing murmur. There was no apparent enlargement of the heart. The abdomen was moderately distended and tympanitic, the bowel sounds numerous. The ECG ie: showed signs of anterolateral infarction, which, in view of the other laboratory findings, was probably rather recent (Figure 1-A). The leucocyte count was 12,750. The sedimentation rate (Wintrobe) was 31 mm. There was absolutely no history of chest pain or breathlessness, sweating or weakness, but he indicated that he had become infuriated, being a man of short temper, at all times, with a policeman who, he felt, had criticized him unjustly in a traffic incident within the preceding few days.

He settled with me, grudgingly, for remaining at home for two weeks, spending 12 hours a day in bed, the other 12 hours in a chair, and then he returned to work. Two and one-half years later he developed congestive heart failure, was digitalized and continues, at this writing, to seem quite well. His heart shows some enlargement of the left ventricle and the relic of anterolateral infarction appears in his electrocardiogram.

Another male, aged 54 years, had always had a fast pulse when he visited a doctor, but, though not robust, he had never had a serious medical illness. He had abrupt onset of diarrhea early in the morning of Sept. 4, 1958, and came in for an office call on Sept. 9. In giving his history he said that there had been a feeling of a "knot" in

* Robert M. Moore Heart Clinic, Marion County General Hospital.

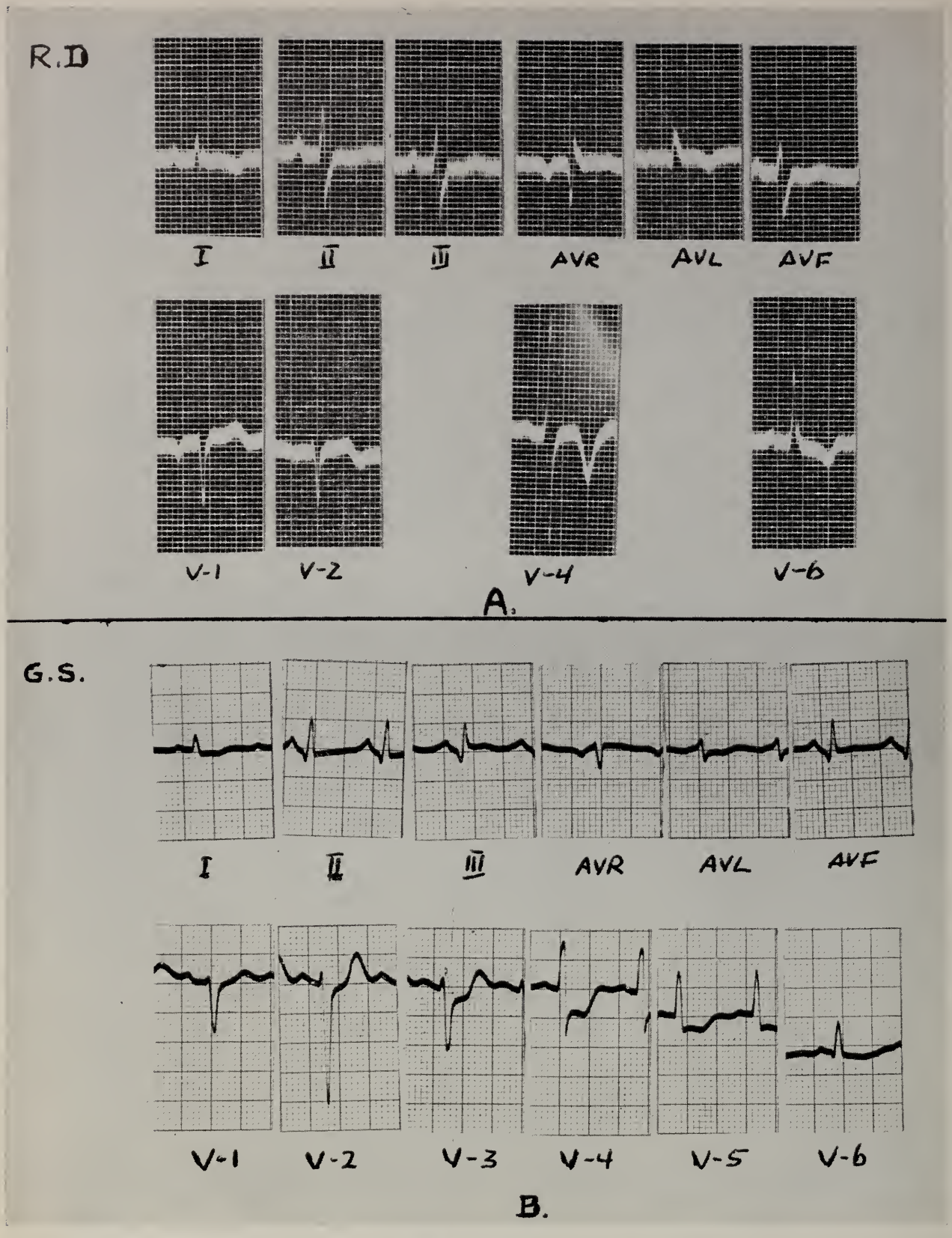


FIGURE 1

A. Typical signs of anterolateral infarction in patient No. 1.
B. Signs of posterolateral infarction in patient No. 2.

his stomach the night of Sept. 3, but said he had experienced a similar symptom, with failing appetite, belching and flatulence for several months. He had been examined thoroughly on Jan. 28, 1957 and an ECG done which showed an upright T wave in lead aVr, but there were no other abnormal findings. His blood pressure then was 164/84. He had had a laminectomy and extirpation of the fifth lumbar intervertebral disc on March 4, 1957.

When he was examined on Sept. 9, his temperature was normal, his pulse 104 beats per minute and regular, his blood pressure 120/68. There was slight impairment of quality of both heart tones at the apex and a low grade systolic murmur was heard and became louder when he sat upright and leaned forward. At this time, also, a systolic gallop was audible. The leucocyte count was 9,550, the sedimentation rate (Wintrobe) was 19 mm. An ECG showed signs of early posterolateral infarction (Figure 1-B).

He was taken to the hospital immediately. During the next four days, the ECG developed a Q wave in leads 2, 3, aVf, V4, V5 and V6. The ST segment became elevated and T became inverted in leads 2 and 3 and aVf, while ST segment depression accompanied T inversion in V4, V5 and V6. The patient received standard treatment with dicoumarol and rest. He never had a chest pain or dyspnea and was released from the hospital on Oct. 10, 1958. His subsequent course has not been remarkable except that he has had some tightness in his chest on walking a few blocks.

Comment

In this day of advanced methods of diagnosis, one still hears by word of mouth, and reads in the public press of this person or that who has just left his doctor's office and drops dead, or who has been "perfectly well" and dies suddenly in his home, office or some public place. The cause of sudden death in coronary heart disease is usually ventricular fibrillation, a catastrophic form of rapid heart action which probably never appears in a normal heart and does appear most frequently as a terminal event in myocardial ischemia or infarction.

It is my belief that it is a most rare case in which this occurs without premonition to the patient in the form of some symptom of illness, which may, however, seem entirely unconnected with the cardiac situation. This is not to say that every raw throat, or attack of diarrhea, should alert the physician to the possibility of a threatening cardiac disturbance. However, the frequency with which coronary disease manifests itself in a certain vulnerable group, composed in its majority of males between the ages of 40 and 65, should serve to emphasize to every practicing physician, be he general practitioner, internist, cardiologist or surgeon, the almost epidemic incidence of coronary artery disease. Papers such as that of Yater and others which reviewed autopsy material from hundreds of apparently healthy young soldiers in Korea who died in combat or of causes unrelated to heart disease and showed an incidence of coronary disease of over 70% should be regarded with utmost seriousness.

Nevertheless, this problem should not be approached in a defeatist state of mind. By far the greater proportion of patients having a first coronary thrombosis may be expected to recover under adequate treatment to a degree sufficient to enable them to return to their occupations. Blumgart and Schlesinger proved that there is a remarkable propensity to development of collateral coronary circulation. I believe that the development of angina pectoris or coronary closure need not cast a permanent pall upon the future of the patient, and that the physician caring for these cases must carefully examine his own attitude toward the disease and control his own feelings to the extent that an atmosphere of hopelessness and resignation is not allowed to influence management on his part and response on the part of the patient.

I know that persistent reassurance, gentle encouragement, thoughtful inquiry as to emotional conflicts, along with thorough physical examination and judicious medication provided against a background of basic knowledge of the anatomy, physiology and pathology of the coronary system, will produce favorable threapeutic results. Cases such as the two reported herewith are not isolated or unusual and I believe that reasonable alertness in the simple procedures of history-taking and physical examination are vital to prevention of death and disability from coronary artery disease. ◄

when the
rheumatic
disorder
is more
than salicylates
alone
can control...

MORE
HIGHLY INDIVIDUALIZED
THERAPY
FOR THE
RHEUMATIC
"IN-BETWEEN"

...but
control
requires less
than
intensive
steroid therapy
alone

Aristo

wider latitude in adjusting dosage

ARISTOGESIC is particularly effective for relief of chronic — but less severe — pain of rheumatic origin. ARISTOGESIC combines the anti-inflammatory effects of ARISTOCORT® Triamcinolone with the analgesic action of salicylamide, a highly potent salicylate. Dosage requirements for ARISTOGESIC are substantially lower than generally required for each agent alone. The exceptionally wide latitude of dosage adjustment with ARISTOGESIC permits well-tolerated therapy for long periods of time with fewer side effects.

Indications: Mild cases of rheumatoid arthritis, tenosynovitis, synovitis, bursitis, mild spondylitis, myositis, fibrositis, neuritis, and certain muscular strains.

Dosage: Average initial dosage: 2 capsules 3 or 4 times daily. Maintenance dosage to be adjusted according to response.

Precautions: All precautions and contraindications traditional to corticosteroid therapy should be observed. The amount of drug used should be carefully adjusted to the lowest dosage which will suppress symptoms. Discontinuance of therapy must be carried out gradually after patients have been on steroids for prolonged periods.

Each ARISTOGESIC Capsule contains:

ARISTOCORT® Triamcinolone	0.5 mg.
Salicylamide	325 mg.
Dried Aluminum Hydroxide Gel	75 mg.
Ascorbic Acid	20 mg.

Supply: Bottles of 100 and 1,000.



Lederle

LEDERLE LABORATORIES, A Division of AMERICAN CYANAMID COMPANY, Pearl River, New York

Not all congestive failure is cardiac. Non-cardiac failure does not 'get well' with cardiac treatment.

'Non-Cardiac' Congestive Heart Failure

DEAN A. MILLER, M.D.

Indianapolis

ONE OF THE causes of "refractory" heart failure is an erroneous diagnosis in which the state of venous congestion is ascribed to heart disease as the underlying cause. Although venous circulatory congestion is most commonly due to cardiac failure, on occasions it may be due to non-cardiac states, or if due to heart failure, the latter is secondary to a primary non-cardiac disturbance. The recognition of this possibility is of more than academic interest, for unless it is differentiated from primary heart disease with failure, erroneous treatment will result. The following cases are presented to illustrate the points in question. The underlying disturbance in each instance was severe anemia, extracardiac obstruction, and acute glomerulonephritis respectively.

Case I

A 58-year-old woman was admitted to the hospital for evaluation of painless swelling of the feet and legs of three weeks duration. Direct questioning and review of systems elicited no other complaints. Blood pressure was 120/70 mm Hg, pulse 82. The patient was thin and appeared chronically ill. Examination of the heart revealed the PMI to be in the 5th ICS in the anterior axillary line. Heart sounds were of poor quality. No thrills were palpable. $P_2 > A_2$. A grade II-III systolic murmur was heard at the apex. The liver was palpable 5 cm below the right costal margin, was smooth and slightly tender. Examination of the extremities revealed pitting edema to the knees. The remainder of the examination was within normal limits.

Laboratory studies on admission revealed a hemoglobin of 2.5 gm, hematocrit 14, total WBC 2,600, RBC 1.46 million, reticulocyte count 0.3%, VDRL negative. Urinalysis was not abnormal.

A roentgenogram of the chest revealed enlargement of the cardiac silhouette, TCD 15.5 cm., TTD 25.5 cm. with congestive changes of the lungs (Figure 1A).

A complete hematological workup revealed an anemia compatible with iron deficiency. An intensive evaluation revealed no source of blood loss, and all other radiological and biochemical studies were within normal limits.

The patient was started on ferrous sulfate by mouth and a rapid rise in reticulocyte count and hemoglobin was noted. Upon release from the hospital the heart was normal in size and no murmurs were heard. There were no signs of venous congestion. Roentgenogram of the chest showed a marked decrease in cardiac silhouette (Figure 1B).

The patient was seen several times following discharge in the outpatient clinic, and has had no further difficulties.

From the Robert M. Moore Heart Clinic, Marion County General Hospital and the Department of Medicine, Indiana University School of Medicine, Indianapolis.

Supported by the Herman C. Krannert Fund of the Indiana Heart Association and the Indiana State Board of Health, Indianapolis.



Figure 1A

ROENTGENOGRAM of the chest in Case I on admission.



Figure 1B

ROENTGENOGRAM in Case I during convalesence. A change in heart size is readily apparent.

Case II

A 46-year-old male with inoperable bronchogenic carcinoma of the lung was admitted to the hospital because of severe dyspnea of one week duration. Examination revealed an acutely ill, cyanotic patient. Blood pressure was not obtainable. Apical heart rate was 150, respirations 46/min. Marked venous distention was present in a sitting position. Examination of the heart and lungs revealed dullness to percussion in the right anterior and lateral hemithorax, with absent breath sounds in this area. Bilateral moist rales and ronchi were noted. The left border of cardiac dullness was at the anterior axillary line. The PMI was not felt. Heart tones were of poor quality, no murmurs were heard. The liver edge was palpated 6 cm below the right costal margin.

Admission hemogram and urinalysis were within normal limits. Roentgenogram of the chest showed a homogeneous density of the right base with marked enlargement of the cardiac silhouette (Figure 2A).

A diagnosis of pericardial effusion with tamponade, secondary to metastatic spread of bronchogenic carcinoma, was confirmed by pericardiocentesis. Following removal of 250 cc of hemorrhagic fluid from the pericardium 0.5 Mgm/kilo of nitrogen mustard was injected into the pericardial sac. Following this procedure the blood pressure was easily obtained and cyanosis was no longer evident.

Symptoms recurred three days later and a second pericardiocentesis was performed with insertion of a polyethelene tube for continued drainage. The tube remained in place for five days, at which time it was removed with no further recurrence of symptoms and disappearance of congestive changes. Roentgenogram of the chest showed a marked decrease in cardiac silhouette (Figure 2B).

The patient was discharged free of cardiac symptoms to be followed in the outpatient clinic.

Case III

A 17-year-old female was admitted to the hospital with shortness of breath, orthopnea and swelling of the legs of one week duration. She had no prior hospitalizations, but had noted a "sore throat" three weeks prior to admission. Review of systems elicited no other complaints. Blood pressure was 155/90 mm Hg., pulse 84. The patient was well developed and well nour-

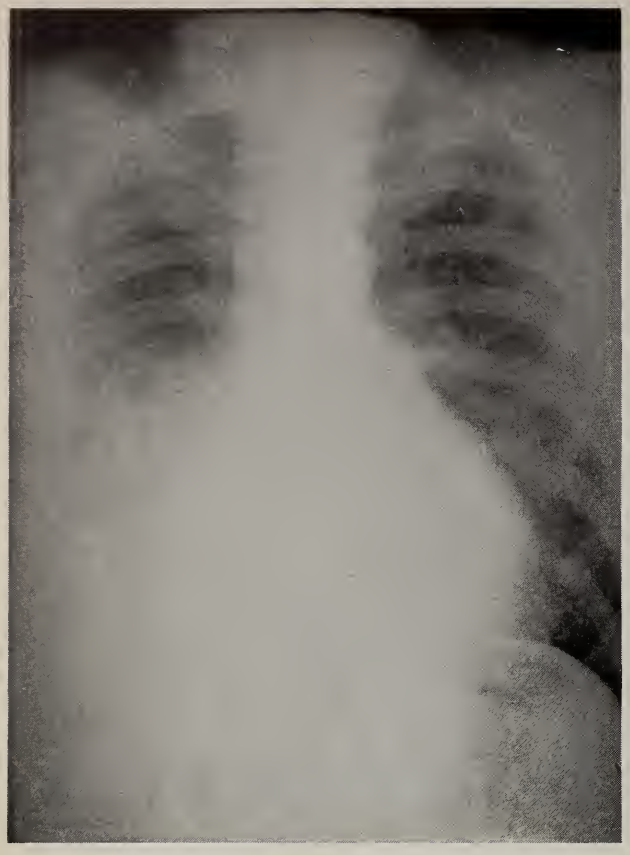


Figure 2A

ROENTGENOGRAM of chest in Case II on admission.

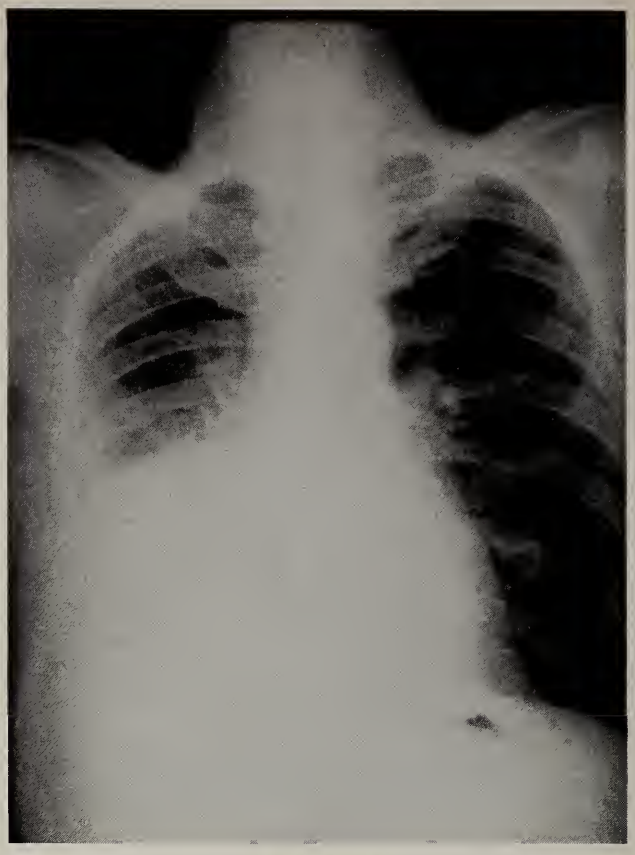


Figure 2B

ROENTGENOGRAM in Case II upon discharge, demonstrating a marked decrease in cardiac silhouette.

ished. She had some periorbital edema. Examination of the chest revealed rales in the right posterior base, but no dullness was noted. The heart was felt to be slightly enlarged. No thrills were palpable. $A_2 > P_2$. A grade II-III systolic murmur was heard over the entire precordium. The liver was felt to be enlarged to 3 cm below the right costal margin. Edema of both feet and ankles was noted extending to the knee. The remainder of the examination was within normal limits.

Admission hemogram revealed a hemoglobin 9.7 gm, hematocrit 27, total WBC 6000. Urinalysis: Acid, Sp.Gr. 1.016, Albumin 4+, WBC 8-10/HPF, RBC 30-40/HPF, with numerous red cell casts. The roentgenogram of the chest revealed slight cardiomegaly, TCD 14.2 cm, TTD 25.4 cm, with congestive changes bilaterally and a right pleural effusion (Figure 3A).

A diagnosis of acute glomerulonephritis was made. Immediately following hospitalization the patient was given digitoxin which caused no apparent beneficial change in her condition. However, with sodium restriction and a high carbohydrate diet she gradually responded to therapy and became asymptomatic. During the remainder of her hospitalization she showed no further evidence of congestion in spite of development of a nephrotic phase with marked edema and ascites (Figure 3B). The patient is being followed in the outpatint clinic and, although she has evidence of chronic renal disease, she remains asymptomatic at this time.

Discussion

Congestive heart failure is a syndrome secondary to heart disease and is manifested by certain alterations of circulatory dynamics and abnormalities of fluids and electrolytes. Nonmyocardial venous circulatory congestion differs from congestive heart failure in that alterations of circulatory dynamics and fluid or electrolyte balance precede the development of congestion and/or secondary failure of a normal heart.

Cardiac failure of a "normal" heart is seen in three clinical situations: (1) High output states such as anemia, hyperthyroidism, beri beri and A-V shunts. High output states result in venous congestion because of the increased demand put on the heart by such disturbances



Figure 3A

ROENTGENOGRAM of chest in Case III on admission.



Figure 3B

ROENTGENOGRAM in Case III, demonstrating a decrease in cardiac silhouette and disappearance of congestive changes.

(Case I). (2) When there is some mechanical circulatory obstruction as in cardiac tamponade, constrictive pericarditis, amyloidosis, pure mitral stenosis and subendocardial fibroelastosis. Mechanical obstruction interferes with diastolic filling of the heart and with cardiac contraction due to increased intracardiac pressure. The resultant impairment of inflow is followed by a rapid elevation of venous pressure (Case II). (3) In hypervolemic states such as glomerulonephritis, lower nephron nephrosis, excess fluid or steroid administration, venous congestion appears to be due to excessive sodium retention (Case III).

Secondary cardiac failure with venous congestion as presented in these three cases is distinguished from primary heart disease in several ways: (1) In non-myocardial venous congestion failure is secondary to extracardiac causes with the exception of mitral stenosis. As in the cases presented, no evidence of preceding heart disease can be elicited, and following correction of the underlying disease process without specific cardiac therapy, the congestion clears and the heart size returns to normal. (2) Most important is the difference in response to therapy. Although non-cardiac and cardiac venous congestion produce identical symptoms, relief of symptoms must be effected in a different manner. In non-cardiac venous congestion minimal or no response is seen with administration of cardiac glycosides and treatment must be directed at the primary disease. On the other hand, primary myocardial failure often responds dramatically to digitalis and rest.

Summary

Three cases representative of the three major groups of venous circulatory congestion are presented and the mechanism of production is reviewed. The importance of the recognition of the syndrome for proper therapy is stressed. ◄

Report of Two Cases:

Lipoma of the Heart

An interesting report of two rare tumors of the heart.

*EMMETT C. PIERCE, M.D.**
*ROBERT E. BAKEMEIER, M.D.***
Indianapolis

PRIMARY LIPOMAS of the heart are extremely rare, and are usually encountered as an incidental finding at autopsy. Verliac and Morel[1] in 1909 reported one case and in a review of the literature summarized the findings in 10 previously reported cases. Several of these cases are well documented with histologic as well as gross findings reported. Martin[2] in 1929 reported a single case and mentioned that there were 20 previously reported cases of lipoma of the heart, but he did not list the bibliographic references. Maurer[3] in 1952 reported the first successful surgical removal of a lipoma of the heart. The tumor was exceptionally large (3½ pounds) and Maurer believes it to be the largest primary tumor of the heart to be reported.

The location of lipomas in the heart is variable,[1,2] as they may be subendocardial, subpericardial or in the myocardium. Usually they are small and are sessile. In Maurer's case[3] the lipoma was pedunculated and arose from the myocardium and projected into the pericardial sac. Brewis[4] reported a lipoma of the heart in an infant. This pedunculated mass was attached to the interventricular septum and protruded into the right ventricle. Death was caused by the herniation of this tumor through the tricuspid valve. These are the unusual instances as in most cases the lipomas are small and asymptomatic.

The following two cases are typical examples of lipoma of the heart and are being reported merely because this lesion is a pathologic rarity.

Case Reports

Case No. 1

A 70-year-old white female was admitted to the Marion County General Hospital in May, 1956 with a partial bowel obstruction. A carcinoma of the ascending colon was found at time of surgery, so the ascending colon and a portion of the ileum were resected. Six days following surgery a generalized peritonitis developed and the patient expired five days later.

At autopsy there was a generalized purulent peritonitis and separation of the bowel anastomosis. The bowel appeared necrotic only at the site of the anastomosis.

The weight of the heart was 580 gm. The coronary arteries were slightly arteriosclerotic and the lumina were narrowed but not occluded. The valves were not remarkable other than one small area of calcification at the base of an aortic cusp. The interauricular septum was found to be thickened by a rubbery mass located superior to the foramen ovale. This tumor was 3 cm in its greatest diameter and appeared well circumscribed. It was reddish-yellow and lobulated. Microscopically the tumor was composed of adult adipose tissue, blood vessels, a few

From the Department of Pathology, Marion County General Hospital, Indianapolis.

* Assistant pathologist, Marion County General Hospital, and the Department of Pathology, Indiana University School of Medicine.

** Resident in surgery, Marion County General Hospital.



Figure 1

THE HEART from Case I. The tumor has been incised, the greater portion appearing in the right upper portion of the heart and the lesser portion in the upper central area of the heart.

fibers of connective tissue, and a few atrophic myocardial fibers.

Case No. 2

A 78-year-old negro female was admitted to the Marion County General Hospital Sept. 6, 1959 with the signs and symptoms of an acute myocardial infarction. She had a history of angina pectoris of 12 years duration and hypertension of seven years duration. She expired five days after admission.

At autopsy the heart weight was 700 gm. All of the coronary arteries were arteriosclerotic with varying amounts of narrowing of the lumia. There was a recent thrombosis of the anterior descending branch of the left coronary artery. There was a large area of myocardial infarction in the apical portion of the septum. This portion of the myocardium was yellow in color with hemorrhagic areas present. In the interauricular septum was a mass measuring 3.5 cm x 3.5 cm x 1.5 cm. It appeared well circumscribed and had a yellow, lobulated appearance. Microscopically the tumor was composed of adult adipose tissue, blood vessels, fibrous connective tissue and atrophic myocardial fibers.

Discussion

Although both of these tumors on gross examination appeared to be well circumscribed, microscopically they were not well circumsrcibed and there was no evidence of a capsule. Throughout both tumors were atrophic myocardial fibers varying in amount from single fibers to groups of fibers. The question must then be raised as to the true nature of these lesions. Do they represent true neoplasms which grow by expansion and do not have a capsule or are they circumscribed areas of fatty infiltration?[5] This is a problem that is not unusual with lipomas, regardless of their site, as incorporation of tissues of the part where it is located is not an unusual feature of lipomas.[6] Also lipomas of the heart usually arise in the endocardium which is usually free from fat. We believe that the gross appearance is of great importance in the diagnosis of these tumors, and that they should be classified as lipomas if they are well circumscribed, occur in a location where fatty tissue is unusual, have the typical lobulated appearance, and the yellow coloration characteristic of lipomas. The presence of adipose tissue with strands of myocardial fibers, fibrous connective tissue and blood vessels demonstrated on microscopic examination should confirm the diagnosis.



Figure 2

THE HEART from Case 2. The tumor has been incised and appea in the upper right portion of the heart.

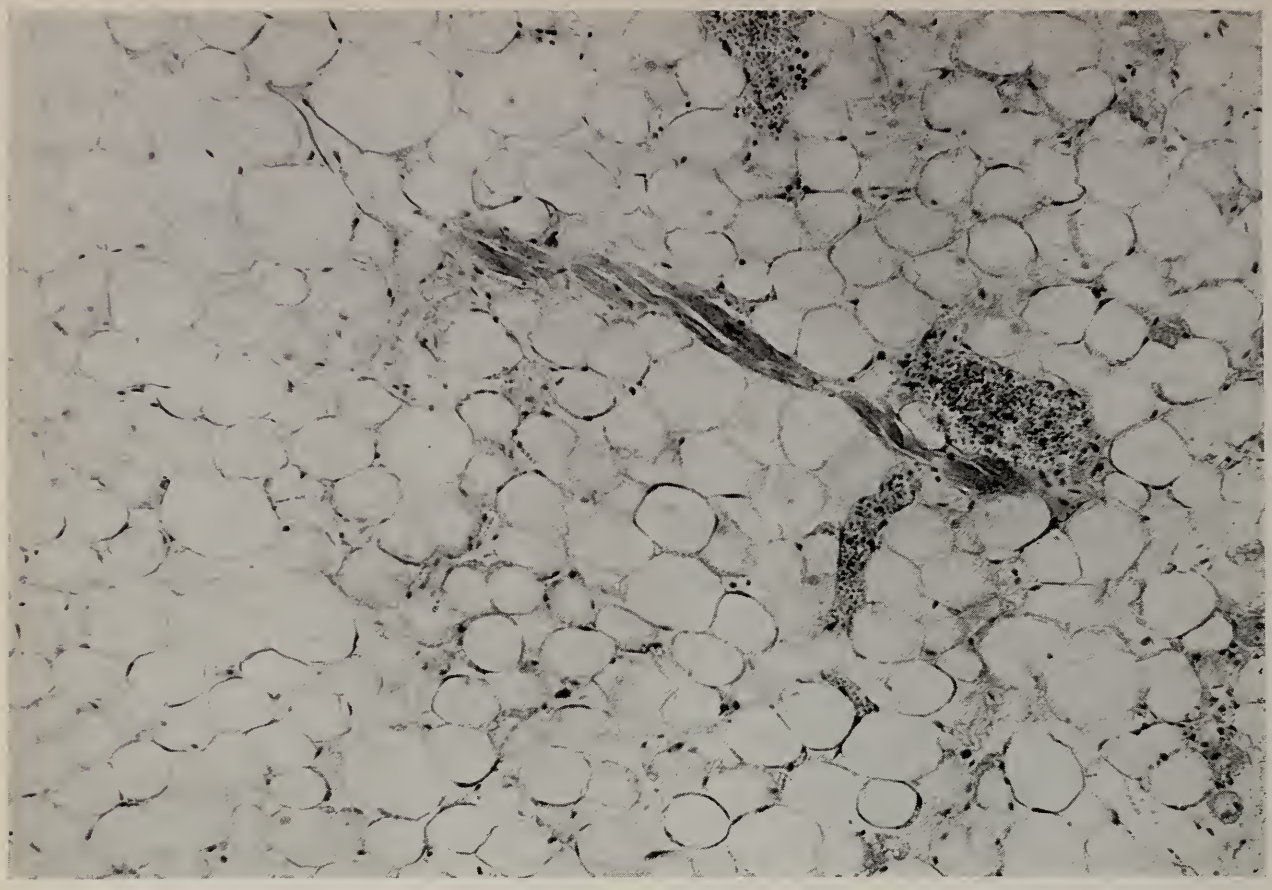


Figure 3

MICROSCOPIC section from the tumor in Case 1. Scattered throughout the adult adipose tissue are vessels congested with erythrocytes and a few atrophic myocardial fibers. The tumor in Case 2 had a similar microscopic appearance.

ACKNOWLEDGMENT

We gratefully acknowledge the assistance of Thomas G. Samter, M.D., of the Pathology Department, Indiana University School of Medicine, for the translation of the references written in the French language, and Robert Albright, photographer, Marion County General Hospital.

REFERENCES

1. Verliac, H., Morel, L.: Etude sur le Lipome du Coeur, *Arch. d. Mal. du Coeur* 2: 152-161, 1909.
2. Martin, E.: De la Pathogenie de Certaines Tumeurs du Coeur; Contribution d' L'Etude des Myxomes et des Lipomes du Coeur, *Ann. d. Anat. Path.* 6: 159-188, 1929.
3. Maurer, E. R.: Successful Removal of Tumor of the Heart, *J. Thor. Surg.* 23: 479-485, 1952.
4. Brewis, R. A: A Case Report of Lipoma in the Right Ventricle of the Heart, *Lancet* 2: 829, 1905.
5. Saphir, O.: Neoplasms of the Pericardium and Heart, *Pathology of the Heart* edited by S. E. Gould, Charles C. Thomas, Springfield, Illinois, 1953.
6. Willis, R. A.: *Pathology of Tumours,* Butterworth & Co. (Publishers) Ltd., London, England, The C. V. Mosby Company, St. Louis, Mo., 1948. ◄

Medicare Benefits Total $185 Million

Hospital and medical care benefits totaling more than $185 million have been provided dependents of the members of our armed services since the Medicare program was initiated.

From the day of its inception, Dec. 6, 1956, through June 30, 1959, benefits amounting to $185,400,000 were paid out—$91 million for hospital care and $94 million for doctor bills.—*Blue Shield Newsletter,* November, 1959.

A case of ventricular aneurysm with characteristic EKG changes is reported. The criteria for diagnosis of this anomaly are briefly reviewed.

Report of a Case:

Ventricular Aneurysm with Characteristic EKG Changes

HOWARD M. RICE, M.D.
CHARLES FISCH, M.D.
EVERETT L. HAYS, M.D.

Indianapolis

VENTRICULAR ANEURYSM is a relatively frequent complication of myocardial infarction and report of a single case is rarely justified. The case in question, however, is interesting in that we are able to (1) observe the early natural history of the aneurysm and to show the development of x-ray features of this anomaly and (2) to present a relatively rare instance with electrocardiographic changes considered characteristic of ventricular aneurysm.

Case Report

The patient is a 59-year-old white male patient at Central State Hospital. On Oct. 28, 1958 he suffered a massive anterior myocardial infarction.

Significant physical findings were confined to the cardio-vascular system. The blood pressure was 125/80 and pulse rate 68 and regular. The PMI was 12 cm to the left of the midsternal line in the fourth intercostal space. There was a separate pulsation felt best 10 cm to the left of the midsternal line in the third intercostal space. This area of pulsation was 2 cm wide. There was a grade II blowing systolic murmur heard best at the apex. M_1 was greater than M_2 and P_2 was greater than A_2. The patient survived the episode and at the present is in relatively good health without any subjective symptoms or signs of failure.

The first EKG (Figure 1) was taken 10 hours after onset of symptoms. The PR interval is 0.16 seconds. A deep Q wave is seen in lead 1 and AVL. There is diminution of the R wave in V_2 and V_3. There is a Q wave in V_4 and V_5 and the T wave is inverted in V_2, V_3 and V_4. A chest x-ray taken at the same time revealed a bilateral pleural effusion more marked on the left. The heart was increased in size. Repeat EKG a week later showed the presence of a deep Q wave in the standard limb leads and in AVR and AVL. In V_5 and V_6 there are elevated ST segments. Tracings taken on Dec. 12, 1958,

From the Department of Medicine, Central State Hospital and the Robert M. Moore Heart Clinic, Marion County General Hospital, Indianapolis.

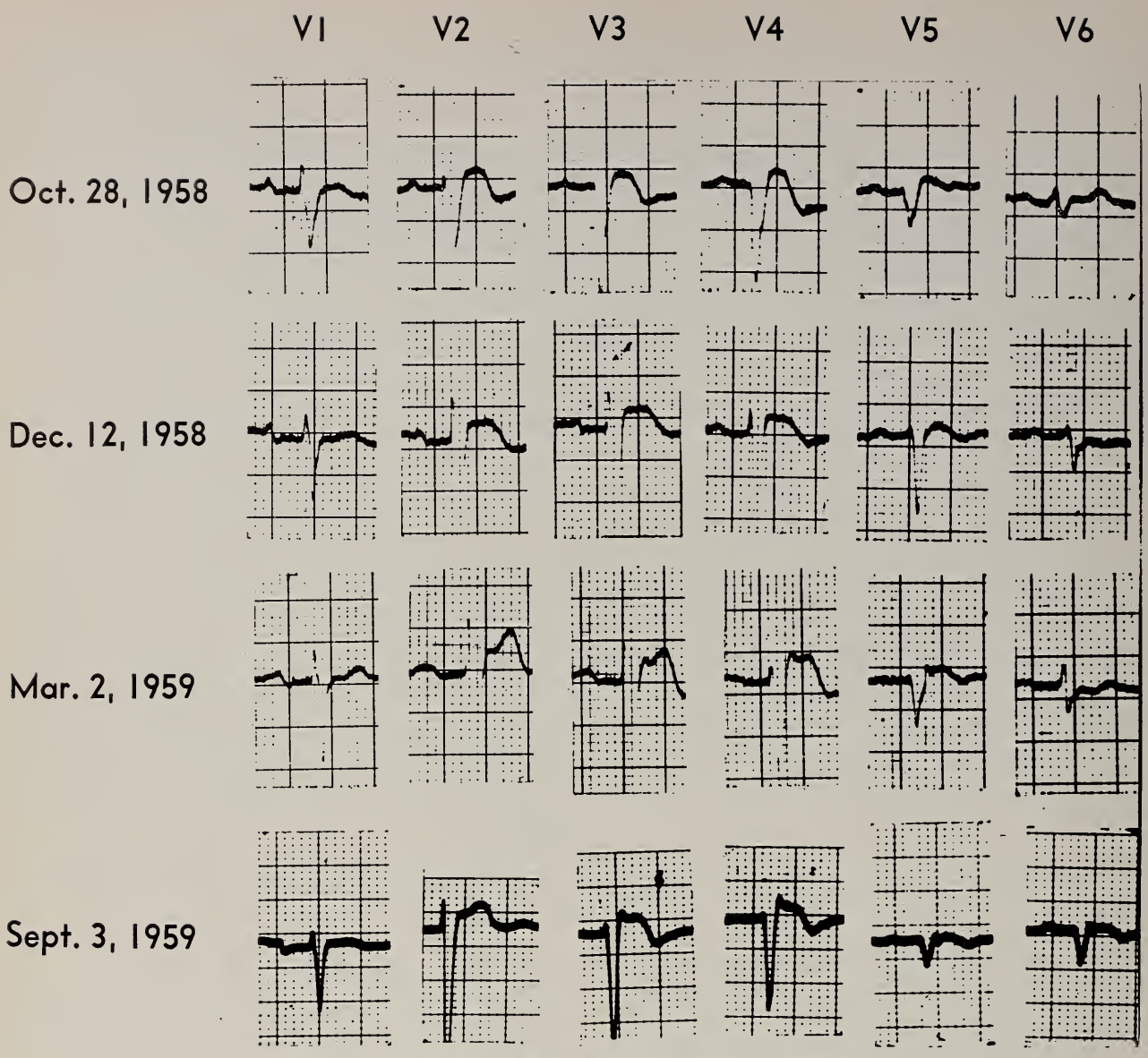


Figure 1

THIS TRACING (precordial leads only) shows the loss of R wave characteristic of infarction and the persistent elevation of S-T segments.

March 8, 1959 and Sept. 3, 1959, showed the residuals of a massive anterior infarction and persistent elevation of the ST segments in leads I, AVL, V_1-V_5 (Figure 1). This suggested the development of a ventricular aneurysm. Serial chest films confirmed this impression and disclosed the presence of a ventricular aneurysm (Figure 2). Fluoroscopic examination in September, 1959 confirmed the presence of a ventricular aneurysm with paradoxical bulging.

Discussion

The most common cause of acquired aneurysm is myocardial infarction with or without coronary occlusion due to arteriosclerotic coronary disease.[1] This accounts for 85% of cardiac aneurysms.[2] A small number of rheumatic, syphilitic, congenital, traumatic and mycoitc origin have been reported.[3] They have also been reported following myocardial abscess and ulcerating bacterial endocarditis.[4]

An aneurysm due to occlusion of the anterior descending coronary artery is usually situated at the apex, but quite commonly it involves the anterior wall of the left ventricle above the apex. Aneurysms of the posterior wall of the left ventricle are relatively rare, though infarction of this wall is quite frequent. Aneurysm due to other causes may involve any part of the left ventricle especially the base or septum. Aneurysm of the right ventricle is an extreme rarity.[5]

There have been many series of cases of ventricular aneurysm following myocardial infarction in the literature.[1,2] The incidence has

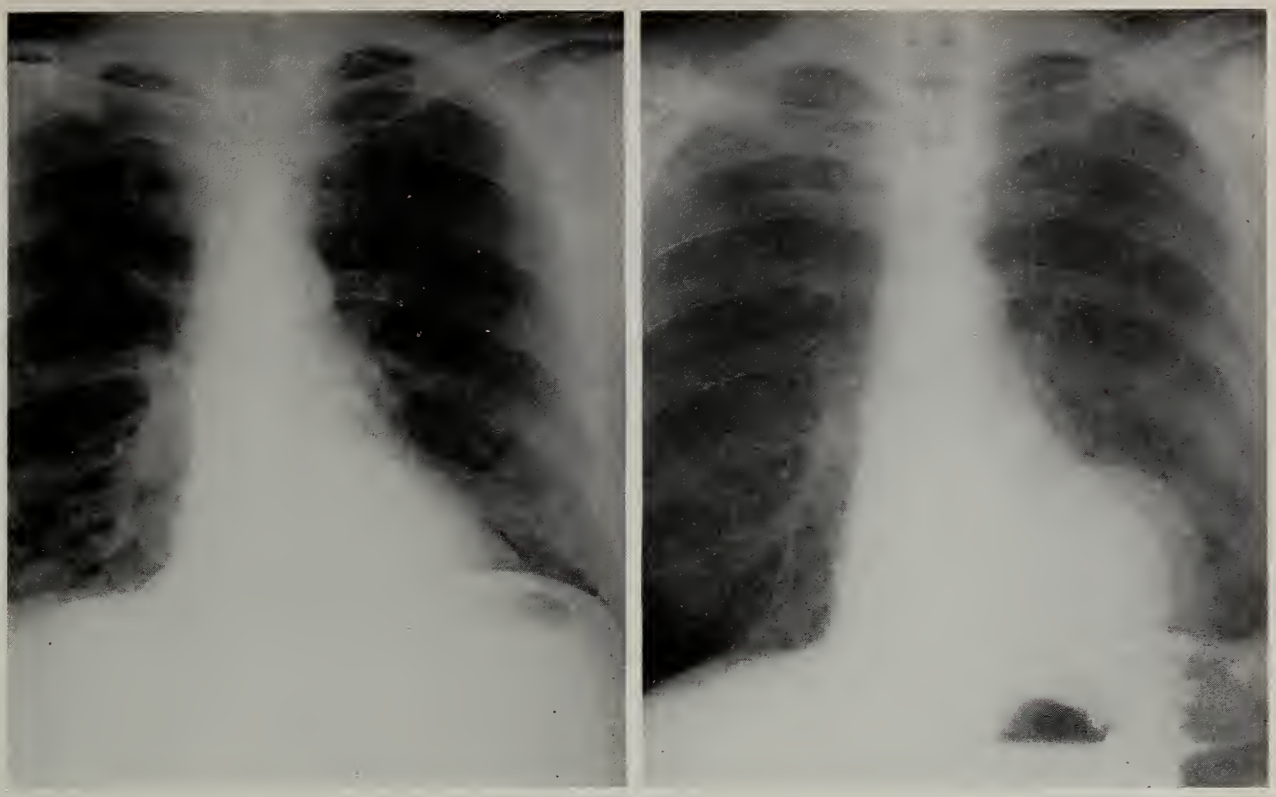


Figure 2

ROENTGENOGRAMS taken before (left) and after (right) show the development of ventricular aneurysm.

varied widely, being as low as 5% and as high as 38%.[7] The average of the more recent reports is that 15% of all cases of coronary occlusion develop ventricular aneurysms.[1]

There are no symptoms which are specific for ventricular aneurysm.[1] A sensation of precordial pain has been reported.[8,9]

A pulsation in the cardiac area is the most frequent sign of cardiac aneurysm.[9] The maximum pulsation is found at the level of the fifth rib near the left mid-clavicular line. The pulsation is diffuse with a large cardiac thrust; it extends over several intercostal spaces and often measures 7 to 9 cm. The pulsation occasionaly extends considerably beyond the left mid-clavicular line or it may extend medially in aneurysms of the anterior ventricle near the septum. In our case this pulsation was felt best 10 cm to the left of the midsternal line in the third intercostal space.

Many EKG patterns in patients with ventricular aneurysm have been described. A low R wave in lead 1 with a deep S wave in leads 2 and 3 was said to be suggestive. If this was associated with elevated ST segments in all leads, it was thought to be even more helpful since regression of the pattern to normal often occurs after uncomplicated infarction.[8,9] Eliaser and Konisberg[10] described an EKG syndrome occurring in 27.3% of 22 cases of aneurysm of the left ventricle in which there was a downward major deflection in lead 1 with inversion of the T wave, an upright P wave, and an upright ventricular complex in lead 3. In 36.4% of their 22 cases there were downward directed ventricular complexes in leads 2 and 3, and a major upright QRS deflection in lead 1. 18.2% showed a left bundle branch block and a large number of equivocal records consistent with disease of the coronary arteries, but otherwise of no significance.

Other findings have been described such as low voltage or absence of the R wave in lead 1 and some depression of the S-T segments in leads 2 and 3 if the aneurysm is localized in the anterior wall of the left ventricle.[11] T waves may be upright, inverted or diphasic. Extensive destruction of the posterior wall of the left ventricle probably explains the absence of S-T elevation and the presence of RS complexes in some cases of aneurysm.[12]

Recent investigators have found that the outstanding EKG change in ventricular aneurysm is a persistent elevation of the RS-T segment. In fact, the elevation tends to increase with time.[8,9,13-16] This was the outstanding fea-

ture in the case presented here. This RS-T displacement may be the result of continuous myocardial injury of the subepicardial or subendocardial ventricular wall.[13] Others believe that the elevation is due to hypertrophy of the opposite heart wall and lack of modifying potential from destroyed myocardium.[17]

The diagnosis of ventricular aneurysm is frequently made radiologically. Parkinson and Thomson[5] have outlined several criteria for making the diagnosis. These consist of an enlargement of the left ventricle with deformity of its contour, a localized protruberance inseparable from the heart shadow on rotation of the patient, an abnormal or absent pulsation of the aneurysmal zone, some evidence of adhesions between the heart and the chest wall or diaphragm, and calcification of the wall of the sac or of its contained clot. The first three criteria were fulfilled in the case presented.

REFERENCES

1. Schlicter, J., Hellerstein, H. K., Katz, L. N.: Aneurysm of the Heart: A Correlative Study of One Hundred and Two Proved Cases, *Medicine,* 33:43-86, 1954.
2. Gould, S. E.: *Pathology of the Heart,* pp. 610-13, Charles C. Thomas Co., Springfield, Ill., 1943.
3. Fisher, R. L.: Cardiac Aneurysm with Rupture, *Am. Heart J.,* 30:133-140, 1945.
4. Friedberg, C. K.: *Diseases of the Heart,* pp. 458-460, W. B. Saunders Co., Philadelphia, 1949.
5. Parkinson, J., Bedford, D. E., Thomson, W. A. R.: Cardiac Aneurysms, *Quart. J. Med.* 7:455-478, 1938.
6. Lisa, J. R. and Ring, A.: Myocardial Infarction or Gross Fibrosis: Analysis of 100 Necropsies, *Arch. Int. Med.,* 50:131-141, 1932.
7. Applebaum, E., Nicholson, G. H. B.: Occlusive Disease of the Coronary Arteries: Analysis of the Pathological Anatomy in 168 cases with Electrocardiographic Correlation of 36 of These, *Am. Heart J.,* 10:662-680, 1935.
8. Caplan, M. and Sherwood, P. M.: Cardiac Aneurysm, *New Eng. J. Med.,* 240:629-637, 1949.
9. Dressler, W., Pfeiffer, R.: Cardiac Aneurysm: Report of 10 Cases, *Ann. Int. Med.,* 14:100-121, 1940.
10. Eliaser, M. Jr., Konisberg, J.: Electrocardiographic Findings in a Case of Ventricular Aneurysm, *Arch. Int. Med.,* 64:493-504, 1939.
11. Sigler, L. H.: Early Development and Long Duration of Massive Ventricular Aneurysm in Myocardial Infarction, *Am. J. Card.,* 2:375-380, 1958.
12. Stevans, R. A.: Electrocardiographic Findings in Cardiac Aneurysm, *Ann. Int. Med.,* 34:747-758, 1951.
13. Pipilis, G. A., Wosika, P. H.: Unipolar Precordial EKG's in Ventricular Aneurysm, *JAMA,* 145:147-152, 1951.
14. Ford, R. V., Levine, H. D.: The Electrocardiographic Clue to Ventricular Aneurysm, *Ann. Int. Med.,* 34:998-1016, 1951.
15. Rosenburg, B., Messinger, W. J.: The Electrocardiogram in Ventricular Aneurysm, *Am. Heart J.,* 37:267-277, 1949.
16. Evans, E.: Ventricular Aneurysm: A Cause of Persistent RS-T Segment Displacement, *Ann. Int.* Med., 34:1048-1055, 1951.
17. Moyer, J. B., Hiller, G. I.: Cardiac Aneurysm: Clinical and Electrocardiographic Analysis, *Am. Heart J.,* 41:340-357, 1951. ◄

Blue Shield Implements AMA Resolution

The nationwide Blue Shield Plans and their sponsoring medical societies have registered outstanding progress in implementing the American Medical Association resolution—passed one year ago today—calling for the development of medical care coverage for the aged by voluntary means.

Only eight of the 67 Blue Shield Plans located in the United States, with only 2% of total Blue Shield membership, have no programs for senior citizens in the works at the present time.

The remaining 59 plans either have special aged programs already being offered in their area, or have programs in various stages of development.

The Journal

of the INDIANA STATE MEDICAL ASSOCIATION

Devoted to the interests of the medical profession of Indiana

Editor: Frank B. Ramsey, M.D., 1802 North Illinois Street, Indianapolis 2, Indiana

Associate Editors: A. W. Cavins, M.D., 221 South Sixth Street, Terre Haute, Indiana; Lall G. Montgomery, M.D., Ball Memorial Hospital, Muncie, Indiana; David A. Bickel, M.D., 515 Odd Fellows Building, South Bend, Indiana; Stephen L. Johnson, M.D., 521 Sycamore Street, Evansville, Indiana.

Editorial Board:	Term Expires
George M. Johnson, M.D., Richmond	Dec. 31, 1960
Irvin W. Wilkens, M.D., Indianapolis	Dec. 31, 1960
Harold D. Lynch, M.D., Evansville	Dec. 31, 1961
Jene R. Bennett, South Bend	Dec. 31, 1961
Samuel R. Mercer M.D., Fort Wayne	Dec. 31, 1962
Franklin F. Premuda, M.D., Hammond	Dec. 31, 1962

Necrologist: James B. Maple, M.D., 117 West Washington Street, Sullivan, Indiana.

Assistant Editor: Corki Wilson

Editorial Assistant: Sara M. Snyder

Business Manager: James A. Waggener

1019 Hume Mansur Building, Indianapolis 4, Indiana

FAT METABOLISM AND CHOLESTEROL

THE FOOD and Drug Administration of the U. S. Public Health Service recently issued to the public a warning about alleged claims that the use of salad oils, shortenings and oleomargarine would prevent heart attack or strokes.

The release stated that sellers of unsaturated fats and oils, in making such health claims, might be in violation of federal misbranding laws.

The release continued: "Addition of unsaturated fats and oils to the otherwise unchanged ordinary diet will not reduce blood cholesterol and prevent heart attacks and strokes. The role of cholesterol in heart and artery disease has not been established. A causal relationship between blood cholesterol levels and these diseases has not been proved. The advisability of making extensive changes in the nature of the dietary fat intake of the people of this country has not been demonstrated."

While the above statements are in part true, and even though they are issued to protect the public from possible exaggerated claims of advertisers, the tenor of the release as a whole is to deny the validity of much of the research work which has been done on the subject of fats and cholesterol and their possible role in atherosclerosis.

Recently a reliable authority stated in part as follows: "Encouraging progress has already been made in determining the part diet may play in at least several types of . . . cardiovascular diseases.

"Most medical scientists now agree that there is a relation between the amount of cholesterol in the blood and the depositing of fat in the blood vessels.

"Some fats in the diet actually lower blood cholesterol, while other fats raise the level in the blood. It is not yet entirely clear why this is so. Current experiments indicate that the degree of 'saturation' of the fats may be a factor. Saturated fats in general are those which are solid

at room temperature, and these usually raise blood cholesterol. Most unsaturated fats are liquid and can be poured at room temperature. Some of these do not raise blood cholesterol; in fact, some actually lower it.

"Animal fats are the ones which contain cholesterol, and most animal fats are also relatively high in saturation, so that diets which restrict cholesterol automatically restrict many of the saturated fats which raise blood cholesterol levels."

Reliable authority? The above four paragraphs are exerpts from a pamphlet entitled "The Food You Eat and Heart Disease," published and distributed in 1957 by the U. S. Public Health Service.

It has been demonstrated by clinical study that the blood cholesterol level may be lowered in patients by limiting animal fats and substituting vegetable oils. Unsaturated fats of vegetable origin which have been solidified by the hydrogenation method become saturated and behave as animal fats when eaten. Vegetable oils reduce cholesterol levels only when ingested in their natural state or when they have been solidified by methods other than hydrogenation.

It is important that the public not be misled by overemphasizing the possibility that maintaining a normal blood cholesterol level will minimize or prevent atherosclerosis. This may prove to be true at some future time. At present the evidence points in this direction, but falls short of clinical proof. Many years of clinical observation may be necessary to prove or disprove this relationship.

In the meantime it will help for the public to be informed on the subject of saturated and unsaturated fats. It is important that they be not misled by assuming that hydrogenated vegetable oils are effective in lowering cholesterol levels. Since the period of clinical observation necessary to establish the relationship of cholesterol levels and atherosclerosis in the human may extend over many years, it is essential that the therapeutic use of unsaturated fats be carried out in the most careful manner.

ACCIDENTAL POISONINGS ARE PREVENTABLE

ACCIDENTAL DEATH from poisoning, especially in young children, is on the increase in the United States.

1,450 deaths were reported in the nation last year from poisonings by agents other than poison gases and spoiled food. Over 400 of these deaths were in children less than five years old.

Dr. Harold Jacobziner, assistant commissioner of the New York City Department of Health, reported on the problem in a recent issue of *J. A. M. A.* He stated that in 1958 more children under the age of five died in New York City from accidental poisoning than from diphtheria, poliomyelitis, rheumatic fever, scarlet fever and other streptococcic infections combined.

The toll is not limited to the fatalities alone. Non-fatal poisonings, on which no statistics are quoted, add immeasurably to the damage produced by carelessness and lack of knowledge. Almost all accidental poisonings are preventable.

Proper control of household drug supplies, notably barbiturates and aspirin, would have prevented almost half of the deaths. Various toxic household preparations, many of them newly on the market and with a wide distribtuion, account for most of the remainder.

Laws providing for the proper labeling of toxic substances, such as the Indiana Household Poisons Act, are recommended on a national basis as one of the necessary preventives.

Dr. Jacobziner calls for an educational program, under the guidance of the medical profession with emphasis on the dangers and the need for keeping all drugs and poisons out of the reach of children. Regulations and proper labeling is but the basis of an effective safety program. Education of the entire population is the real answer.

In the case of children, the safeguarding of barbiturates, aspirin and all other drugs is all that is necessary to save hundreds of lives. Discouragement of the use of flavored aspirin for children would accomplish much. No other "poisons" are flavored and made to resemble candy; aspirin should be treated in the same way.

Dr. Jacobziner concludes his article by saying, "Prevention is posible through education at all levels. Education requires an integrated team approach with the family physician as key member of the team. Accident prevention . . . merits the greater attention and involvement of the practicing physician."

DRUG PRICES

NEW YORK MEDICINE, in its Nov. 5, 1959 issue, discussed the present Congressional investigations on the cost of drugs in a cogent, rational and informing manner.

The editorialist opens his discussion and almost wins the argument in the third paragraph by pointing out that the national cost of medical care (doctors, hospitals, dentists and drugs) in 1939 amounted to 4.7% of disposable income. Today the percentage for medical care is 4.6.

We have often said that the medical care people receive today is the biggest bargain they get. It is now costing them the same proportional part of their income that it did 20 years ago, and is far superior in effectiveness.

Buying 15 capsules at $2.00 each sounds expensive. However, if the medication is acquired to treat peneumonia, it is probable that the patient will be cured practically overnight, that his stay in the hospital will be measured in days instead of weeks, and that he will be back to work and earn enough money, before his counterpart of 1935 would have earned a dime, to pay for the medicine 10 times over.

Hospital care, doctors' services, and the drugs of today are the biggest bargain people ever had. The total bill is no more and the product is far superior.

AMEF SHOWS STEADY BUT VIGOROUS GROWTH

THE AMERICAN Medical Education Foundation in 1959 again demonstrated the steady and vigorous year by year growth which has characterized its operations since it was organized in 1951.

Each year has ended with a larger number of dollars and with an increased number of contributors. Another source of aid for the medical schools consists of direct contributions of alumni to individual schools. This part of the medical school support program is also on the increase.

Dr. Louis Orr, president of the AMA, announced in December that on Oct. 31 the A. M. E. F. was 13.5% ahead of the previous year and at that time had received money from more than 20,000 contributors.

The Fund in 1959 was well over one million dollars. This will be distributed to all the medical schools in the United States on an unrestricted basis, and may be used by the schools in whatever fashion each school desires, in order to maintain high standards of medical education.

In most of the states which set aside a part of each member's dues for A. M. E. F., as does Indiana, it has been observed that the individual gifts to A. M. E. F. and the direct gifts to schools have increased after the dues method was adopted. Both the Women's Auxiliary to the Indiana State Medical Association and the association itself were honored by Awards of Merit in 1958-59 for participation in the A. M. E. F. drive.

The need for supplementary funds has not lessened since the inauguration of A. M. E. F. In fact the costs of medical education have risen with inflationary trends and with the growing complexity of medical practice and the methods of teaching. All schools are faced with the need and desirability of graduating as many physicians as is possible in order to maintain a reasonable ratio of doctors to an increasing population.

The necessity of maintaining medicine as a free profession, without federal subsidies for the continuance of high quality medical education, is as great and as important as ever.

1960 should be a year in which the profession's interest in education should be greater than ever before. An increase in the number of contributors and an even larger contribution to A. M. E. F. in 1960 will be needed to continue the support which physicians have voluntarily organized and underwritten in such a splendid manner. This should be our goal for 1960.

From New York:

WHY BLAME BLUE CROSS?

HOSPITAL INSURANCE under Blue Cross administration has accomplished wonders, almost the impossible. It has taken millions of our citizens out of the charity wards and made them private self-reliant patients with the aid of the companion plan for doctor care, Blue Shield. This great performance began when the old established insurance industry pronounced hospital care costs to be uninsurable risks.

After 25 years of successful pioneering services, Blue Cross is being blamed today for the increasing charges for hospital care. Public officials, politicians, labor leaders and others are criticizing Blue Cross for demands made by hospitals for higher per diem charges. Blue Cross is no more responsible for regulation of hospital costs than are those who criticize Blue Cross rates.

"Public hearings" on proposed rate increases for insurance may satisfy the desire of some leaders and officials for spotlight publicity, but they contribute little or nothing toward lowering the need for increased rates. Surveys, "investigations," and collegiate "studies" seem to be aimed at Blue Cross . . . as though Blue Cross could regulate hospital operating costs. The real truth is that Blue Cross can only calculate how much money must be in hand to pay the charges of the hospitals for the contract benefits allotted to subscriber members of the plan.

To say, as some do, that hospital costs will go on mounting, at least by a 5% increase year after year, is a challenge which must be met. It takes no wizard in mathematics to know we do not have resources to meet such drains.

Present-day hospital activities are made up of customs, procedures and rituals handed down from the nebulous past. Necessity now demands a going-over of these institutional affairs by a carefully selected group of persons who have the know-how to bring the rocketing costs back to earth. Doctors should be in the front rank of this assembly of talent; this is no place for boys with fanciful dreams of utopian perfection. The thinking must be practical and regular expenditures limited to real necessities. The voluntary hospital is a place to help doctors restore patients to their usual levels of health. Should patients continue to be burdened with the disbursements for "research" and for maintenance of nurse education? Educated and skilled talent surely should not continue to be wasted on clerical records and manual duties.

These and other considerations should be directed at what goes on in the hospital, not at Blue Cross. "Can the costs of hospitalization be lowered?" is an academic question. The crisis is here. Action and revisions of procedure must be developed.

Why not put away recrimination and give the Blue Cross officers and their staffs the recognition they have earned? They have done much for many. They have taken much undeserved blame because hospitals have increaced the charges for their services. Why not look for the real facts, for what must be done if the free, voluntary hospital system is to survive?

Reprinted from *New York State Journal of Medicine,* Vol. 60, No. 1, pp. 42-43, Jan., 1960, Laurance D. Redway, M.D., editor.

From American Red Cross:

FIFTY YEARS OF CONSERVING HUMAN LIFE

THE AMERICAN Red Cross first aid program this year begins its second half century of conserving human life through training persons to prevent accidents and to protect accident victims and care for their injuries. In the 50 years since the Red Cross officially launched its program on Jan. 1, 1910, the lives of untold thousands of accident victims have been saved

because first aid-trained persons have known what to do and—even more important—what *not* to do until the doctor came.

Some 21,000,000 Red Cross first aid certificates have been issued since 1910, with an all-time peak of 3,600,000 issued in the 12 months before and after Pearl Harbor. In the peacetime years since the Korean War, the number of certificates granted annually has fluctuated between 680,000 and 975,000. At the present time, there are more than 85,000 authorized Red Cross first aid instructors.

Although the roots of present-day first aid training go back far beyond 1910, the birth of systematic first aid instruction for the general public in America is quite recent. The place—Jermyn, Pa. The year—1899. Local coal miners, many of them first aid-trained by the St. John's Ambulance Association in their native England, decided to do something about the lack of immediate help for their injured coworkers.

They asked a local physician, Dr. Matthew J. Shields, to teach them emergency care of the injured. He agreed, and this "father of first aid in America" continued his work for the next decade, staging first aid competitions to dramatize his efforts.

Meanwhile, with Army approval and cooperation, the Red Cross had engaged a medical officer, Maj. Charles Lynch, to give a series of first aid lectures. During this period, he also served as a judge of Dr. Shields' competitions. In 1908, Major Lynch compiled these lectures and they were distributed under Red Cross auspices as its preliminary first aid textbook. In 1910 the first published Red Cross first aid textbook was released.

Major Lynch was named the first national director of the Red Cross first aid program in late 1909 and he chose Dr. Shields as his assistant. Under their inspiring leadership and that of their many competent and dedicated successors, the teaching of first aid to the American public has made great progress.

With the approval of the medical profession, Red Cross-trained lay instructors began teaching classes, once a prerogative only of physicians, and the Red Cross was able to meet the ever-increasing demands by industries, police and fire departments, and the military for proper first aid instruction of their employees and members.

Working closely with physicians and doctors, the Red Cross has continually revised its program to include all the latest medically approved technics. Today, first aid training is a portable safety program that helps the individual to prevent accidents and to care for himself and others when accident do occur. ◄

British Conservatives Thwart Health Cost Increase

Great Britain was recently spared a major financial increase in the cost of the National Health Service Program as the Conservative Party, led by Prime Minister Harold Macmillan, convincingly defeated the Labor Party which advocated a broad platform of socialistic proposals.

As reported in the October 24 edition of *The Weekly Underwriter,* the Labor Party had intended to add some £100,000,000 ($280,000,000) in new disbursements to the already economically burdensome cost of socialized medicine—£740,000,000 ($2,072,000,000) per year. This increase in funds was to have provided the British with many new hospitals, a substantial build-up in group practice, reductions in the waiting lists at hospitals and doctors' offices, and "the complete elimination of any charges attendant on medical care."

Seemingly unimpressed by these facts, the article pointed out that some of our own Congressmen have signified their full support of socialized medicine and have expressed their wishes of initiating a program of this nature in the United States. And, were it not for the strong opposition of the American Medical Association and our private health insurance companies, this fallacious thinking would have continued unabated. The tremendous cost of the National Health Service Act, and the mediocrity of medical care provided under such a program, should for all times induce our legislators to avoid any such similar programs. —*Blue Shield Newsletter,* December, 1959.

President's Page

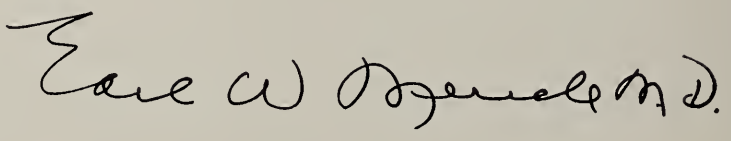
The holidays are over and once again we return to the ordinary manner of living in which the perplexities and problems confronting us are uppermost in one's thinking.

Medicine generally is concerned with a struggle to provide the best possible care for our patients. As a matter of first importance it would be well if we would devote all our energies to this end. Recent years have shown us that we may individually take care of patients but as an organization we must take care of the society in which we live.

We have learned a great deal about political issues in the past few years. We have learned that we have friends whose goals parallel ours; these goals—to keep our people unencumbered from governmental bureaucratic practices.

There are those who disagree with us and want government intervention in the doctor-patient relationship. Already there is consideration by one of the major parties to include medical care for all recipients of social security in a government sponsored program. This is even further in intervention than the Forand bill.

It is time that every physician become interested and contribute effort to our cause. Remember, as Dr. Louis Orr says, we can lose only once.



The Woman's Auxiliary

REPORTS TO I.S.M.A.



MRS. ACHER
Chairman



MRS. SCHMOLL
Member



MRS. CARPENTIER
Member

State Safety Committee

The Woman's Auxiliary to the American Medical Association has again listed safety as one of its goals.

This program includes suggestions based upon recommendations by the American Medical Association. Safety in (1) auto-design, (2) highway safety, and (3) greater home and farm safety are the three aims of the auxiliary program.

The action for these three aims included programs to stimulate the use of seat belts and to stimulate individuals as well as organizations to secure safety features as standard equipment for all cars. Also stressed was education on chemical tests for intoxication and pedestrian safety for oldsters and drivers, as well as schoolboy patrol. Other suggestions for action were to warn parents against the reuse and missuse of plastic film and to develop and encourage the formation of poison control centers.

In our state auxiliary each county is encouraged to participate in their own community in the interest of safety for their citizens. Many of these counties have sponsored safety programs by means of speakers and films for their own members, assisted in school safety programs, and individually served on safety programs in the community.

The State Safety Committee for this year is:

Mrs. Robert Schmoll, Fort Wayne
Mrs. H. F. Carpentier, Princeton
Mrs. Leslie Laird, Richmond
Mrs. Robert Acher, chairman, Greensburg

Dear Doctor:

Please urge your wife to send in her reservations for our April House of Delegates meeting to be held at French Lick. It is only through active participation that we can learn how to help you.

Mary Annette Black
President

Medical Panorama

CARE FOR THE INDIGENT—INDIGENT CARE?

A. W. CAVINS, M.D.

Terre Haute

TRADITIONALLY the South is traditional in outlook, at least, up North, it is. However, an editorial in the *Journal* of the Florida Medical Asociation for November, 1959, gives the lie to this concept and is, indeed, of interest to all American physicians. This is not to imply that we feel our Florida brother has said the last word on this subject—actually his plea is a challenge, not a solution.

The material quoted below is not the entire editorial, but constitutes the main portion without the introductory argument. The title is "Indigent Care for the Indigent." Whether you agree with "J.J.L." or not, he calls attention to a modern trend which must be dealt with sooner or later—and probably *sooner*.

"We, as physicians, being conservative men, would probably continue on our Don Quixotic way of caring for the poor, but this is the age of the common man. No longer may the feudal baron give scraps to his serf to eat. No longer may the plantation owner care for his slaves with paternalistic if meager fare. This is the age in which another war may be fought to preserve the dignity of man. It is therefore apparent that the philosophy which called upon physicians to treat the indigent without charge has been discarded.

"The good physician must temper rapid change with some degree of conservatism, but if he were to submit to no change, he would still be using leeches and letting blood. Even our medical schools are in a state of flux, re-examining and changing their methods of teaching more radically than at any time since the twentieth century began.

"It is thus apparent that we, as physicians, must stop our anachronistic attitude of trying to solve a twentieth century problem with a medieval philosophy. We can no longer use the argument that it was good enough for our fathers and hence, it is good enough for us. Our social philosophy now holds that the basic concept of life and the pursuit of happiness also includes health. As physicians we can no longer remain aloof and disdain anything that smells of social change. What the public wants, eventually the public will get, with or without our help. We must stop nurturing the immature hope that 200,000 physicians are going to stop any social change though some of our number believe that because we as physicians will not accept social security benefits, all those now receiving them will magically not want theirs and that our nonparticipation will strengthen our fight against socialized medicine. Socialized medicine will come when the majority of the public is dissatisfied with the medical care they receive and with the price they pay for it.

"We physicians have given up our ideas of humors and the supernatural. We no longer use amulets or potions. We should realize the following facts and use a fresh approach to the problem of care for the indigent.

"Basically the average American does not want charity. Being a charity patient does not fit the dignity of an American.

"Under our present setup, there will always be patients who will not be cared for.

"The young physician has not been imbued with the traditions of giving free service to the indigent any more than the grocer gives free food or the clothier free apparel.

Continued



RELA—a new myogesic for better relaxant *and* analgesic therapy—more adept management of spasm and pain in strains, sprains and low back pains.

RELA—though a single drug—is a true myogesic and works rapidly to achieve three desired effects...

Rela relaxes acute muscle spasm
Relief of muscle spasm (96% excellent to good effectiveness)[1]

Rela provides a unique quality of persistent pain relief through its relaxant and analgesic actions
"Relief from pain was usually rapid and sometimes dramatic"[1]

Rela, through relaxation and analgesia, assures daytime ease and nighttime rest
"... A number of patients reported freedom from insomnia which they attributed to freedom from pain."[1]

indications: RELA is most beneficial in those conditions of the musculoskeletal system manifesting pain, stiffness and spasm.

safety: Studies of more than 1400 patients indicate that the toxicity of RELA is exceptionally low. In human subjects, respiratory, blood pressure or blood chemistry changes and/or renal, hepatic or endocrine dysfunction have not been reported.

dosage: The usual adult dosage of RELA is one tablet 3 times daily and at bedtime. RELA has a rapid onset of action, with relief usually apparent within 30 minutes, and persisting for at least 6 hours.

supply: RELA is available as 350 mg., pink, coated tablets in bottles of 30.

1. Kuge, T.: To be published.

H-227

MYOGESIC
muscle—analgesic relaxant

Schering

School Phobia: Psychiatric First Aid

GORDON T. BROWN, M.D.

Indianapolis

SCHOOL PHOBIA is one of the most commonly encountered psychiatric disorders in children. The attitudes and management utilized by the family physician or pediatrician first consulted by the concerned parents may determine in large measure the degree of ultimate psychiatric impairment.

General Characteristics

School phobia occurs with approximately equal distribution in both sexes and occurs most frequently among children of grade school age. These children are often apprehensive about achievement. They tend to be either perfectionists—or they prefer not to try at all for fear of failure. They are the product of a small family and are frequently the baby of the family. The families are inbred with feelings of close interdependence. There are many phone calls by grandparents and other interested relatives regarding the child's "problem." All of this tends to blow up the symptom in importance.

Family Dynamics

The parents of these children are involved in an immature marital adjustment. The father is anxious and uncertain of his paternal role. The mother feels inadequate but attempts to cover up her inadequacy by a facade of self-sufficiency. She often has failed to resolve her dependent relationship with her own mother and the resentment associated with this. This inability to resolve her dependent relationship with her mother is in turn passed on to her child, resulting in a hostile, dependent relationship between the mother and child, in which both are rendered anxious by any threat of separation. To the child, the trangible presence and closeness of the mother offers ready reassurance that the child's unspoken angry feelings toward the mother have not come true and destroyed her.

Viewed in this light, the school phobia represents a separation anxiety in which the child is protecting himself from the imagined consequences of his impulses toward mother by refusing to be separated from her. The child does not so much fear school as he fears separation from his mother. Often the child may betray his hostility toward parents in the disguised form of preoccupation with death and dreams of the parents' injury or demise.

At the same time, the mother may deny her angry feelings toward the child and overcompensate by becoming over-protective, controlling and indispensable to the child. In a young infant, this presents no great problem but as he begins to mature and reach school age, he finds his struggles to become independent conflicting with the mother's emotional needs and wishes. The mother's protectiveness permits the child few opportunities to learn to master difficult situations himself, thereby requiring the continuing support of his parents.

As the child in his anxiety refuses to be separated from the parents by school attendance, the parents often are overcome by guilt. They vacillate and give in to his entreaties, thereby convincing the child that his fears are well founded and that his parents, too, are afraid of separation.

Hostility Toward School

In these cases, the school erroneously becomes the villian and the focus of the problems. Inasmuch as school attendance is a social demand and noncompliance is disturbing to parents, failure to attend becomes a useful device in the service of the child's hostility toward the parents.

Continued



it started as a "cold"...

to prevent the sequelae of u.r.i. ... and relieve the symptom complex

ACHROCIDIN®

Tetracycline-Antihistamine-Analgesic Compound Lederle

Pneumonitis, otitis, tonsillitis, adenitis, sinusitis or bronchitis develops as a serious bacterial complication in about one in eight cases of acute upper respiratory infection.[1] To protect and relieve the "cold" patient...ACHROCIDIN.

Usual dosage: 2 tablets or teaspoonfuls q.i.d. (equiv. 1 Gm. tetracycline). Each TABLET contains: ACHROMYCIN® Tetracycline (125 mg.); phenacetin (120 mg.); caffeine (30 mg.); salicylamide (150 mg.); chlorothen citrate (25 mg.). Also as SYRUP (lemon-lime flavored), caffeine-free.

1. Based on estimate by Van Volkenburgh, V. A., and Frost, W. H.: Am. J. Hygiene 71:122 (Jan.) 1933

Lederle LEDERLE LABORATORIES, a Division of AMERICAN CYANAMID COMPANY, Pearl River, New York

School Phobia

Continued

Paradoxically the parents are often found to be unconsciously hostile toward the school and authority and are, themselves, deriving vicarious gratification from the child's defiance of authority. When this is the case, the child invariably perceives and responds to the unconscious communication from the parents despite their conscious efforts to elicit conformity.

In the service of this particular pattern of pathology, the child and the parents often utilize somatic and hysterical symptoms and the family physician may be led into the trap of providing a medical excuse for the child's release from school. This is particlarly true when, as is occasionally the case, the school phobia arises after a bona fide illness which may have triggered this mechanism and provided the child and parents a ready-made device for accomplishing their unconsicious goals.

Management

Early detection and intervention is of primary importance in the management of these cases. The longer the child remains out of school, the more the difficulty is compounded by falling behind in school, social ostracism and ridicule from his peers. The longer treatment is delayed, the more his prognosis is jeopardized.

Therapeutic efforts must be directed primarily toward the mother. While the mother characteristically wishes to be dependent and to be given directive counsel and guidance, she will often resist this and fight against it. It is well then initially to offer her some support and encouragement and relieve her guilt about the problem. She may be relieved by being accorded an opportunity to ventilate her hostility toward the child with an understanding listener and thereby become more comfortable with these angry feelings. This permits some relief of her separation anxiety and enables her to handle with greater comfort and certainty the strained relationship with the child.

In view of the underlying hostile dependency, however, it is not surprising that an occasional mother will resist improvement in the child and fight any efforts to effect a separation by renouncing the doctor and withdrawing from treatment.

Continued

Nation's Leading Designers and Builders of prefab "Medical Buildings"



An Erdman prefabricated medical building

• *designed to insure efficiency*

An efficient suite for medical use is not just a group of rooms. It has to be engineered to make the best use of space. Erdman prefabricated medical offices are individually designed for the selected building site and with your specific needs in mind, just as we have done for more than 275 doctors throughout the country.

• *prefabricated to save money*

Because of standardized plans, mass-produced parts and materials, and experienced craftsmen — Erdman saves much in costs, minimizes construction time and insures an ideal building.

If you are interested in a medical building, write Marshall Erdman and Associates, Inc., 5117 University Ave., Madison 5, Wisconsin.



Just one prescription for **Engran** Term-Pak
SQUIBB VITAMIN-MINERAL SUPPLEMENT *(270 tablets)*
calling for just one tablet per day will carry her through term to the six-week postpartum check-up. Thus, you help to assure a nutritionally perfect pregnancy, while providing the convenience and economy of the re-usable Term-Pak. Engran is also available in bottles of 100 tablets.

SQUIBB *Squibb Quality—The Priceless Ingredient*

'ENGRAN'® AND 'TERM-PAK'® ARE SQUIBB TRADEMARKS

(Advertisement)

Tetracycline Phosphate Complex (TETREX®)
U.S. PAT. NO. 2,791,609
in the Therapy of PNEUMONIA

Preferably, antibiotic therapy should be based on pretreatment culture of the offending pathogen, but in bacterial pneumonia the problem may well be too pressing to permit the required delay of 24 to 48 hours. A differential diagnosis among bacterial pneumonias, based on such clinical grounds as speed of onset, sepsis and pain may guide the choice of antibiotic for initiation of therapy.

Should clinical judgment dictate that antibiotic therapy be started immediately, at the same time a sputum sample or a subglottic swab can be sent to the laboratory for culture and sensitivity studies. If the response to the first antimicrobial agent proves unsatisfactory, a reasonable basis for changing therapy will then be at hand.

Choosing the Antibiotic

Since therapy must be started at once for bacterial pneumonia, it is advisable to choose a broad-spectrum antibiotic that quickly produces high levels of active agent (e.g., tetracycline phosphate complex, TETREX). Such an antibiotic probably has the best chance of controlling the pathogen, whether it be gram-negative or gram-positive. And if the laboratory report shows that the invading organism is much less sensitive to tetracycline than to other agents, the patient can then be changed to an appropriate antibiotic. If the difference in sensitivity is slight, then the possibility of side effects, sensitization, and toxicity should be evaluated before changing therapy to another antibiotic.

The greatest number of bacterial pneumonias are caused by pneumococci, which respond very well to penicillin, tetracycline, and chloramphenicol. Also, these antibiotics are usually effective against the other gram-positive coccal pneumonias. But penicillin is ineffective against the viral pneumonias and the gram-negative *Hemophilus influenzae* and *Klebsiella pneumoniae*. Although *K. pneumoniae* causes only about 1 to 2 per cent of pneumonia cases on the average,[1] these are apt to be acute and fulminating (Friedländer's pneumonia), with a high mortality rate if not effectively treated. Since pneumococcal pneumonia may be difficult to distinguish clinically from Friedländer's, except by gram-stained sputum smear, it may be wiser to start treatment with an agent also effective against Klebsiella.

Penicillin, however, in addition to having a limited spectrum, also causes many minor and some serious sensitivity reactions. In a recent survey[2] it was found that penicillin produced severe skin reaction. But most important was the observation that anaphylactic shock, with a fatality rate of about 9 per cent, was the most frequent serious reaction. Such severe reactions are almost always associated with parenteral administration.

Tetracycline is also clinically effective in primary atypical pneumonia.[3]

The tetracyclines (e.g., TETREX) have the advantage of a broad range of antimicrobial activity and low toxicity. And in addition, the physician does not have to trouble himself or his patients with repeated blood studies when he prescribes TETREX. Minor reactions such as gastric upsets or mild skin rashes occur occasionally. The most serious side effects are staphylococcal and monilial overgrowth, but these are rare and can be adequately controlled.

No one would deny that appropriate antibiotic therapy has greatly reduced morbidity and saved many lives of patients with bacterial pneumonia. Nevertheless, general supportive measures in the care of patients remain important even today. Especially in the desperately ill patient, antibiotics are not considered as substitutes for the individual evaluation, clinical observation and judgment of the physician.

***Some Micro-organisms Susceptible*[a] *to Tetracycline* (TETREX)[b]**

Streptococcus; Staphylococcus; Pneumococcus; Gonococcus; Meningococcus; *C. diphtheriae; B. anthracis; E. coli;* Proteus; *A. aerogenes; Ps. aeruginosa; K. pneumoniae;* Shigella; Brucella; *P. tularensis; H. influenzae; T. pallidum;* Rickettsiae; Viruses of psittacosis and ornithosis, lymphogranuloma inguinale, primary atypical pneumonia; *E. histolytica; D. granulomatosis.*

a Some strains are not susceptible.

b Table adapted from Goodman, L. S., and Gilman, A.: The Pharmaceutical Basis of Therapeutics. 2nd edition, New York, The Macmillan Co., 1956, pp. 1322-1323.

References: 1. Wood, W. E., Jr.: In: A Textbook of Medicine. Edited by Cecil, R. L., and Loeb, R. F., 9th edition, Philadelphia, W. B. Saunders Co., 1955, p. 145. 2. Welch, H.; Lewis, C. H.; Weinstein, H. I., and Boeckman, B. B.: Severe reactions to antibiotics. A nationwide survey. Antibiotic Med. & Clin. Ther. 4:800 (Dec.) 1957. 3. Keefer, C. S.: The choice of an anti-infective agent. In: Drugs of Choice, 1958-1959. Edited by Walter Modell, St. Louis, The C. V. Mosby Co., 1958, p. 135.

BRISTOL LABORATORIES INC., SYRACUSE, NEW YORK

School Phobia

Continued

Immediate Goal

The immediate goal with the child is to get him to school. The authoritarian role of the family physician is useful in accomplishing this. It is important that a definite stand be taken by all concerned and that there be no equivocation or bargaining with the child. In view of the mother's greater anxiety and guilt it is often beneficial to enlist the aid of the father or school personnel in actually getting the child into school. General experience confirms the inadvisability of utilizing home teachers or tutors, inasmuch as this confirms to the child that his condition is intractable and that by it he can control his environment. Since, for this child, school attendance deprives him of his most useful mechanism of hostility, it may be important to help him develop healthier and more appropriate means of expressing angry feelings.

While it is apparent that school attendance may not resolve all the underlying emotional pathology, it often serves to prevent more chronic and socially incapacitating forms of psychopathology. The emotional dividends to the child will prove well worth the concerted efforts of the family doctor, the school and the parents, even though as one mother expressed it plaintively during the successful outcome of such management, "but who will I mother now?"

1949 E. 11th Street
Indianapolis 1



immortals of chinese mythology:



Han Hsiang-tzu

This nature-loving physician achieved immortality by falling out of a tree

TODAY..

this trail-blazing steroid is achieving lasting recognition by its unsurpassed record of accomplishment

METICORTEN

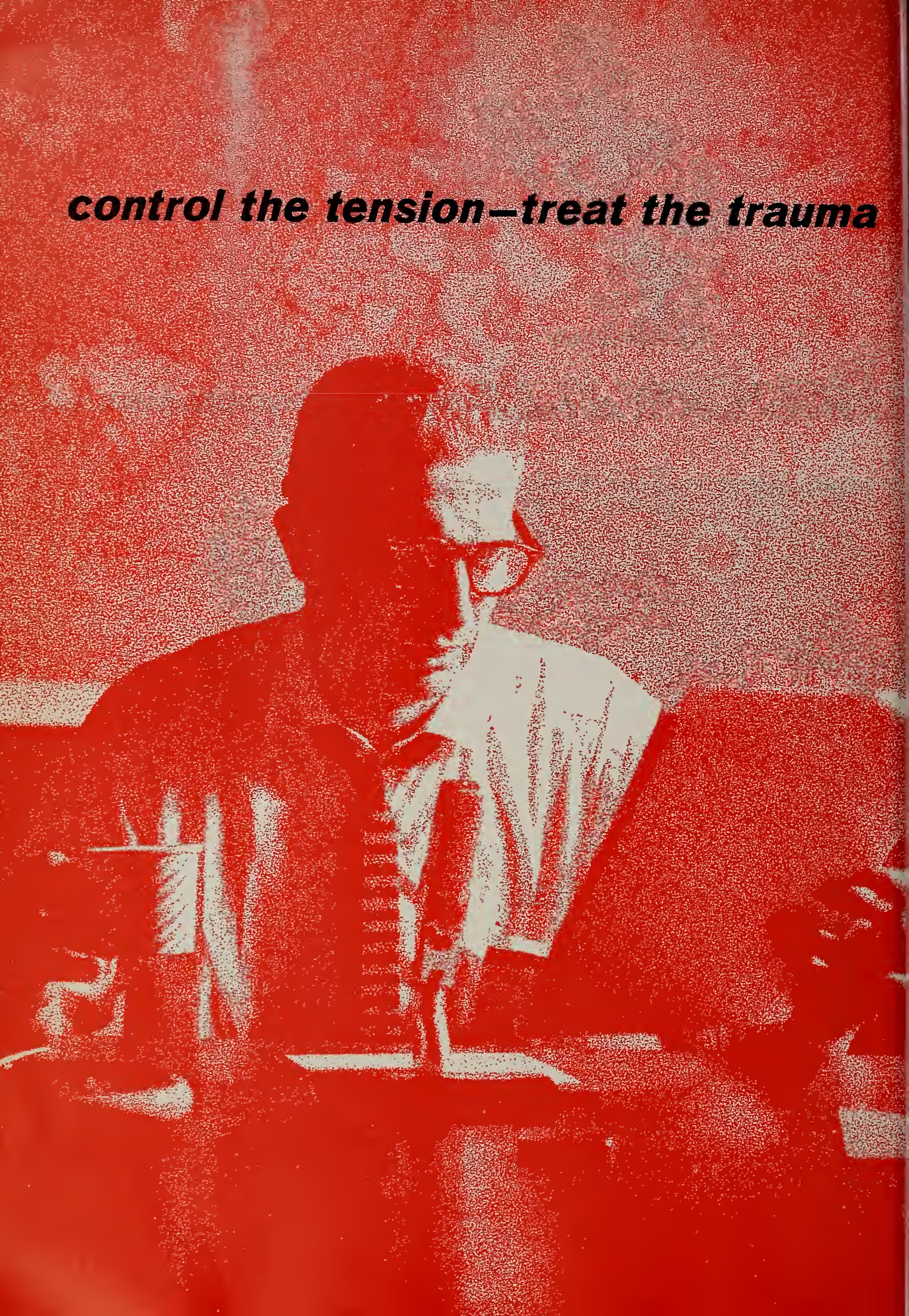
METICORTEN,® brand of prednisone, 5 mg. tablets.

SCHERING CORPORATION • BLOOMFIELD, NEW JERSEY

You will soon receive in your mail a handmade, full-color, three-dimensional figure of this Chinese Immortal, mounted and suitable for framing.

S-348B

Schering


control the tension–treat the trauma

...Pathibamate® 400 200

meprobamate with PATHILON® tridihexethyl chloride Lederle

greater flexibility in the control of tension, hypermotility and excessive secretion in gastrointestinal dysfunctions

PATHIBAMATE combines two highly effective and well-tolerated therapeutic agents:

mebrobamate (400 mg. or 200 mg.) widely accepted tranquilizer and . . .

PATHILON (25 mg.)—anticholinergic noted for its peripheral, atropine-like action, with few side effects.

The clinical advantages of PATHIBAMATE have been confirmed by nearly two years' experience in the treatment of duodenal ulcer; gastric ulcer; intestinal colic; spastic and irritable colon; ileitis; esophageal spasm; anxiety neurosis with gastrointestinal symptoms and gastric hypermotility.

Two dosage strengths—PATHIBAMATE-400 and PATHIBAMATE-200 facilitate individualization of treatment in respect to both the degree of tension and associated G.I. sequelae, as well as the response of different patients to the component drugs.

Supplied: **PATHIBAMATE-400**—Each tablet (yellow, 1/2-scored) contains meprobamate, 400 mg.; PATHILON tridihexethyl chloride, 25 mg.
PATHIBAMATE-200—Each tablet (yellow, coated) contains meprobamate, 200 mg.; PATHILON tridihexethyl chloride, 25 mg.

Administration and Dosage: **PATHIBAMATE-400**—1 tablet three times a day at mealtime and 2 tablets at bedtime.
PATHIBAMATE-200—1 or 2 tablets three times a day at mealtime and 2 tablets at bedtime.
Adjust to patient response.

Contraindications: glaucoma; pyloric obstruction, and obstruction of the urinary bladder neck.

Lederle

LEDERLE LABORATORIES, A Division of AMERICAN CYANAMID COMPANY, Pearl River, New York

Contributions of the Pharmaceutical Industry to Medical Science

JOHN E. McKEEN
President
Chas. Pfizer & Co., Inc.

"Two contrary laws seem to be wrestling with each other nowadays; the one a law of blood and of death, ever imagining new means of destruction and forcing nations to be constantly ready for the battlefield; the other a law of peace, work and health, ever evolving new means for delivering man from the scourges which beset him."

THOSE WORDS might well have been spoken yesterday or even the day before because they reflect so clearly the awesome problem of our times. But they were not spoken yesterday—or even 10 or 20 years ago. They were spoken first in 1888 by Louis Pasteur, a man to whom we in this industry—and indeed all humanity—owe our deepest gratitude.

Unfortunately, the conflict of which Pasteur spoke is still with us today. Yet if science and technology have added a terifying new dimension to the forces of destruction, they have at the same time added undreamed-of strength to the nobler cause of peace and health. It will always be the source of this industry's distinction that it has mobilized its scientific resources on the side of civilization's most humanitarian aspirations—that it has helped establish an age of health and well-being the like of which the world has never known. It has not only been a generous contributor to the most heartwarming revolution in human history, but it has sparked that very revolution itself by touching off an explosive expansion of medical knowledge in the past quarter-century.

Effects of Revolution

Speaking of the effects of this revolution, the *Journal of the American Medical Association* recently had this to say:

"No three decades in medical history have seen as many additions to the physician's armamentarium as we have experienced in our time. The impact of the sulfonamides and the antibiotics upon the life of the average citizen has been incalculable. Specific preparations have been introduced to aid in combating tuberculosis, malaria and hypertension. Anticoagulants and liver extract, unknown 30 years ago, are in common use today. Developments in the field of endocrinology have been outstanding, with the identification and synthesis of various hormones. Antihistamines have become valuable tools in the field of allergy, as have tranquilizing drugs in the field of mental health. Vitamins, just appearing on the horizon a generation ago, have become household words and widespread usage has done much to improve the nutrition of our people."

The things which have so radically changed

Continued on page 334

Presented before the Research and Development Section of the Pharmaceutical Manufacturers Association, The Greenbrier, White Sulphur Springs, W. Va., Nov. 4, 1959.

SOMA RELIEVES PAIN in a unique way by modifying central perception of pain without abolishing natural defense reflexes.

SOMA RELAXES MUSCLE SPASM . . . approximately 8 times more potent than meprobamate or mephenesin.

PHYSICIANS' REPORTS:

"Marked pain-relieving effects of the new drug [SOMA] were seen in conditions involving muscle spasm and stiffness, whether acute or chronic. Relief from pain was usually rapid and sometimes dramatic." (90 patients.)
Kuge, T.: Submitted for publication.

"In 86 percent of the patients there were excellent or good results. . . . Relief of pain was noted by the patients' statements, by the diminished need for analgesic drugs, and by improved sleep." (154 patients.)
Wein, A. B.: The Use of Carisoprodol in Orthopedic Surgery and Rehabilitation. Proceedings of the Symposium on The Pharmacology and Clinical Usefulness of Carisoprodol. Wayne State University Press, Detroit, 1959, p. 156.

In a double-blind study, SOMA was reported to be "clinically effective to a highly significant degree." (92 patients.)
Cooper, C. D., and Epstein, J. H.: The Clinical Evaluation of Carisoprodol by a double-blind technique. Ibid. p. 97.

Notable safety—extremely low toxicity; no known contraindications; side effects are rare; drowsiness may occur, usually at higher dosage

Rapid action—starts to act quickly

Sustained effect—relief lasts up to 6 hours

Easy to use—usual adult dose is one 350 mg. tablet 3 times daily and at bedtime

Supplied—as white, coated, 350 mg. tablets, bottles of 50.
Also available for pediatric use: 250 mg. orange capsules, bottles of 50.

SOMA™

(carisoprodol Wallace)

BIBLIOGRAPHY: 1. Berger, F.M., Kletzkin, M., Ludwig, B.J., Margolin, S. and Powell, L. S.: J. Pharm. Exp. Ther. *127*:66 (Sept.) 1959. 2. Leake, Chauncey D.: Proceedings of the Symposium on The Pharmacology and Clinical Usefulness of Carisoprodol, Wayne State University Press, Detroit, 1959, p. 8. 3. Kestler, Otto: Ibid. p. 143. 4. Proctor, Richard C.: Ibid. p. 122. 5. Berger, Frank M., Ibid. p. 25. 6. Goodgold, Joseph, Hohmann, Thomas and Tajima, Toshihiro: Ibid. p. 66. 7. Gammon, George D. and Tucker, Samuel: Ibid. p. 70. 8. Baird, Henry W. and Menta, Dominic A.: Ibid. p. 85. 9. Cooper, C. David and Epstein, Jerome H.: Ibid. p. 97. 10. Korst, Donald R., Gerard, R. W., Miller, James G., Small, Iver F., Graham, I. J. and Winkelman, Eugene I : Ibid. p. 104. 11. Friedman, Arnold P.: Ibid. p. 115. 12. Trimpi, Howard D.: Ibid. p. 150. 13. Wein, Arthur B.: Ibid. p. 156. 14. Olds, James and Travis, R. P.: Ibid. p. 39. 15. Hess, Eckhard H., Polt, James M. and Goodwin, Elizabeth: Ibid. p. 51. 16. Phelps, Winthrop M.: Ibid. p. 131. 17. Spears, Catherine E.: Ibid. p. 138. 18. Hyde, L. P. and Hough, Charles E.: Ibid. p. 166. 19. Spears, Catherine E. and Phelps, Winthrop M.: Arch Pediat., *76*:287 (July) 1959. 20. Phelps, Winthrop M.: Arch. Pediat., *76*:243 (June) 1959. 21. Friedman, Arnold P.: Paper presented at Scientific Meeting, New York State Society of Industrial Medicine, Inc., New York, Sept. 30, 1959. 22. Frankel, Kalman: Ibid. 23. Fransway, Robert L.: Ibid. 24. Kuge, T.: Unpublished reports.

Literature and samples on request WALLACE LABORATORIES, New Brunswick, New Jersey

Pharmaceutical Industry

Continued from page 328

modern medicine, of course, involve more than drugs alone. They involve such fantastic new technics as open-heart surgery, the cobalt bomb for cancer therapy, the electronic instruments of diagnosis, tracer chemistry and knowledge that has brought new understandings of pathology, metabolism and etiology. It is inevitable that such sciences as electronics and nuclear physics should become part of the domain of modern medicine, for this bespeaks the fundamental unity of all sciences. So too is there a fundamental unity among the laboratories of the medical schools, private foundations, government and industry—for all of these have together created the impressive edifice of modern medicine.

Widespread Impact

All of this, as the *A.M.A. Journal* states, has had widespread impact on the average citizen—his health and his very life. And it has also had profound and lasting effects on the practice of medicine itself.

To what extent has the pharmaceutical industry contributed to this upheaval in medical science?

No one would deny that while modern drugs have helped make the hospital and the physician more effective guardians of the public's life and health, they have also—by making possible rapid recovery—cut deeply into the cost of medical care to the patient. Chemotherapy, for example, has contributed substantially to the decrease in average length of hospital stay, from 12.5 days two decades ago to about 8.6 days today. According to a recent hospital study, modern drugs have cut in half the required hospital-time for treating ear, nose and throat infections. Before antibiotics and sulfa drugs, a victim of lobar pneumonia was often hospitalized for several weeks at a cost of $400 or more for doctors, nurses, oxygen and medicine, not to mention lost wages for an average of six weeks. Today, more often than not, the pneumonia patient is treated at home, is back on the job in two weeks, and rarely pays out more than $25 for drugs and about $35 for doctor bills.

Examples of Progress

That is but one example. Here are a few others:

☆ The doors of mental hospitals are beginning to open outward. Despite mounting admissions, there has been a 13% increase in the number of patients released from mental institutions in recent years, thanks largely to drugs developed by pharmaceutical firms.

☆ Private industry has been the leader in the development of antibiotics. According to a U. S. government report, more than four out of every five antibiotics patents granted between 1942 and 1956—some 86%—went to industrial scientists of American corporations.

☆ These antibiotics have saved untold millions of lives. Between 1944 and 1954, mortality from rheumatic fever dropped 73%; from appendicitis, 76%; tuberculosis, 73%; maternal deaths dropped 77%, infant deaths dropped 33%.

☆ It has been estimated that insulin alone gave life to a million diabetics. A diabetic who once faced two-to-one odds of death can now live normally at half the cost of a pack of cigarettes daily and the new oral anti-

a
logical
combination
for
appetite suppression

meprobamate *plus* d-amphetamine

. . . suppresses appetite . . . elevates mood
. . . reduces tension . . . *without* insomnia,
overstimulation, or barbiturate hangover.

anorectic-ataractic
BAMADEX®
MEPROBAMATE WITH D-AMPHETAMINE SULFATE LEDERLE

Each coated tablet (pink) contains: meprobamate, 400 mg.; d-amphetamine sulfate, 5 mg.
Dosage: One tablet one-half to one hour before each meal.

Lederle
LEDERLE LABORATORIES
A Division of AMERICAN CYANAMID COMPANY, Pearl River, New York

now –

control

virtually all runaway diarrheas.. promptly, effectively with



Donnagel®

Robins

or Donnagel® with Neomycin

Prompt and more dependable control of virtually all diarrheas can be achieved with the comprehensive DONNAGEL formula, which provides adsorbent, demulcent, antispasmodic and sedative effects—with or without an antibiotic. Early re-establishment of normal bowel function is assured—for all ages, in all seasons.

DONNAGEL: In each 30 cc. (1 fl. oz.):

Kaolin (90 gr.)	6.0 Gm.
Pectin (2 gr.)	142.8 mg.
Hyoscyamine sulfate	0.1037 mg.
Atropine sulfate	0.0194 mg.
Hyoscine hydrobromide	0.0065 mg.
Phenobarbital (¼ gr.)	16.2 mg.

DONNAGEL WITH NEOMYCIN

Same formula, plus

Neomycin sulfate	300 mg.

(Equal to neomycin base, 210 mg.)

A. H. ROBINS CO., INC., Richmond 20, Virginia · *Ethical Pharmaceuticals of Merit since 1878*

Pharmaceutical Industry

Continued

diabetic drugs have added a new dimension to this victory.

☆ With steroids, physicians are able to control up to 50% of rheumatoid arthritis patients. Industry's research has helped reduce arthritis from a crippler to a nuisance in many cases.

These are but a few measures of the impact of the industry on modern medicine and modern society. But they cannot convey the full sweep of the industry's contributions. Its effects have at once been too large and too intangible for that.

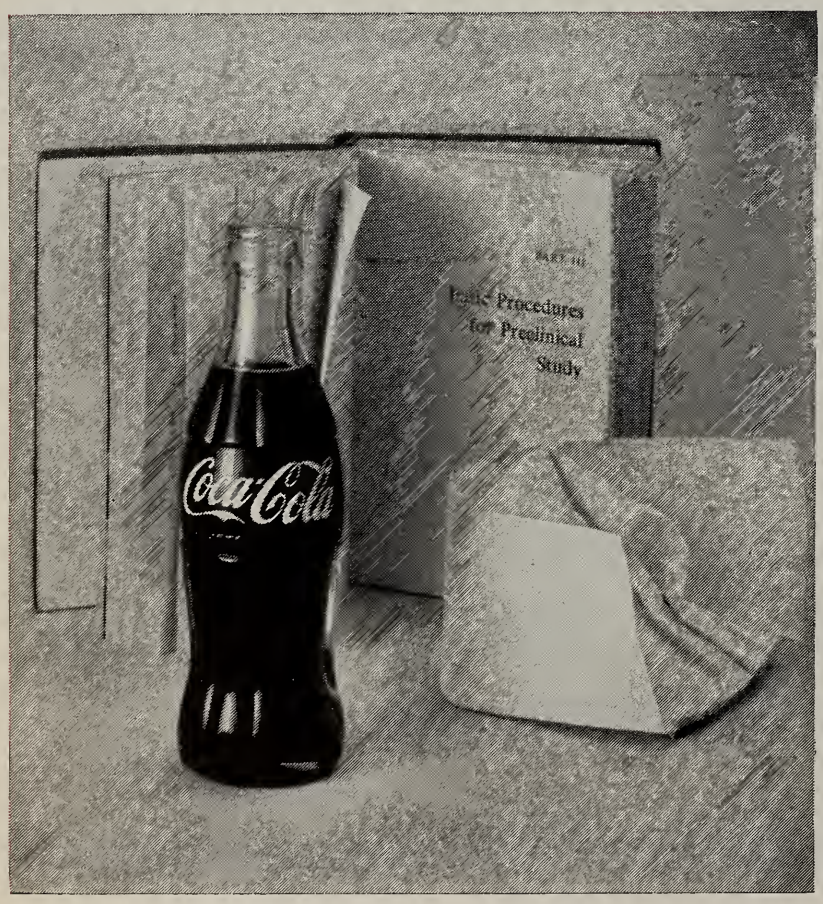
Effect on Medical Education

Just ponder, for a moment, the effect of the industry's growth on medical education alone. If the pharmaceutical revolution has helped make the practicing physician a more effective healer, it has at the same time placed new demands on medical teaching institutions, for the curriculum, reflecting this whirlwind pace of progress, has become both more complex—and more costly. Technics of medical education have undergone radical changes in the past decade alone. Unlike the medical school of bygone days with its single lecturer for hundreds of students, today's classes must be small, the ratio of students to teachers much higher, and students spend much of their time working in the laboratories rather than listening in the lecture hall. Medical education has become a most complex and expensive proposition.

As members of an industry intimately concerned with health and medical progress, we recognize our indebtedness to medical schools, not only for supplying the physicians so vital to our continued progress, but for the fundamental research which is so often the wellspring of practical discoveries. We have drawn heavily on medical education—for people and for knowledge. Thus, we are rightly concerned that the shortage of teachers on medical faculties is fast developing to a crisis. The Council on Medical Education has reported that in 1957 there were 331 unfilled positions on the faculties of our medical schools. Last year vacancies climbed to 619.

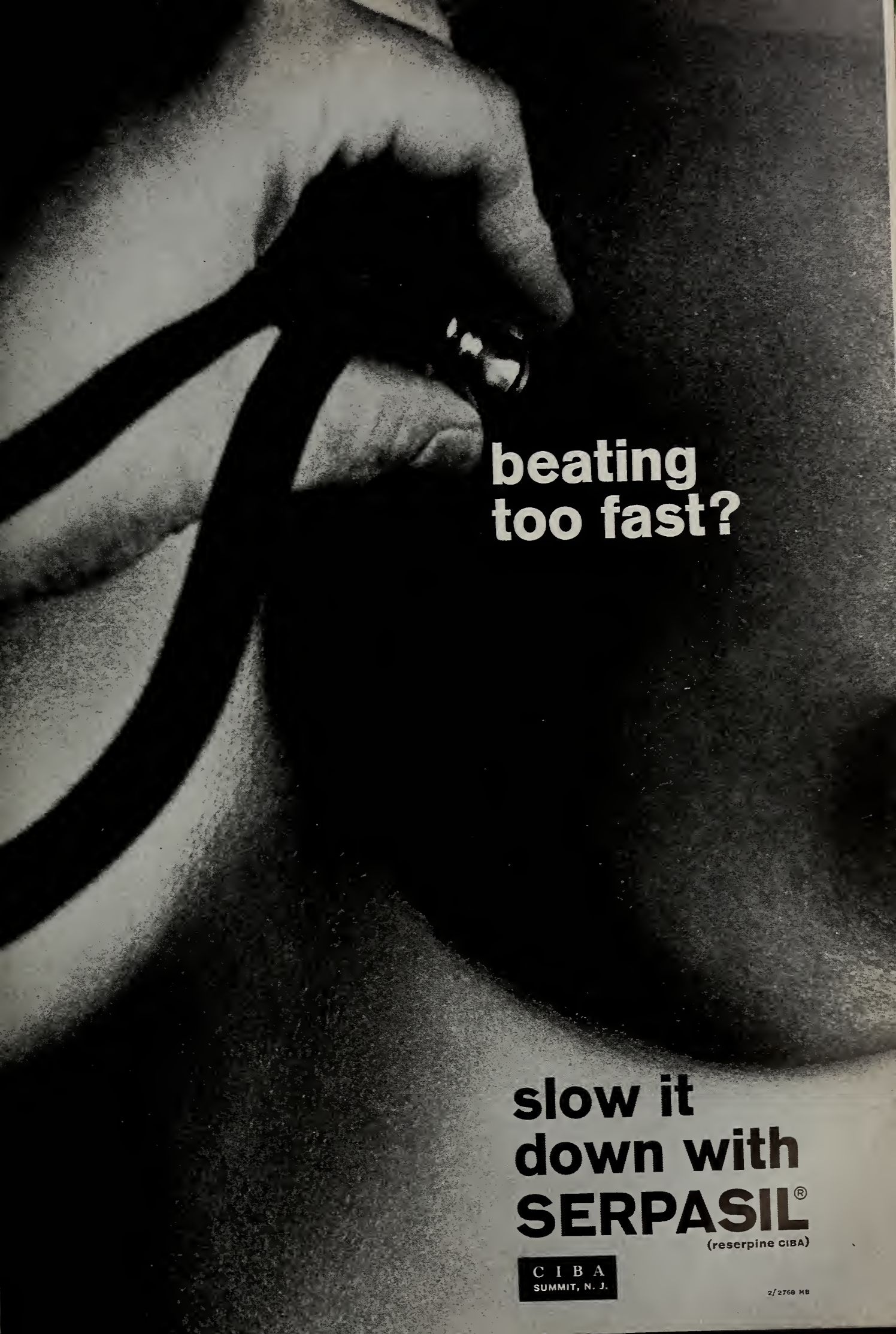
Training Imperiled

Not only does the crisis in medical education imperil the training of future physicians, but it



When too many tasks
seem to crowd
the unyielding hours,
a welcome
"pause that refreshes"
with ice-cold Coca-Cola
often puts things
into manageable order.

DRINK
Coca-Cola
REG. U.S. PAT. OFF.


beating
too fast?
slow it
down with
SERPASIL®
(reserpine CIBA)
CIBA
SUMMIT, N. J.
2/2768 MB

Pharmaceutical Industry

Continued

may very well act as a brake on the advance of medical knowledge itself. Given these conditions, industry support of medical education is as much a necessity as it is a philanthropy.

In 1958 the pharmaceutical industry authorized grants to medical schools totaling more than $20.5 million for fellowships, individual aid and research projects. In addition, since its inception in 1953, the Drug and Pharmaceutical Division of the National Fund for Medical Education, of which I happen to be the current chairman, has contributed more than $1.25 million in cash. Those contributions reflect our abiding interest in medical education as the ultimate source of the nation's continued progress in health.

For our industry, support of medical education really has two meanings. One is direct contribution in dollars and cents; the other merges into the whole broad area of knowledge and the communication of knowledge.

It speaks well of the industry that many companies have produced medical teaching films that rank among the world's finest, and others have been trailblazers in such advanced communications technics as closed circuit television. Smith Kline & Frenh has been honored by the American Medical Association for its work in this field. Upjohn, through its Grand Rounds series, has made valuable contributions to postgraduate medical education by televising leading medical educators at work in surgery and in other fields.

Teaching Without Teachers

If the need for more teachers cannot be met, then education must devise ways of stretching the available supply of teaching talent. The Teleposium series sponsored by Lederle suggests how successful television might be in making available more knowledge. One telecast provided three-way communication between clinicians and students in three Georgia medical schools. Add to these the special broadcasts by Ciba and other firms, and the total contribution of the pharmaceutical industry in this field of medical communications is an impressive one.

It is this revolution in communications technics—symbolized by television and radio—which lends special significance to our medical problems today. None of us has forgotten the great international interest which penicillin created. Once the news of this incredible drug was out—and it spread like wildfire—the demand for it was world-wide. And it was the United States pharmaceutical industry to which the world turned to satisfy that demand. The industry, in cooperation with government and other scientists, had cracked the problems of antibiotics production, and in so doing had opened up a whole new potential for medical progress on a global scale.

Industrial Urgency

It is not, however, communications itself, but a new awakening in man's thinking that is sweeping the world—and changing it. Today, two out of three human beings live out a life of poverty, stricken by mass-disease, held in economic bondage by malnutrition and ill health. In underdeveloped nations, the industrial strength of our own civilization has become the symbol of prosperity and security. Industrialization has taken on tremendous urgency.

This wide gap in human living conditions has long existed, but it is only in our own times that science and technology have begun to point the



WABASH VALLEY SANITARIUM—HOSPITAL

Lafayette, Indiana
Telephone Riverside 3-1679

A hospital for the treatment of neuro-psychiatric disorders.

Custodial cases are accepted in limited numbers.

— OPEN STAFF —

DONALD R. KINZER
Manager

IN MANY CASES: ENDS THE NEED FOR PAINFUL PENICILLIN INJECTIONS

COMPOCILLIN®-VK

(POTASSIUM PENICILLIN V, ABBOTT)

OFFERS THE HIGH BLOOD LEVELS OF POTASSIUM PENICILLIN V



Available in tiny, easy-to-swallow Filmtabs® and in tasty, cherry-flavored Oral Solution.

ABBOTT

001187

®FILMTAB - FILM-SEALED TABLETS, ABBOTT.

HEALTH SCIENCES LIBRARY
UNIVERSITY OF MARYLAND
BALTIMORE

Pharmaceutical Industry

Continued

way toward something infinitely better. It is the medical man, more often than not, who first bridges this gap—and it is the modern drugs he employs that exemplify the fruits of our civilization and our way of life.

Thus, symbolizing as it does both the prosperity of industrialization and the benevolence of modern medicine, the United States pharmaceutical industry has become a powerful social and economic force in the world at large.

International Interest

It has not only exported the drugs that are so vital to the progress of other nations, but by building plants and laboratories abroad it has beome a part of those nations and it has contributed to their standards of living and to their economic strength. There is a foundation of mutual economic interest that underlies this industry's international growth.

Many of the newly developing nations face the choice of industrialization through state control or private enterprise. We believe deeply that private initiative is the best way to a progress with dignity and honor, and w that our own future prosperity abroad wil in demonstrating the truth of this principle.

I mentioned a moment ago that it was mu interest that underlies our interests abroad years ago medicine was available only privileged few in the prosperous civiliz tions. Today the public takes for granted fact that millions of childern in the tropics c escape the threat of infection and blindn through mass medicine. The world's medi knowledge is available to everyone.

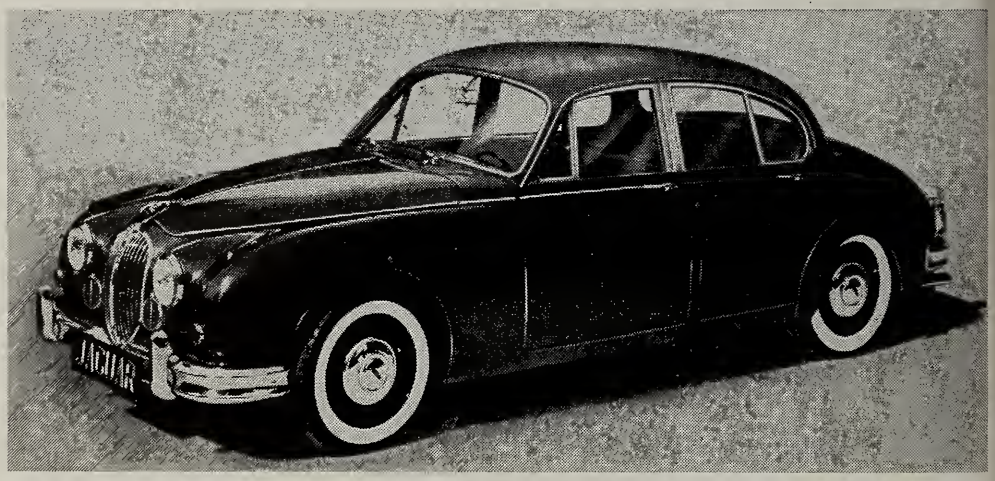
Marketplace of Knowledge

And the world is more than a market fo pharmaceutical commodities; it is a marketplac of knowledge. Because medical knowledg knows no national boundaries, it offers its bene fits with an impartial hand. With this industry's world growth, it has fashioned a pipeline through which medical knowledge flows from the farthest corners of the globe. Penicillin was a British discovery, mass produced by Americans. The sulfa drugs were born in the German dye industry, investigated by French chemists and brought

Sports Car Performance

• • • •

Family Car Comfort



Drive the incomparable new Jaguar 3.8 Litre Sports Sedan!

The only 5-passenger sedan in the world that combines competition sports car performance (the famous Jaguar XK engine has won countless trophies round the globe) with unmatched riding luxury. Blazing acceleration. Maximum safety with race-proved disc brakes. Greater visibility with wrap-around windows, thinner pillars. New high-output heating and defrosting system. Optional power steering and automatic transmission. Also be sure to see the luxurious Mark IX sedan and the classic XK 150 sports models. Convenient terms!

JAGUAR

2330 NORTH MERIDIAN STREET

MIDWEST DISTRIBUTORS, Inc.

• INDIANAPOLIS

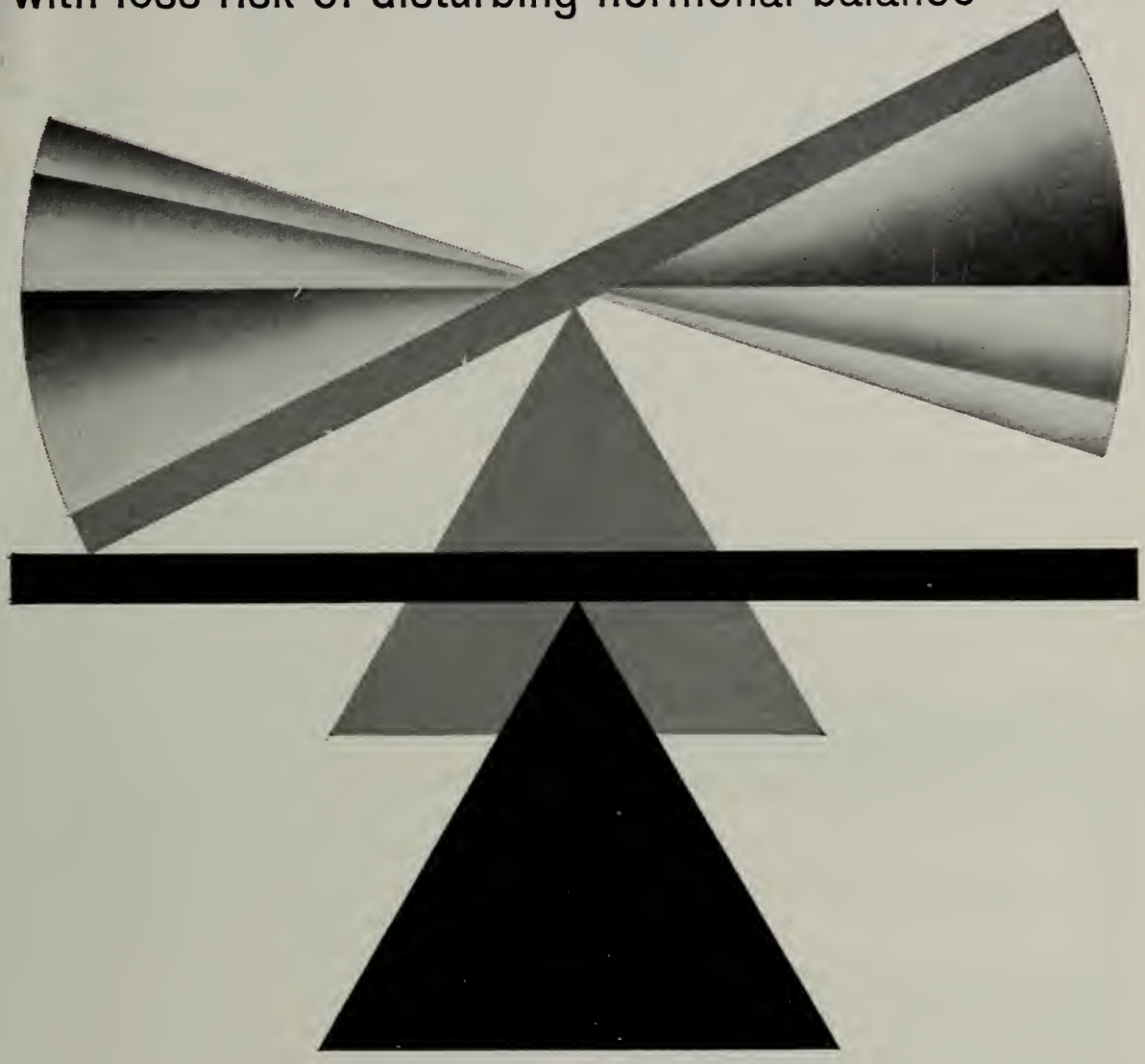
Effective relief in rheumatic disorders

Sterazolidin® capsules

prednisone-phenylbutazone Geigy

Geigy

with less risk of disturbing hormonal balance



In the treatment of the rheumatic disorders new Sterazolidin provides a method of limiting the gravest danger inherent in steroid therapy... hypercortisonism arising from excessive dosage.

Repeatedly it has been shown that the addition of low dosage of Butazolidin sharply reduces hormone requirement.[1-4] Sterazolidin is a combination of prednisone (1.25 mg.) and Butazolidin (50 mg.) which provides, in the majority of cases, consistent relief at a stable uniform maintenance dosage significantly below the level at which serious hormonal imbalance is likely to occur.

Sterazolidin® (prednisone-phenylbutazone Geigy). Each capsule contains prednisone 1.25 mg.; phenylbutazone 50 mg.; dried aluminum hydroxide gel 100 mg.; magnesium trisilicate 150 mg. and homatropine methylbromide 1.25 mg.

1. Kuzell, W. C., and others.: Arch. Int. Med. 92:646, 1953. 2. Wolfson, W. Q.: J. Michigan M. Soc. 54:323, 1955. 3. Strandberg, B.: Brit. J. Phys. Med. 19:9, 1956. 4. Platt, W. D., Jr., and Steinberg, I. H.: New England J. Med. 256:823 (May 2) 1957.

Geigy, Ardsley, New York

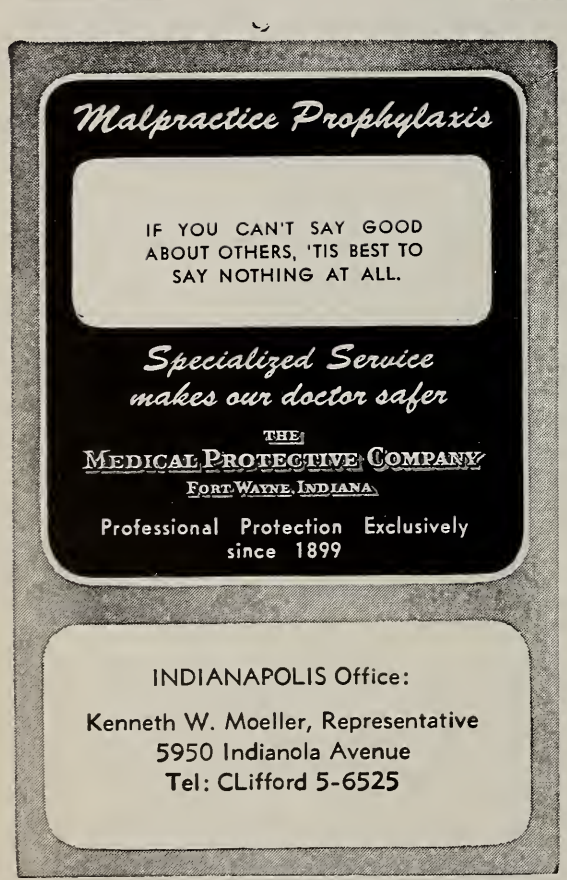
03859

Pharmaceutical Industry

Continued

to perfection by this country's pharmaceutical industry.

When Squibb, through its Centennial Lecture Series, brings eminent scientists from abroad to lecture in this country's medical schools, the industry is performing a service to medical science that would have astonished the physician of a generation ago. It provides an exchange of knowledge that a doctor could once obtain only through thousands of miles of travel to the world's leading medical centers. At Pfizer's Pasteur Fermentation Centennial two years ago, American scientists met with others from France, England, Japan, Cuba and Russia. Regardless of their political differences, those scientists shared a common interest in gaining insights that could not be gleaned from a textbook. In increasing numbers, the industry sends its scientists abroad to report at world scientific meetings, and equally important, to bring back knowledge to this country.



Industrial Scientists in Medicine

By contrast, there was a time not long ago when the industrial scientist played virtually no part in the exchange of medical knowledge. Today, he is found at major medical meetings throughout the world. The thousands of scientific papers published and delivered at meetings by industry scientists, the medical periodicals issued by pharmaceutical houses, the symposia sponsored by the industry on every conceivable medical subject—all of these constitute a monumental contribution to scientific knowledge and to medicine.

In itself, the industry's direct contribution to medical literature is impressive. But it is worth noting too that individual pharmaceutical companies have stimulated valuable contributions by other investigators by offering substantial awards for research in such varied fields as endocrinology, nutrition and tropical medicine, to mention only a few.

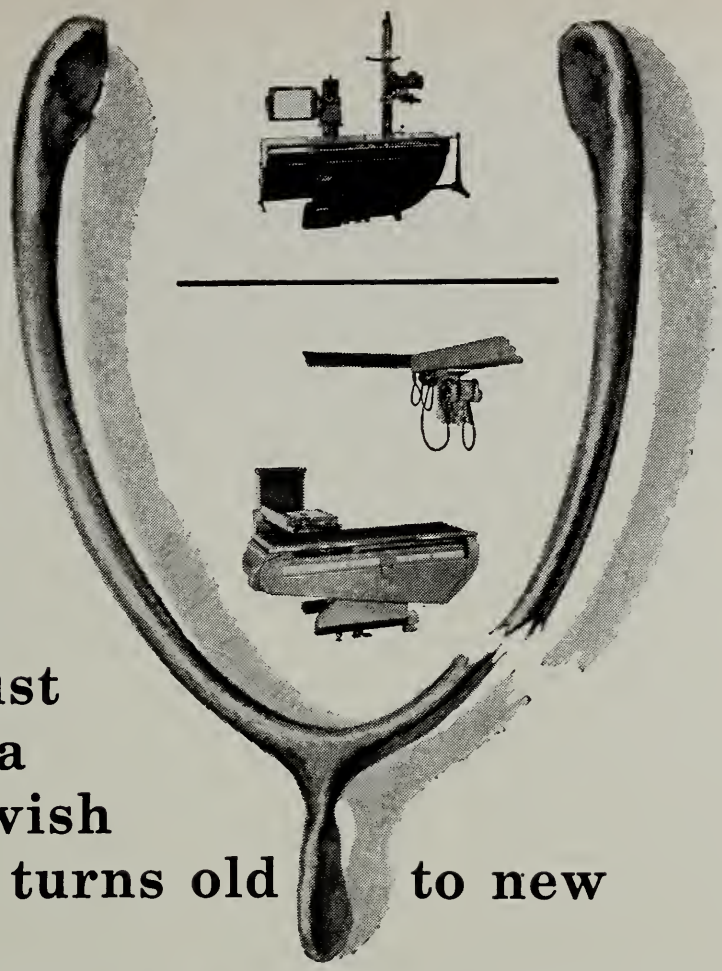
It is this fruitful give-and-take of scientific knowledge which is the binding force of the industry's unique alliance with medicine, and indeed it is the source of the promise of a better life for all humanity.

It is also the source of the continued pace of therapeutic progress, for as a recent government study points out:

"Publication of research results—in the form of patent documents or otherwise—serves as a major stimulant to research activity. Each new development plants the seeds of thought in the minds of others, thereby sparking new ideas and new lines of inquiry.

Fruitful Cross-fertilizations

This industry abounds with examples of this kind of fruitful cross-fertilizations, and step-by-step progress to achievements of great value to mankind. It is by now a familiar fact that the long, arduous and costly developmental work on isoniazid by Hoffman-La Roche, Squibb and Bayer produced a rare contribution to medicine, but like many another development it has, I suspect, returned little to any one company on this huge investment. Yet it led to iproniazid, opened up the whole concept of monoamineoxidase inhibitors, and stimulated the development of anti-depressants in a number of other pharmaceutical laboratories. Thus, the industry's all-



Just a wish turns old to new

Modernize without capital outlay on the G-E Maxiservice® x-ray rental plan

Think of renting x-ray equipment as conveniently as you subscribe for telephone service! Exclusive Maxiservice rental plan offers all new-model G-E x-ray units . . . takes no capital from your savings. Makes it worry-free to "go modern" in x-ray and always stay that way. For complete details, contact your G-E x-ray representative, listed below.

All this for one monthly fee —

- Modern x-ray equipment, free of obsolescence worries
- Comprehensive coverage: periodic inspection, maintenance, tubes, parts, emergency repairs
- Freedom to add or replace equipment as improvements appear
- Full property insurance on equipment — in case of accidental damage or loss, G.E. repairs or replaces equipment
- Local property taxes paid in full

Progress Is Our Most Important Product

GENERAL ELECTRIC

DIRECT FACTORY BRANCHES

CHICAGO
1061 W. Jackson Blvd. • SEeley 3-0700
CINCINNATI
3056 W. McMicken Ave. • MUlberry 1-7230—31
INDIANAPOLIS
1845 W. 18th St. • MElrose 5-4576
LOUISVILLE
501 W. Oak St. • JUniper 3-9562

RESIDENT REPRESENTATIVES

FORT WAYNE
H. J. Wallace • 918 Oakdale • Kenmore 9749

Pharmaceutical Industry

Continued

out attack on TB, through successive stages of research, ultimately opened a new pathway to the conquest of mental depression.

And as an important by-product of this work, Squibb developed the Rake-Donovick Mouse Test, and with it accomplished in 48 months the gigantic task of screening that would otherwise have required as many years. It is largely through such developments in laboratory research that the industry has been able to accelerate vastly the whole time-scale of discovery. A major therapeutic discovery every 25 years was once considered good progress. Today, a major discovery every year is not uncommon.

And the work of the pharmaceutical manufacturers in solving problems of synthetic chemistry, extraction, purification, biological assay and mass production has had far-reaching effects. Not only have the production achievements of the pharmaceutical industry made drugs widely available to the patient; they have also made possible the clinical research without which therapeutic progress would be slowed to a standstill.

It was so in the early days of World War II, when the lack of mass production technics limited the clinical testing of penicillin so severely. It is so today in Russia, where a leading scientist has recently complained of the inability of the Soviet pharmaceutical industry to produce such essential drugs as cortisone. "It is necessary," he declared, "to master the production of a series of important chemical compounds, lacking which normal work of bio-chemical laboratories and clinical chemistry is inconceivable." And he mentioned in particular "amino acids, vitamins, synthetic hormones and other biologically-active substances."

a
logical
prescription
for
overweight patients

meprobamate *plus* d-amphetamine

...depresses appetite...elevates mood...eases tensions of dieting...*without* overstimulation, insomnia, or barbiturate hangover.

anorectic-ataractic

BAMADEX®

MEPROBAMATE WITH D-AMPHETAMINE SULFATE LEDERLE

Each coated tablet (pink) contains: meprobamate, 400 mg.; d-amphetamine sulfate, 5 mg.
Dosage: One tablet one-half to one hour before each meal.

Lederle

LEDERLE LABORATORIES
A Division of AMERICAN CYANAMID COMPANY, Pearl River, N.Y.

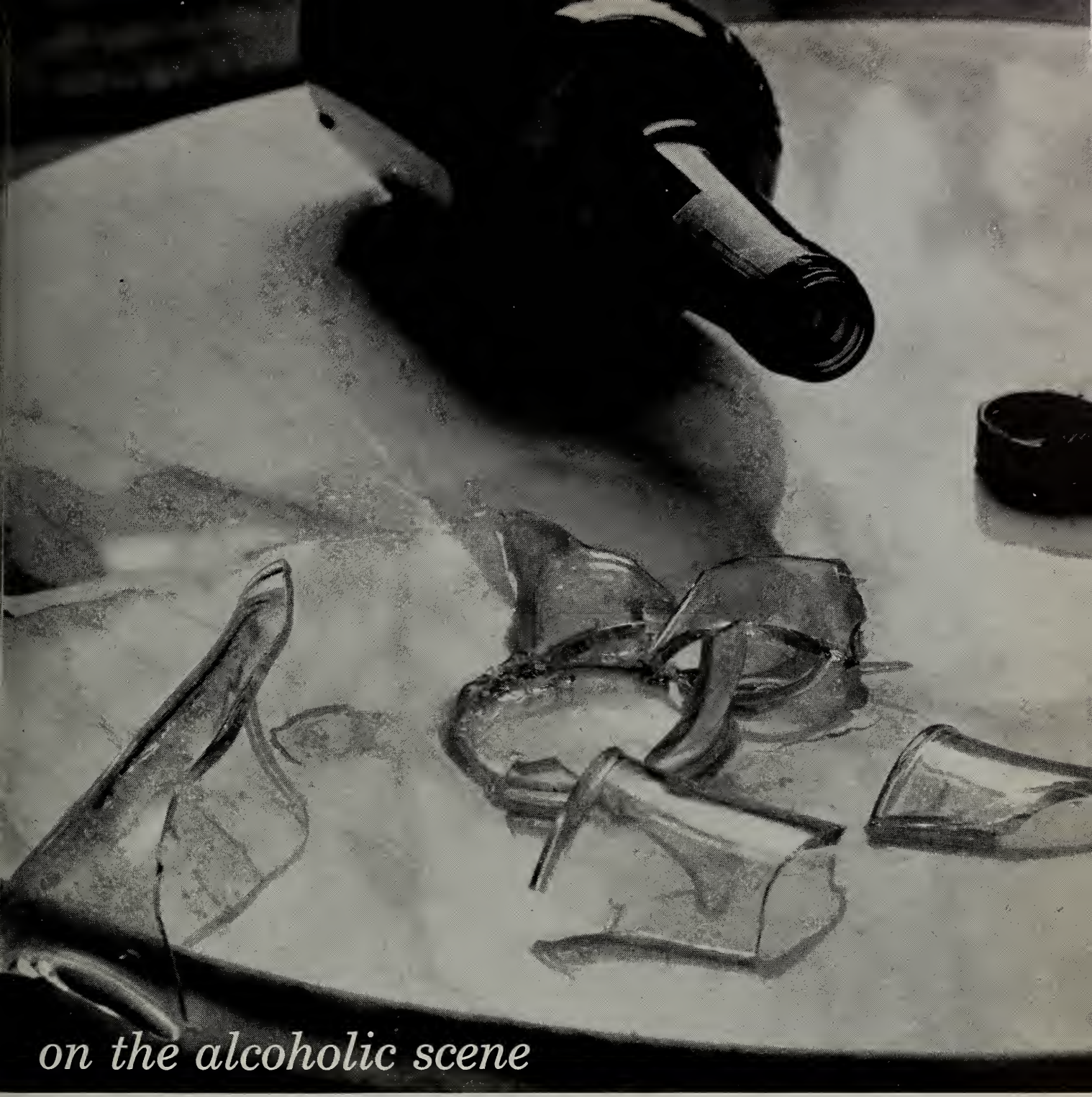
All of these, of course, our own pharmaceutical industry turns out in abundance not only for American medicine, but for the entire free world. It has taken vast amounts of money to build the production plants and research laboratories of this industry. According to the Department of Commerce, drug manufacturers invested more than $181 million in new plants and equipment between 1954 and 1956 alone.

Money Well Spent

It has been money well spent, for this scientific and technological network—equipped as it is with the most modern research tools and scientific manpower—is capable of undertaking prodigious tasks. It is, for example, helping make possible the screening of 40,000 chemicals a year in the search for cancer drugs, and it is playing a major role in the National aCncer Chemotherapy Screening Program.

Although these efforts have produced nothing which strikes cancer cells with the death blows antibiotics deal against pathogens, it is significant that this industry—through Lederle's long-standing cancer research program—produced the first agent to suppress a solid malignant tumor, an achievement announced by Dr. Roy Hertz of the National Cancer Institute.

No one can speak of cancer without mentioning radio-isotopes. This is a good illustration of the way fundamental discoveries unite scientific disciplines that seem miles apart. At first glance there would seem to be no connection between an atomic explosion and the solution of medical problems. But it was the nuclear reactor which gave us radio-isotopes to use, as Pasteur suggested, for the battlefield or for peace and health. It is to this industry's credit that through



Vistaril®

quiets agitation

hydroxyzine pamoate

"... an efficient and convenient means of dealing with the problem of acute agitation in alcoholic intoxication ... important was the absence of noticeable respiratory depression...."

Miller, R. F.: Clin. Rev. 1:10 (July) 1958

Capsules—25, 50, and 100 mg.
Parenteral Solution (as the HCl)— 25 mg. per cc., 10 cc. vials and 2 cc. Steraject® Cartridges; 50 mg. per cc., 2 cc. ampules.

Pfizer Laboratories
Division, Chas. Pfizer & Co., Inc.
Brooklyn 6, New York

Pfizer *Science for the world's well-being™*

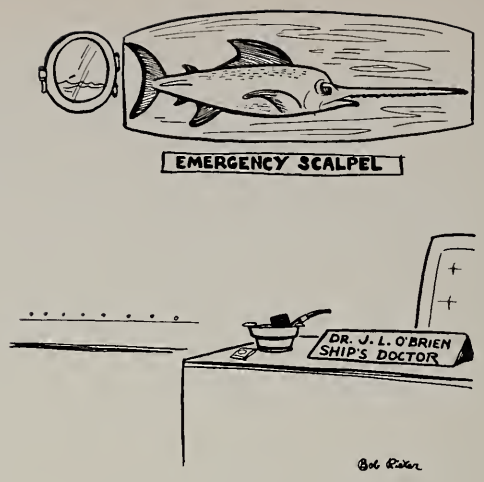
Pharmaceutical Industry

Continued

Abbott's pioneering work, diagnostic and therapeutic isotopes have helped nearly a quarter of a million people.

A Rare Turning Point

Taken together, the achievements of the pharmaceutical industry—its vast and still-growing research effort, its contributions to medical education, to international scientific knowledge and to world health and prosperity—taken together those achievements mark one of those rare turning points of history that influence the course of humanity. For what this industry accomplished in those brief, dramatic years that followed the sulfa drugs and penicillin was ultimately more significant than the so-called "miracle drugs" themselves. The series of events and discoveries packed so tightly into those years changed the timetable of medical advance. It changed the slow and measured "March of Medicine" into a spirited charge against disease. It helped set Medicine on an entirely new road.



In the long sweep of history, the pharmaceutical industry will be applauded not so much for this or that particular drug—precious as they are today—but for helping prove to mankind that knowledge can defeat disease. This is the historic measure of our achievements. This is our deepest and most lasting contribution. ◄



NEWS NOTES—from State and Nation

Help Given Mother Needing Medical Care, Home for Children

(Note: Following is a case report and information on services offered by the Children's Bureau to the Indianapolis Orphan Asylum which may prove valuable to physicians throughout the state with patients needing such services. The Journal staff thanks the bureau for this vital information.)

How many times have you prescribed medication for a patient, knowing that medicine alone could not restore physical and emotional health?

Perhaps there has been a death in the family, mental illness or even desertion of one of the marriage partners. Or maybe a "problem" child, unmarried motherhood or a generally unstable homelife has contributed to the patient's illness.

Sometimes the patient might benefit by referral to a social agency whose trained caseworkers can help alleviate the emotional stress and financial difficulties that compound his health problems.

Such an organization is the Children's Bureau to the Indianapolis Orphan Asylum, 615 N. Alabama. The Children's Bureau, a private, non-sectarian agency, is a member of the United Fund, Health and Welfare Council and the Child Welfare League of America.

Although the bulk of the bureau's work centers around families in Indianapolis and Marion County, its records show hundreds of persons from throughout Indiana and even other states have been served by the agency.

The bureau staff is made up of 14 skilled caseworkers, a pediatrician and a consulting psychologist and psychiatrist. Dr. John Heubi examines and treats all children under the care of the Children's Bureau. Dr. William H. Wood is the staff psychiatrist and Dr. Hazel Stevens is the consulting psychologist.

Many persons have found their way to the bureau offices through a doctor's referral, as well as through the agency's regular newspaper ads, referral of friends, clergy or other social agencies.

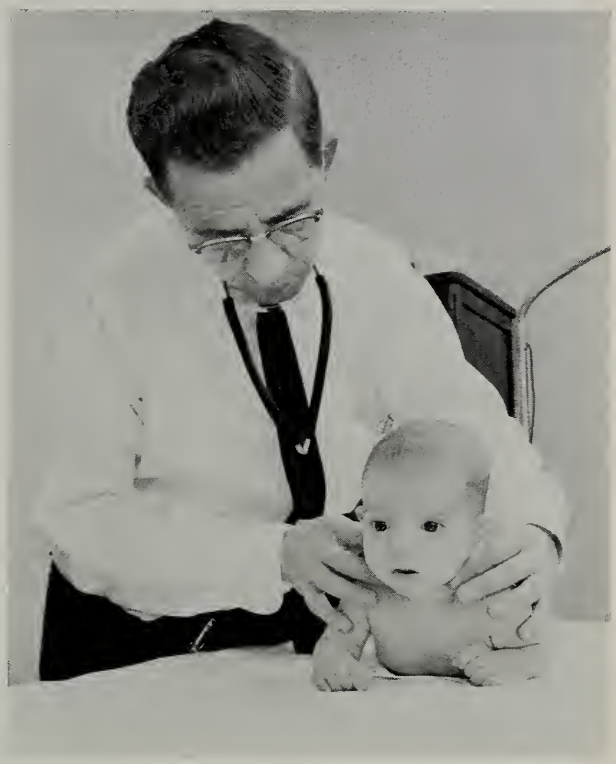


Photo by LARRY GEORGE,
Indianapolis News Photographer

AN INFANT IN NEED
Children's Bureau gives Aid to many

A typical case is that of Janet Forey, a 26-year-old mother of three children expecting her fourth. Janet reluctantly sought a physician's care when frequent fainting spells threatened to cost her job.

The doctor's examination showed that Mrs. Forey was 13 weeks pregnant and was suffering from anemia. Thin, looking older than her years, she seemed harried and depressed. Under the doctor's patient questioning, the story came out . . .

Her husband had deserted her and their three little boys about two months before, when Janet confirmed her pregnancy. An immature young man, Ed Forey had drifted from one job to another, moving from town to town, apartment to apartment during the six years of their marriage. Another child was just more than he could cope with.

Janet was left with a few dollars for food

Help Given Mother

Continued

and rent. She obtained a job as a clerk in a neighborhood laundry for $35 per week, knowing that her pregnancy would cost her even that meager paycheck. She moved to a smaller apartment and agreed to pay the landlady an extra $10 a week to look after her children, ages 2, 3 and 5, while she worked. The youngsters' grandparents lived in a distant state and the Foreys had no friends in the city who could help out financially in her emergency situation.

Soon it became apparent that the landlady was paying little attention to the youngsters and she sometimes "forgot" to give them lunch. The budget allowed Janet little money for food and none for needed clothing for the children. Shortly after her husband left, Janet's worries, meal skipping and general physical changes manifested themselves in dizziness and fainting spells.

While unburdening herself to the doctor, Mrs. Forey admitted that she needed outside help—that she could not afford regular physician's care or the prescribed medication, or for that matter, care for the children properly.



PROTECTION AGAINST LOSS OF INCOME FROM ACCIDENT & SICKNESS AS WELL AS HOSPITAL EXPENSE BENEFITS FOR YOU AND ALL YOUR ELIGIBLE DEPENDENTS

ALL PREMIUMS COME FROM

PHYSICIANS SURGEONS DENTISTS

ALL BENEFITS GO TO

PHYSICIANS CASUALTY & HEALTH ASSOCIATIONS

OMAHA 31, NEBRASKA

Since 1902

Handsome Professional Appointment Book Sent to you FREE upon request.

After hearing her story, the doctor talked with her about the Children's Bureau, its foster boarding home plan for children, casework and physical help for the parents. With her permission he called the bureau office and made an appointment for Mrs. Forey.

Later Janet told the bureau caseworker that she could no longer care for her three youngsters by herself. She felt that she could support herself until the baby was born, then hoped to get a better job and work toward having her family with her again.

The caseworker explained that under the agency's foster home plan, the three children could be placed in a private home on a temporary basis—until their mother was able to care for them again. She told Janet that the normal board rate was $42 per month per child, but explained if Janet could not pay this amount, then she would be held responsible for as large a part of the total as was financially possible. Janet agreed to pay the agency $7 each week and to increase this amount if and when she could.

The Forey children were placed with a middle-aged couple, whose home had been licensed by the State Department of Public Welfare upon the recommendation of the Children's Bureau. Though the children thrived under their new "parents'" diet of love and attention, coupled with the first normal routine they had ever known, they looked forward to their mother's weekly visits and the time when they could return home with her.

In the meantime, the caseworker was able to get Janet admitted to a city hospital under a maternity clinic plan. Mrs. Forey confided that she was uncertain whether or not she could support four children and she talked with the worker about the possibility of releasing her baby for adoption.

The caseworker explained how the Children's Bureau adoption plan works—how the adoptive parents are "matched" with the baby as closely as possible, according to both the natural parents' background and that of the adoptive parents. She explained that all work with both sets of parents was completely confidential and the agency's aim was to secure a happy, normal home for the child which was satisfactory to all parties concerned.

Janet was assured that even if she made up her mind to release the baby, that decision


in every arthritic state
long-term therapy
with maximum relief of pain
without steroids
Buffered
Pabirin®
Tablets
improved salicylate therapy
SMITH DORSEY • a division of The Wander Company • Lincoln, Nebraska

Help Given Mother

Continued

would not be put into writing—a legal release—until after the baby was born. If she decided to keep the baby, but was unable to care for it immediately because of financial or physical reasons, the baby could be placed in a foster boarding home similar to that in which her other children were living. This arrangement would also be on a temporary basis—only until the mother could work out her plan for caring for the children herself.

Perhaps Janet's story has a happy ending. Maybe within the year she was reconciled with her husband, whose increasing acceptance of his responsibilities allowed her to once again assume the role of housewife and mother. Or maybe she was able to obtain a good job and was able to support all four children and to afford reliable care for them while she worked.

Many times the solution is not so simple and it may take longer than a year for the parent to work out a plan agreeable to herself and the agency in taking care of the children. The Bureau's aim is always to return the children to their natural parents whenever possible and the caseworker's interest and help is always directed toward this aim.

Sometimes the mother-to-be is unmarried and goes to the Children's Bureau for physical help, such as doctor's care, food and shelter during her pregnancy, as well as help in making a decision whether or not to release her baby for adoption.

Foster home care, instead of that in a maternity home, is made available for some of these unmarried mothers during their pregnancies. Foster homes are also used for other children who for some reason cannot be cared for in their own homes temporarily—as in the case of problems surrounding death, divorce, severe physical or mental illness. Occasionally emotionally disturbed or mentally incapacitated children who create a problem in their own homes, are placed in foster homes until institutional facilities or special schooling is made available to the child.

The Children's Bureau wants to make its services better known to the community and the state. Doctors knowing persons interested in adopting a child, taking children into their own homes under the foster boarding plan, or who wish help with their family problems, are asked to refer such persons to the Children's Bureau.

COOK COUNTY
GRADUATE SCHOOL OF MEDICINE

INTENSIVE POSTGRADUATE COURSES
STARTING DATES — SPRING, 1960

GENERAL SURGERY

Surgical Technic, Two Weeks, March 21, April 18
Basic Principles in General Surgery, Two Weeks, April 4
Blood Vessel Surgery, One Week, May 9
Surgery of Colon and Rectum, One Week, May 2
General Surgery, One Week, March 7; Two Weeks, May 2
Gallbladder Surgery, Three Days, April 18
Surgery of Hernia, Three Days, April 21
Surgery of Hand, One Week, April 18
Pediatric Surgery, One Week, April 25
Head, Neck and Plastic Surgery, One Week, April 11
Advancements in Surgery, One Week, March 21
Fractures & Traumatic Surgery, Two Weeks, March 21
Proctoscopy & Sigmoidoscopy, One Week, March 28
Femoral Arteriography & Aortography, Four Days, March 29
Numerous other courses will be offered by the Divisions of Internal Medicine, Gynecology, Obstetrics, Urology, Radiology and Dermatology. Circulars available upon request.

TEACHING FACULTY—ATTENDING STAFF OF COOK COUNTY HOSPITAL

Address:
REGISTRAR, 707 South Wood Street, Chicago 12, Illinois

Hoosier Allergists to Participate in Meeting and Courses at Miami

The American College of Allergists will conduct its graduate instructional course from Feb. 28 to March 1 and its annual meeting March 2-4, at the Americana Hotel in Miami Beach. The graduate instructional course is approved by the Academy of General Practice for Category II credit.

Dr. Kenneth L. Craft of Indianapolis will be chairman of one of the afternoon sessions of the course. Dr. Mark H. Mothersill, Indianapolis, will be co-chairman of the first morning session of the annual meeting. Drs. Bennett Kraft and James C. Armstrong, Indianapolis, will present a scientific paper on "Studies of a New Bronchodilator Analog of Ephedrine, Isoprophenamine Hydrochloride in Children."

Inquiries should be directed to Dr. John D. Gillaspie, 2049 Broadway, Boulder, Colorado.

Lung Cancer Risk Can be Reduced By Elimination of Smoking: Burney

"Unless the use of tobacco can be made safe, the individual's risk of lung cancer can be reduced best by the elimination of smoking," Dr. Leroy E. Burney, Surgeon General of the Public Health Service, concludes in an article appearing in the Nov. 28 issue of the *Journal of the American Medical Association.*

In the article, which is titled "Smoking and Lung Cancer, A Statement of the Public Health Service," the Surgeon General states: "The weight of evidence at present implicates smoking as the principal etiological (causative) factor in the increase of lung cancer."

The statement contains an extensive review of leading studies made in recent years on the relationship between smoking and lung cancer. The studies cited are both in support of and against the hypothesis that smoking is a principal causative factor in the rising death rate from lung cancer in the United States and other parts of the world.

Dr. John D. Porterfield, Acting Surgeon General in Dr. Burney's absence from the country, said that the service, in submitting the article for publication in the *Journal of the American Medical Association* and in releasing it simultaneously to the public, was following an established policy of making fully available to the medical and health professions all the facts on the smoking and lung cancer question as rapidly as they are developed.

Secretary of Health, Education, and Welfare Arthur S. Flemming said: "I heartily endorsed this policy and commended the service for assembling the data and making public its own conclusions. Both physicians and the public should welcome the views of the Surgeon General and the Public Health Service on the subject."

The service has also concluded, according to the article, that the following statements are supported by present evidence:

1. Cigarette smoking particularly is associated with an increased chance of developing lung cancer.

2. Stopping cigarette smoking even after long exposure is beneficial.

3. No method of treating tobacco or filtering the smoke has been demonstrated to be effective in materially reducing or eliminating the hazard of lung cancer.

4. The non-smoker has a lower incidence of lung cancer than the smoker in all controlled studies, whether in rural areas, urban regions, industrial occupations or by sex.

5. Individuals who have never smoked at all (cigarettes, cigars or pipe) have the best chance of escaping lung cancer.

The article presents the criticisms leveled at the proponents of the smoking and lung cancer relationship by dissenting scientists. A number of investigators, the article points out, have suggested that "increased volumes of automobile exhaust fumes and industrial vapors polluting the air are to a great part responsible for the causation of lung cancer. The possibility that there are other factors yet unknown also has been suggested."

"Since carcinoma of the lung is also a disease

Tomato Red Face



MANY A CHUCKLE was heard 'round Dallas during the AMA Clinical meeting—all at the expense of ISMA Executive Secretary Jim Waggener! Jim, it seems, went in search of something to give away that was typical Indiana. He came up with tomatoes (Indiana grows more than any other state, 'tis said), in form of tomato juice; contracted with Stokely for a shipment of Indiana tomato juice. But visitors found themselves sipping on CALIFORNIA juice! According to Stokley, Indiana tomatoes really were used, being sent to the coast for processing. But the California labels stayed! Here Drs. Earl Mericle and Guy Owsley, ISMA president and president-elect, prepare to see if the juice really comes from good old Hoosier tomatoes. (Anyone for a case of tomato juice?)

Lung Cancer

Continued

of non-smokers," the statement says, "it is evident that factors other than tobacco contribute to its etiology."

The Surgeon General points out that studies of smoking habits "have not accounted adequately for the variation in death rates between men and women."

The service, Dr. Porterfield said, is distributing reprints of the article to members of the medical and public health professions.

The bibliography which accompanies the article consists of 81 citations and includes reference to the work of researh scientists both in the United States and abroad.

If the mayhem of our highways gets any worse, a nuclear war would be sheer anticlimax.—*D. O. Flynn, Quote.*

A college boy sent a telegram home saying, "Mom! Have failed everything—prepare Pop."

The reply came the next day, "Pop prepared—prepare yourself."—*School Activities.*

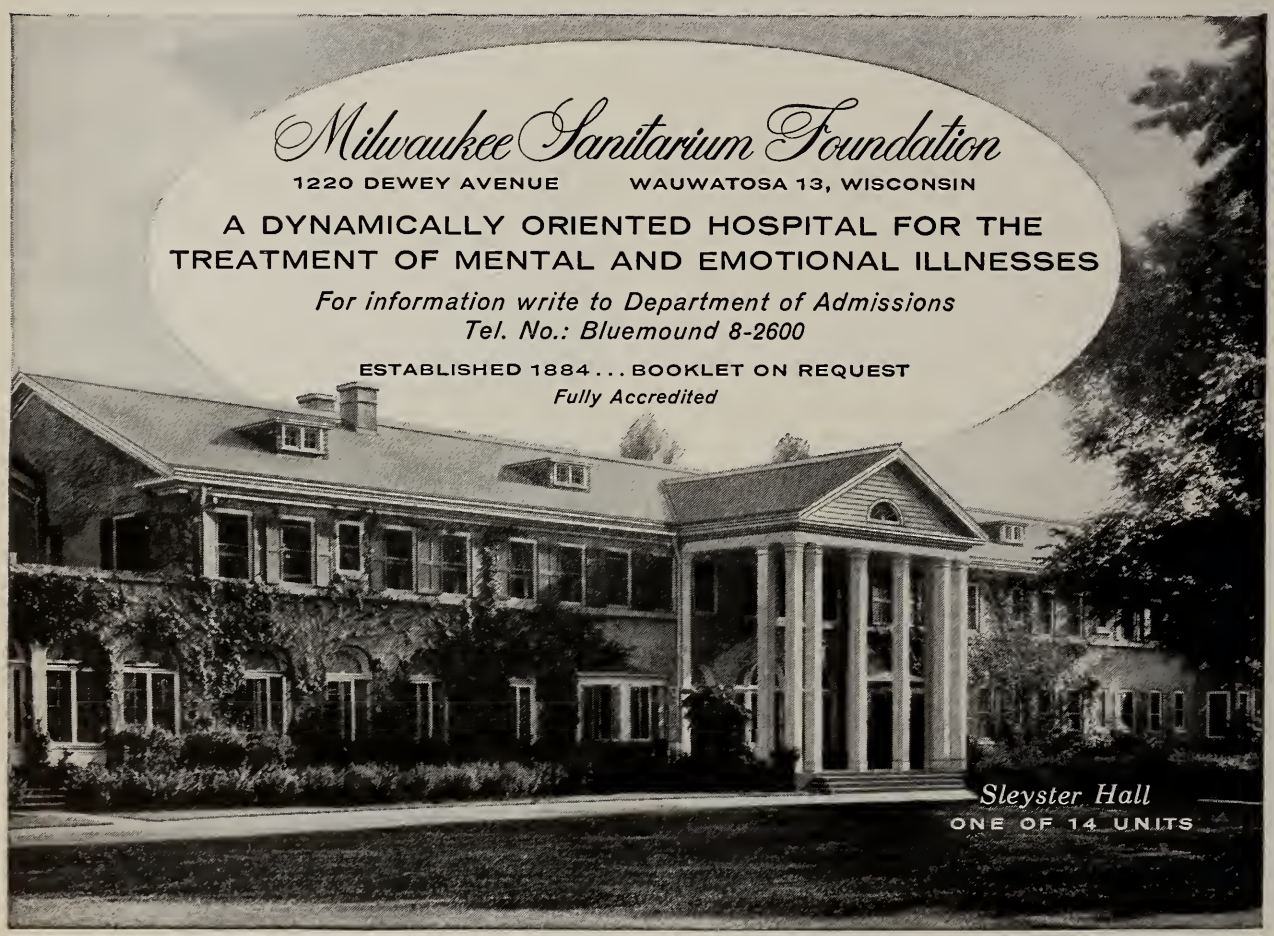
GP 12th Annual Scientific Assembly March 21 to 24 in Philadelphia

The American Academy of General Practice will hold its 12th Annual Scientific Assembly, March 21 to 24, in Philadelphia. A registration of 4,000 members and 3,000 guests is expected. The scientific program will feature recent progress in medicine and surgery.

Thirty-one prominent medical educators will present papers, many of which will be integrated with some of the 100 scientific exhibits. The Congress of Delegates will meet prior to the scientific session.

Pan American Women's Alliance Schedules Congress in Puerto Rico

The Pan American Medical Women's Alliance will hold its Seventh Congress in San Juan, Puerto Rico, June 3-8, 1960, at the Condado Hotel. Any member of the Alliance is invited to present a scientific paper at this meeting. The program chairman is Dr. Cornelia Carithers of Jacksonville, Fla. The meeting will adjourn in time to allow participants to reach Miami for the specialty meetings preceding the AMA meeting.





no irritating crystals[1] · uniform concentration in each drop[2]

STERILE OPHTHALMIC SOLUTION

NEO-HYDELTRASOL®

PREDNISOLONE 21-PHOSPHATE-NEOMYCIN SULFATE

2,000 TIMES MORE SOLUBLE THAN PREDNISOLONE OR HYDROCORTISONE

"The solution of prednisolone has the advantage over the suspension in that no crystalline residue is left in the patient's cul-de-sac or in his lashes . . . . The other advantage is that the patient does not have to shake the drops and is therefore sure of receiving a consistent dosage in each drop."[2]

1. Lippmann, O.: Arch. Ophth. **57**:339, March 1957.
2. Gordon, D.M.: Am. J. Ophth. **46**:740, November 1958.

supplied: 0.5% Sterile Ophthalmic Solution NEO-HYDELTRASOL (with neomycin sulfate) and 0.5% Sterile Ophthalmic Solution HYDELTRASOL®. In 5 cc. and 2.5 cc. dropper vials. Also available as 0.25% Ophthalmic Ointment NEO-HYDELTRASOL (with neomycin sulfate) and 0.25% Ophthalmic Ointment HYDELTRASOL. In 3.5 Gm. tubes.

HYDELTRASOL and NEO-HYDELTRASOL are trademarks of Merck & Co., Inc.

MSD MERCK SHARP & DOHME Division of Merck & Co., Inc., Philadelphia 1, Pa.

Editors and Publishers to Meet April 22 for Second Annual Safety Seminar

Reporters, mayors and state traffic authorities will be invited to participate in the second annual safety seminar for Indiana editors and publishers to be held April 22, 1960, in Indianapolis.

C. Walter McCarty, editor of the *Indianapolis News* and chairman of the seminar's newspaper sponsoring committee, said that the group's name would be "Newspapermen's Safety Seminar."

Subjects to be discussed at the seminar by eminent traffic authorities will be determined by the newspaper sponsoring committee in three premilinary meetings. The first meeting will be held in the northern portion of the state in January; the second in central Indiana in February, and the third in the southern part of the state in March.

Arrangements for the meetings and the advance seminar planning are being made for the sponsoring committee by the six automobile clubs in Indiana—the Chicago Motor Club, the Hoosier Motor Club, the Lafayette Automobile Club, the Terre Haute Auto Club, the Automobile Club of Southern Indiana and the Indiana division of the Cincinnati Automobile Club.

The site for each preliminary meeting will be announced a few weeks in advance.

Some Swiss Watches Radioactive; Manufacturer, AEC Warn Owners

The Atomic Energy Commission and the American Rolex Watch Corporation of New York City are taking immediate steps to recover a number of Rolex GMT-Master wrist watches manufactured by the Swiss firm Montres Rolex, S. A., Geneva, Switzerland.

Some of this special type of watch have been found to contain amounts of radioactive strontium-90 in the movable rim, sufficient to produce radiation in excess of the recommended tolerable amount. Not all examples of this type of watch are so affected. No other watch manufactured by this company has been found to contain strontium-90.

The affected watches may have been purchased in this country or abroad. All GMT-Master wrist watches should be sent to the American Rolex Watch Corporation, 580 Fifth Ave., New York 36, by registered mail. The company will repair the watch and return it to the owner.

Dr. North to Become Director, American College of Surgeons

Dr. John Paul North, Dallas, Texas, will become the Director of the American College of Surgeons, effective January 31, 1961, it was announced recently by Dr. I. S. Ravdin, chairman, Board of Regents, American College of Surgeons. He will succeed Dr. Paul R. Hawley, the College's Director since March, 1950.

Dr. North has been Chief, Surgical Service, Veterans Hospital, Dallas, since 1955, and professor of clinical surgery at Southwestern Medical School of the University of Texas since 1946. He was in the private practice of general surgery in Philadelphia, 1932-42, at which time he held an appointment at the University of Pennsylvania as instructor and associate in surgery. He has been a Fellow of the College since 1935, and a member of the Board of Governors since 1954.

Recent Hill-Burton Grants for Indiana Include Approval of Gibson General Project

Hill-Burton grants for Indiana as of Oct. 31 include 64 projects at a cost of $68,677,607, with federal contributions of $22,587,703, and supplying 3,012 additional beds.

Projects under construction at that date number 23 at a total cost of $23,749,622, including a $6,127,970 federal contribution, and designed to supply 871 additional beds.

The Department of Health, Education and Welfare also reports that during November a project at Gibson General Hospital, Princeton, was approved at an estimated cost of $2,173,625, with a $716,875 federal share, to supply 80 additional beds.

There were 54 projects completed and in operation as of Nov. 30, at a total cost of $62,838,062, including a federal contribution of $21,488,567, and supplying 3,012 additional beds.

At the same time, 13 projects were under construction at a total cost of $19,465,710, including a $5,110,063 federal contribution, and supplying 871 additional beds.

Drs. Harry Pandolfo and Arvine Popplewell, Indianapolis, were among eight Indianapolis southside residents who received plaques commemorating their "outstanding service and achievement" from Greater Southside, Inc.








IF THE HAT FITS, WEAR IT!—Hoosiers at the Dallas AMA clinical meeting in December try on for size Dr. Wendell Stover's 10-gallon hat, the official "badge" of the Sergeant-at-Arms of the House of Delegates. Upper left is Dr. Earl Mericle, ISMA president; upper right, Dr. Charles Alvey and Dr. and Mrs. Cleon Nafe. Middle row left is Dr. E. S. Jones; right, the breakfast meeting of the Indiana delegation and officers. At lower left, members of the Indiana Auxiliary chat with Mrs. Ethel Gastineau of Indianapolis, national president, and other national officers; lower right is Dr. Francis Land, Fort Wayne.

AEC Issues Reactor Permit to Walter Reed Institute

The Atomic Energy Commission has announced that it intends to issue a permit to the Walter Reed Army Institute of Research for construction of a research reactor. The reactor, which will be used for experiments in the field of biophysics and for the production of radioisotopes, will be housed in an addition to the Army Medical Services Graduate School in Washington.

a
logical
adjunct
to the
weight-reducing regimen

meprobamate *plus* d-amphetamine

...reduces appetite...elevates mood...eases tensions of dieting...*without* overstimulation, insomnia, or barbiturate hangover.

anorectic-ataractic

BAMADEX®

MEPROBAMATE WITH D-AMPHETAMINE SULFATE LEDERLE

Each coated tablet (pink) contains:
meprobamate, 400 mg.; d-amphetamine sulfate, 5 mg.
Dosage: One tablet one-half to one hour before each meal.

Lederle

LEDERLE LABORATORIES
A Division of AMERICAN CYANAMID COMPANY, Pearl River, N.Y.

Gill Hospital Congress April 4 to 9

The Gill Memorial Eye, Ear and Throat Hospital of Roanoke, Va. announces its 33rd Annual Spring Congress in Ophthalmology and Otolaryngology April 4-9, 1960. Further information may be obtained by addressing the Superintendent, P. O. Box 1789, Roanoke.

Dr. Leon Blum, Terre Haute, was installed as president of the Indiana Association of Pathologists at a Dec. 13 business meeting. Other officers for 1960 are Drs. John Stepleton, Richmond, president-elect; Anthony Pizzo, Bloomington, board member; Lester Hoyt, Indianapolis, re-elected secretary-treasurer and councilor; and David Adler, Columbus, assemblyman.

Dr. Arba L. Woods, who has practiced in Poseyville for 49 years, has announced that he will retire from active practice soon. Dr. Woods was named to ISMA's 50-Year Club at the 1959 Annual Convention.

Dr. Alfred S. Jaeger, who has served as president of the Indianapolis Social Hygiene Association for the past three years, was named honorary president of that group at an annual election in December.

At a dinner, a rabbi was seated next to a pompous woman. "One of my ancestors," boasted the lady, "signed the Declaration of Independence."

"Is that so?" asked the rabbi. "One of mine wrote the Ten Commandments."—*Mrs. M. V. Franz, Together.*



MARY POGUE SCHOOL, INC.

Founded 1903. Complete facilities for training retarded and epileptic children educationally and socially. Pupils per teacher strictly limited. Excellent educational, physical and occupational therapy programs.

Varied group activities under competent direction on our spacious grounds of 28 acres. Selected movies.

Separate buildings for boys and girls, each with round-the-clock supervision of skilled personnel.

Total enrollment 90.

G. H. Marquardt, M.D. *Medical Director*
Barclay J. MacGregor, B.S. *Registrar*

21 Geneva Road, Wheaton, Ill.
(near Chicago)

Add 1

Presenting a Review of an Article On Medicine By a Patient Whose Friends Are Patients, Too!

by corki

(I have a strong impulse to footnote this column with the commercially used notation "not to be construed as necessarily the opinions of this station" etc. For 'tis true. Me, not ISMA, on the soapbox! And my views are not necessarily those of ISMA. Corki.)



By a Patient

Reams of paper have been filled, particularly by laymen, about present-day medical practice, high fees, high hospital costs, too many clinical specialists and not enuf of the "old GP" who had visible compassion and treated the whole patient out of his little black bag.

Foremost of these writers are representatives of the special interest groups such as backers of free medical care under extended Social Security (more often referred to as the Forand Bill), various groups of the aged, and politicians who see this (as usual in an election year) as an easy ticket to office by appealing to a public compassionate toward problems of our elderly citizens—yet entirely unaware of the phenomenal costs involved, the economics, the potential loss of freedoms and individual initiative derived from such freedoms.

And, unfortunately, all too many professional writers for slick mags seem to go into the story with a preconceived idea and ignore any facts which might challenge that idea.

Therefore, it was a pleasure to see in January *Redbook* an article on the subject by Richard Carter, who tries to present BOTH sides, the patient's and the physician's. And since it was written by a layman, isn't it fitting for a layman to review it?

Doesn't Pull Punches

Mr. Carter doesn't pull any punches. He points out the dark and out-of-focus spots in today's medical picture, but he also points his word reflections toward the psysician's side.

He states, in the beginning, that cost of medical care has been soaring twice as fast as general cost of living during the last 10 years, and he tells of a research study some years back which found that more than 7 million families were in debt because of medical expenses, etc., etc., etc.

I groaned at this point in the reading, thinking, "Oh, no! Not another of those lopsided reports!" My mind went over figures published in a *Journal* editorial on rising costs last May showing the above quite an erroneous interpretation of statistics. It snagged on the thought of how many more than 7 million families buy, say, American autos at a minimum of around $2,000, paying on them for years without hesitation or gripe.

(But when their health is involved, they seem to expect their lives saved for pennies.)

If the Shoe Fits

However, as I read on, I breathed a little easier. Carter tried to be fair. Some few physicians may not agree with me there *if* the shoe fits a little tight where his criticisms of practices followed by some doctors are concerned. However . . .

Although I understand *Life* ran a medical series which many of our members thought quite

fair, this is the first article I personally have read which spells out in no uncertain terms points on the physicians' side as well as gives criticism.

He speaks of the unfairness of comparing medical costs of today with what grandpa might have paid in the face of a life expectancy increased by 25 years, of a patient's potential recovery from diseases which yesterday were fatal, of less hospital time for many illnesses, of modern pharmaceutical research successes, etc.

He also points to a physician's extensive education, particularly in specialty fields, and to the cost of buying, maintaining and replacing office equipment.

In That Little Black Bag

In addition he brings in the extensive "team" of allied fields backing up the licensed physician in dispensing health to the ill. Of course, that old GP could charge relatively little—he carried his "team" around in that little black bag backed with a tremendous use of psychology. Where the Curies and Pasteurs were the unusual then, today there are thousands of medical research scientists carrying out highly expensive programs to give physicians more effective pharmaceuticals and medical knowledge to add to those little black bags.

This is a thumbnail sketch filled in with my own impressions of present problems, please understand. But I also want to include some of those remarks on the red side of the medical ledger.

After discussing prepaid insurance plans, Social Security medical care, etc., Carter points his finger at those physicians who take advantage of insurance plans to "up" their fees where such fee is covered, or partially covered, by insurance.



'Up' their fees.

(This could lead into an involved discussion of the traditional practice of physicians charging according to income and the relative merits of such policy; but please don't let it! This dissertation is only pointing to those who "up" their normal fees for the express purpose of taking advantage of an insurance premium and/or what a patient can pay in addition.)

Let's Face Facts

This policy, and let's face facts—it IS carried out by some—has seriously challenged the prepaid medical insurance systems and is a major weapon in the hands of socialized medicine advocates.

Same goes for overuse of hospital facilities. Granted, some insurance policies are written to actually induce this overuse in that they only pay for certain treatments if the insured has been hospitalized a specified time. This induces a doctor who has regard for his patient's financial problems to admit such patient for treatment which could have been carried out in less time with less cost on an outpatient basis or in a clinic.

However, the practice keeps badly needed hospital beds tied up, raises hospital costs and insurance rates . . . all adding up to a powerfully big headache for the medical profession!

Do As They Please

Carter quotes one of "our foremost medical educators" as saying such abuse (out-of-proportion fees, misuse of hospital facilities) is due in part to a shortage of physicians which allows them to do pretty much as they please, fee-wise.

All of this leads Mr. Carter to one of the latest "answers" to the problem of adequate medical care without pauperizing patients (and, I am almost tempted to say, without letting their autos go back to the finance company, too!). He speaks of group practice.

This is a group or team of physicians in various specialty fields who band together (on their own or thru organization by laymen), offering their combined services for a set, prepaid fee such as Kaiser Foundation and HIP.

However, even these plans have drawbacks, much as they might sound good in theory.

For instance, one study shows that "many HIP enrollees continue to patronize non-HIP doctors and to spend extra money for outside care," according to Carter.

Treated Less Considerately

Most common complaint against some group plans, he says, is that patients sometimes are

treated less considerately than they think they should be. (And if that isn't an argument *against* socialized medicine, I'll eat my proverbial hat!)

There are other reasons reviewed, but I was particularly interested in Mr. Carter's quote from a private physician to the effect that some doctors lose sight of the need for personal warmth in group plans because they are so busy with clinical technics.

And, actually, don't most of the problems of medicine today boil down to this?

Between Physician and Patient

To my way of thinking, the core of the problem still is and always will be THAT PERSONAL RELATIONSHIP BETWEEN PHYSICIAN AND PATIENT!

Our old GP is revered because he "treated the whole patient," as it is stated today. He was friend and counselor. His little black bag may have contained very little in way of "cures," but his whole attitude of interest, understanding and friendliness effected a lot of cures—at least left the patient and/or his family feeling good about treatment received whether it worked or not.

Today all too often a patient goes to a specialist who gives a few clinical tests (which probably show him more in a few minutes than "old GP" ever knew), dispenses a prescription (or sends a report to the patient's GP), ushers said patient out unceremoniously 10 or 15 minutes later and sends a bill for anywhere from $10 to $50.

Feels Horribly Slighted

This patient forgets his cure—he probably already guessed at what was wrong anyhow, and feels he got nothing. He doesn't consider cost of research, equipment, education, etc. He does feel horribly slighted and resents every cent of that bill.

And, if he follows some of those erroneous statements readily available for his consumption, he will be convinced that he could have received twice the treatment for "no cost" with socialized medicine.

However, I feel strongly that this same patient would have been satisfied had the physician looked at him as a person with heart and soul not connected with but still a part of his peptic ulcer.

A Kindly Word

A little time to explain examination, type of illness and treatment, a few added touches in examination whether needed clinically or not, a kindly word, a personal follow-up—all of these would make our patient less resentful of his bill and less gullible to advocates of socialized medicine.



A few added touches.

Now you may say this statement isn't clinical nor is it professional—nor is it meant to be! I'm not a professional in medicine, but *I am a patient,* my friends are patients, and my family and acquaintences, *et al.*

An ill person has psychological problems because he *is* ill. He feels a little sorry for himself—after all, he didn't *ask* to become ill. He's resentful before the physician gets to him.

Treat His Resentment!

If his physician doesn't give him special attention and treat his resentment as well as his illness at the start, then this "chip on his shoulder" will grow and eventually be taken out on the physician—especially when the bill arrives—*and on the medical profession in general.*

So, as a patient, I contend that threat of socialized medicine must first be met in the doctor's office—thru his relationship with patients, and then thru his policies in fee-setting (where insurance is concerned particularly) and his use of hospital facilities.

Then, and only then, can the problem be picked up by leaders in the fields of insurance, government, etc. and be carried on to a fair and successful end of problem.

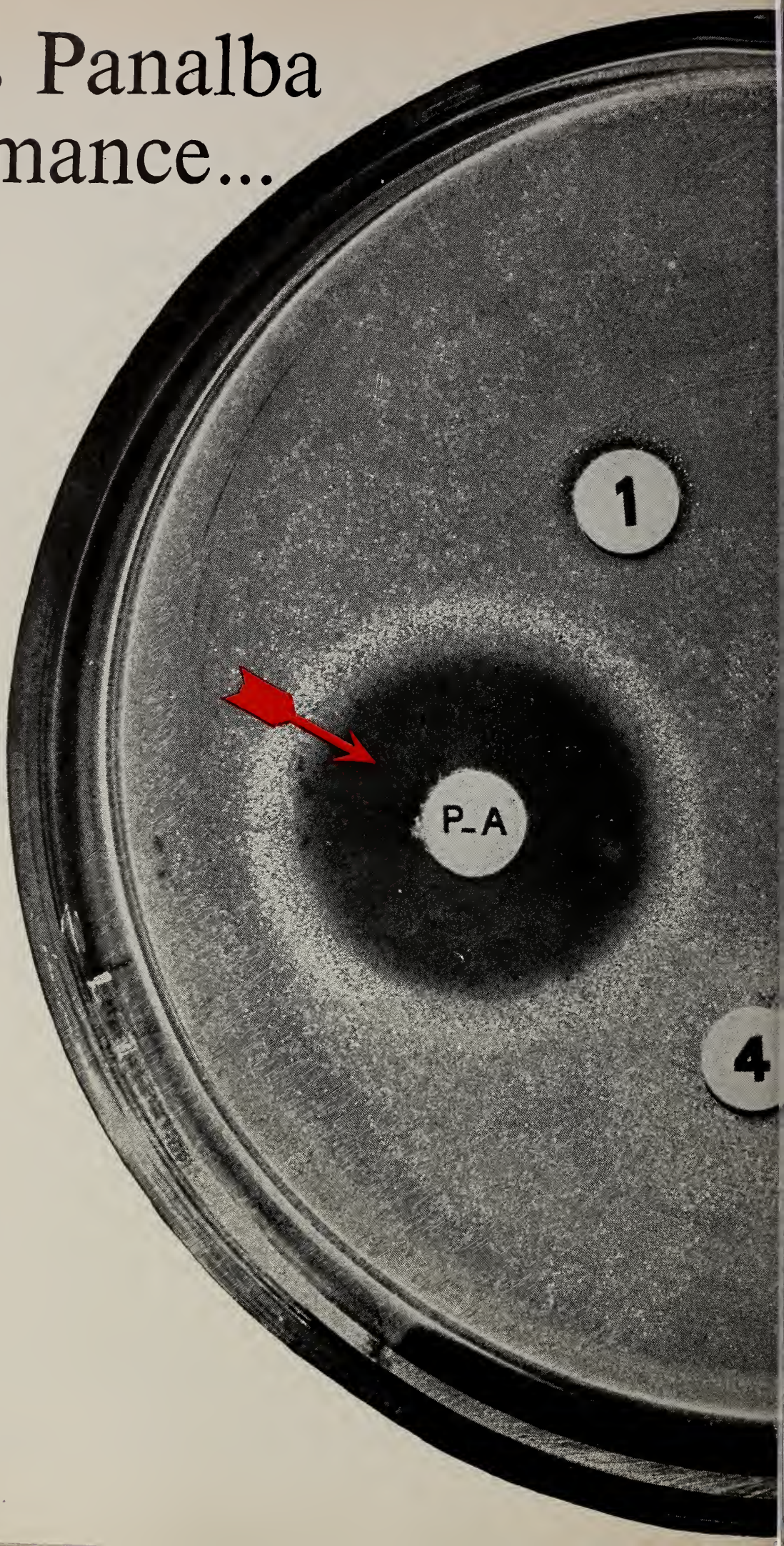
End of report.

End of soapbox.

Maybe end of me!

All you have to do to get the world to beat a path to your door is decide that you want to take a nap.—O. A. *Battista, Quote.*

This is Panalba performance...



A single 5 mg. tablet once a day provides all these advantages[2]

- prolonged action — in excess of 18 hours
- convenient once-a-day dosage
- low daily dosage — more economical for the patient
- no significant alteration in normal electrolyte excretion pattern
- repetitively effective as a diuretic and antihypertensive
- greater potency mg. for mg.—more than 100 times as potent as chlorothiazide
- potency maintained with continued administration
- low toxicity — few side effects — low salt diets not necessary
- comparative studies with chlorothiazide, hydrochlorothiazide, and Naturetin disclose that smallest doses of Naturetin produce greater weight loss per day
- in hypertension, Naturetin, alone or in combination with other antihypertensives, produces significant decreases in mean blood pressure and other favorable clinical effects
- purpura and agranulocytosis not observed
- allergic reactions rarely observed

[2]Reports (1959) to the Squibb Institute for Medical Research.

Naturētin —*Indications:* in control of edema when diuresis is required, in congestive heart failure, in the premenstrual syndrome, nephrosis and nephritis, cirrhosis with ascites, edema induced by drugs (certain steroids); in the management of hypertension, used alone, combined with Raudixin (Squibb Rauwolfia Serpentina Whole Root), or with other antihypertensive drugs, such as ganglionic blocking agents.

Contraindications: none, except in complete renal shutdown.

Precautions: when Naturetin is added to an antihypertensive regimen including hydralazine, veratrum, and/or ganglionic blocking agents, immediate reduction must be made in the dosage for all preparations; the dosage for ganglionic blocking agents must be decreased by 50% to avoid a precipitous drop in blood pressure. This also applies if these hypotensive drugs are added to an established Naturetin regimen . . . in hypochloremic alkalosis with or without hypokalemia . . . in cirrhotic patients or those on digitalis therapy when reductions in serum potassium are noted . . . in diabetic patients or those predisposed to diabetes . . . when increased uric acid concentrations are noted . . . when signs—leg or abdominal cramps, pruritus, paresthesia, rash—suggestive of hypersensitivity, are noted.

Naturētin —*Dosage: in edema,* average dose, 5 mg., once daily, preferably in the morning; to initiate therapy, up to 20 mg., once daily or in divided doses; for maintenance, 2.5 to 5.0 mg., daily in a single dose. *In hypertension:* suggested initial dose, 5 to 20 mg. daily; for maintenance, 2.5 to 15 mg. daily, depending on the individual response of the patient. When Naturetin is added to an antihypertensive regimen with other agents, lower maintenance doses of each drug should be used.

Naturētin —*Supplied:* tablets of 2.5 mg. and 5 mg. (scored).

SQUIBB



Squibb Quality—
the Priceless
Ingredient

Rx
Naturetin 5mg.
Disp. #30
Sig: 1 each
morning.

'RAUDIXIN'® AND 'NATURETIN' ARE SQUIBB TRADEMARKS.

Deaths . . .

Asa W. Brown, M.D.

A Bluffton physician, Dr. Asa W. Brown, died Dec. 8 in his home after a two-year illness.

Named to the ISMA 50-year Club in 1956, Dr. Brown was a graduate of the Indianapolis Medical School, and had practiced in Bluffton since the time of his graduation.

Dr. Brown, a former teacher, was a member of the Church of Christ.

Clayton B. Hathaway, M.D.

A former DeKalb County Medical Society president, Dr. Clayton B. Hathaway, passed away Nov. 30 at his Butler, Ind. home.

Dr. Hathaway, who had also served as secretary of his county society, was a former president and secretary of the North Indiana Academy of Medicine, and had served on the Butler school board and as DeKalb county coroner.

He was a charter member of the Butler Rotary Club, and belonged to the Masonic Lodge and Knights Templar.

Dr. Hathaway was a graduate of Wittenberg College and the Indiana University School of Medicine.

Harley Hiestand, M.D.

Dr. Harley Hiestand, who opened his practice in the Jay County town of Pennville in 1907, died Dec. 23 in his home.

A graduate of the Indiana University School of Medicine in 1906, Dr. Hiestand retired from active practice two years ago. He was a member of Friends church, Masonic lodge, Scottish Rite and Shrine.

Leonard F. Piazza, M.D.

Dr. Leonard F. Piazza, Michigan City, lost his life in an automobile accident which also killed Mrs. Piazza, near Gary, Ind., on Dec. 17.

A graduate of the Indiana University School of Medicine in 1933, Dr. Piazza took his internship at Evansville State Hospital. He was on the staff of St. Anthony and Doctors hospitals in Michigan City.

Milton B. Stewart, M.D.

Dr. Milton B. Stewart, Cass County coroner for 39 years, died Dec. 17 at Memorial Hospital, Logansport, at the age of 86.

He had been coroner longer than any other person in Indiana, having been first elected in 1918, and defeated in only one election.

A graduate of Cleveland Medical School, Dr. Stewart was a member of the Methodist church, Elks, Odd Fellows, Eagles, Moose and Fraternal Order of Police.

Frank C. Walker, M.D.

A 79-year-old retired Indianapolis physician and surgeon, Dr. Frank C. Walker, died Jan. 3 in an Indianapolis hospital.

Dr. Walker was a graduate of DePauw University and the Rush Medical School, class of 1907. He came to Indianapolis after serving his internship in Chicago.

He was a member of the American College of Surgeons, Central Association of Obstetricians and Gynecologists, Nu Sigma Nu, the Masonic Lodge, Scottish Rite and Murat Shrine. During World War I, he spent 18 months overseas with the Lilly Base Hospital No. 32.

The Norbury Sanatorium

Established 1901 — Incorporated
Licensed — Jacksonville, Illinois

FRANK GARM NORBURY, A.M., M.D., Medical Director
HENRY A. DOLLEAR, M.D., Superintendent
FRANK B. NORBURY, M.D., Physician

Operating

Maplecrest—

Restful, congenial homelike surroundings are combined with the most modern diagnostic and therapeutic equipment.

Maplewood—

Most comfortable home for individuals requiring rest, scientific diagnosis and treatment. Fireproof construction.

County News

Adams

Dr. Richard K. Parrish of Decatur has been elected 1960 president of the Adams County Medical Society. Assisting him will be Drs. Joseph Schetgen, secretary-treasurer, and Norman Beaver, vice-president.

Boone

Thirteen members of the Boone County Medical Society met at Lebanon Dec. 1 for a business meeting.

Cass

Members of the Cass County Medical Society met Nov. 2 to hear Dr. Camille Killian Parker speak on "Vision Fields." At their meeting on Dec. 7 the group discussed the Forand Bill.

New officers of the society are Drs. J. Carl Jones, president; Ernest Fogel, vice-president, and Clarence M. Cobb, secretary-treasurer.

Clay

New officers of the Clay County Medical Society, elected at a Dec. 15 business meeting, include Drs. W. C. McCormick, president; Walter C. Bond, vice-president; Robert K. Webster, secretary-treasurer; C. E. Moon, delegate, and Dr. Bond, alternate delegate.

DuBois

Members of the DuBois County Medical Society and their wives met Dec. 10 for a program on the Forand Bill.

Floyd

Dr. John Higgins will serve as 1960 president of the Floyd County Medical Society. Other officers elected at a Dec. 11 meeting include Drs. Irvin Sonne, vice-president; Daniel Cannon, secretary-treasurer; Don LaFollette, delegate; Nelson Wolfe, alternate delegate and Drs. W. F. Edwards, Parvin M. Davis and Kenneth H. Brown, Board of Censors.

Fountain-Warren

Twelve members and several guests of the Fountain-Warren Medical Society met Dec. 3 at Attica for a discussion on problems of the aged.

New officers of the society are Drs. Peter R. Petrich, president; Lowell R. Stephens, vice-president; Edward M. Humphrey, secretary-treasurer; Lee J. Maris and James W. Crain, delegates and Carl A. Nelson and Lowell R. Stephens, alternate delegates.

Hamilton

Seventeen members of the Hamilton County Medical Society met Dec. 8 at Noblesville for a business meeting.

Hancock

Members of the Hancock County Medical Society heard Lloyd Phillips, D.D.S., speak on "Peridental Problems" at their Nov. 23 meeting. Thirty-five doctors attended.

Hendricks

Dr. Walter Able is the new president of the Hendricks County Medical Society. Assisting him will be Drs. James Black, vice-president, and Fred Warbinton, secretary-treasurer.

Henry

Dr. William Saint was elected 1960 president of the Henry County Medical Society at their Nov. 11 meeting. Other new officers are Drs. R. R. McGee, vice-president; W. C. Heilman, Jr., secretary-treasurer; W. S. Robertson, delegate and J. E. Fisher, alternate delegate.

Jackson

New officers of the Jackson County Medical Society include Drs. John W. Ripley, president; Harry R. Baxter, vice-president; Howard E. Rothring, secretary-treasurer; Jack E. Shields, delegate and John W. Ripley, alternate delegate.

Jasper-Newton

Forand Bill Legislation and the Keogh-Simpson Bill were the topics of discussion at the Dec. 9 meeting of the Jasper-Newton Medical Society.

New officers of the society are Dr. Robert W. Greene, president, and Dr. Ralph I. Hartsough, secretary-treasurer.

Jennings

Dr. William A. Johnson is the new president of the Jennings County Medical Society. Other new officers include Dr. Louis Calli, vice-president; Dr. John H. Green, secretary-treasurer; Dr. D. W. Matthews, delegate and Dr. Shaffer B. Berkshire, alternate delegate.

Johnson

Dr. George Tiley is the new president of the Johnson County Medical Society. Assisting him will be Dr. George E. Bullington, secretary.

Knox

At a Dec. 15 meeting in Vincennes, Dr. Walter R. Vaughn was elected president of the Knox County Medical Society. Other new officers include Drs. Charles E. Hendrix, vice-president; Frank Stewart, secretary and Dr. Richard Stein, treasurer.

Kosciusko

Ten members of the Kosciusko County Medical Society met Oct. 20 for a discussion on the Forand Bill.

LaGrange

Members of the LaGrange County Medical Society met Oct. 21 at LaGrange for a discussion on the Forand Bill.

New officers of the society include Drs. C. D. Benedict, president; K. M. Lehman, vice-president and P. E. Yunker, secretary-treasurer.

Laporte

Dr. Milton L. Bankoff is the new president of the Laporte County Medical Society. Other new officers include Drs. Fred S. Carter, vice-president; John B. Cleveland, secretary-treasurer; T. E. Armstrong and J. C. Richter, delegates and G. O. Larson and R. A. Fargher, alternate delegates.

Lawrence

New officers of the Lawrence County Medical Society include Drs. Edgar Bridwell, president; James Oswalt, vice-president; Guy Waldo, secretary-treasurer; Howard Hammel, delegate and William Robinson, alternate delegate.

The group met Dec. 2 for a discussion on the Forand Bill.

Madison

Sixty members of the Madison County Medical Society met at Anderson Oct. 19 for a discussion on the Forand Bill.

Marion

Dr. Myron H. Nourse is the new president-elect of the Marion County Medical Society. Other officers who will serve during 1960 are Drs. Floyd A. Boyer, president; Ray Tharp, vice-president; Jacob E. Gillespie, secretary-treasurer and Bernard D. Rosenak, library committee.

New board of directors members are Drs. John W. Hendricks, Albert M. Donato, Thomas A. Brady, James H. Gosman, Arvine G. Popplewell, Lowell I. Thomas and Basil Fausset.

Noble

A discussion of the duties of county society officers was the program of the Dec. 18 meeting of the Noble County Medical Society. Thirteen members attended.

New society officers include Drs. James A. Chase, president; Dale Mattmiller, vice-president; Frank W. Messer, secretary-treasurer; Q. F. Stultz, delegate, and Robert Bryan, alternate delegate.

Orange

New officers of the Orange County Medical Society elected at a Dec. 22 meeting are Drs. Ivan A. Clark, president; B. E. Sugarman, vice-president and alternate delegate and C. X. McCalla III, secretary-treasurer and delegate.

Owen-Monroe

"Planning of Future Hospital Facilities for Bloomington" was the topic of Mr. Douglas Kincaid Jr.'s talk at the Dec. 17 meeting of the Owen-Monroe Medical Society. Thirty-seven members attended.

Parke-Vermillion

"Carcinoma of the Lung" was the topic of Dr. George McAleese's scientific talk at the Dec. 16 meeting of the Parke-Vermillion Medical Society at Clinton. Thirteen members were present.

Perry

Dr. David A. Dukes spoke on the "Battle of Shiloh" at the Dec. 1 meeting of the Perry County Medical Society.

New society officers are Drs. E. R. Snyder, president; Hargis R. Bush, vice-president; Noel L. Neifort, secretary-treasurer and delegate and J. M. James, alternate delegate.

Pike

Serving as president of the Pike County Medical Society in 1960 will be Dr. Milton H. Omstead.

Pulaski

New officers of the Pulaski County Medical Society elected at a Dec. 8 meeting are Drs. H. J. Hallick, president, and E. L. Hellenberg, secretary-treasurer.

Rush

Dr. Marvin G. Norris is the new president of the Rush County Medical Society. Other new officers include Drs. Harry G. McKee, vice-president; Charles E. Sheets, secretary-treasurer and Frank Green, delegate.

Shelby

Dr. R. W. Gehres is the 1960 president of the Shelby County Medical Society. Other new officers include Drs. R. M. Nigh, vice-president and Wilson Dalton, secretary.

Starke

The 1960 president of the Starke County Medical Society is Dr. Clark McClure. Assisting him will be Drs. Guy B. Ingwell, vice-president and delegate; Earl R. Leinback, secretary-treasurer and J. R. Matthew, alternate delegate.

Tipton

Dr. George L. Compton has been elected president of the Tipton County Medical Society. Other new officers are Drs. M. B. Gossard, vice-president; W. A. Kurtz, secretary-treasurer; A. E. Stouder and M. B. Gossard, delegates and Drs. Compton and Kurtz, alternate delegates.

OVER 80 YEARS' SPECIALIZED EXPERIENCE IN THE RESTORATIVE TREATMENT OF

"THE PROBLEM DRINKER"

At The Keeley Institute your patients are assured of receiving:

- the most modern, coordinated, comprehensive, rehabilitative regimen
- in addition to medical, nutritional and physiotherapeutic treatment, we also offer psychiatric diagnosis and psychotherapy
- full cooperation throughout with the referring physician
- in addition to the care of the alcoholic we also treat narcotic and drug addiction
- surprisingly low cost—to cover all medical care, medicines, laboratory work, room and excellent cuisine

You can obtain more detailed information by writing us direct.

WE WELCOME YOUR REFERRALS...

THE KEELEY INSTITUTE
DWIGHT, ILLINOIS

Member American Hospital Association, Member Illinois Hospital Association. Licensed by the Department of Public Health, State of Illinois.

Vanderburgh

Dr. Herman Baker spoke on "Historic Changes Affecting Medical Care" at the Dec. 8 meeting of the Vanderburgh County Medical Society. Fifty members attended.

Dr. Henry Faul has been named to the newly-created office of vice-president and chairman of the program committee for the society.

Vigo

Dr. James O. Conklin has been elected president of the Vigo County Medical Society. Assisting him during 1960 will be Drs. Don R. Gossom, vice-president; Hubert T. Goodman, secretary-treasurer; Norman Silverman and Stuart R. Combs, delegates and James B. White and A. W. Cavins, alternate delegates.

Wayne-Union

J. Brandon Griffis, Sr., attorney, spoke on "Socio-medical and Legal Problems of Artificial Insemination" at the Dec. 8 meeting of the Wayne-Union Medical Society.

New society officers include Drs. Harold D. Hill, president; Morris Snyder, president-elect; Morris D. Wertenberger, secretary; Frank Hagie, treasurer; Russell Malcolm, Ralph Dreyer, Elwood Meredith and F. B. Warrick, executive committee; Glen Ward Lee and Frank Lewis, delegates; Tom Shields and G. H. Clarkson, alternate delegates, and James Guthrie, Byron Park and Olin Wiland, Board of Censors.

Warrick

Nine members of the Warrick County Medical Society met Dec. 10 to discuss the Forand Bill and elect officers.

Dr. Arthur Rogers, elected president of the society, will have as his assisting officers Drs. Bowen Hoover, vice-president; Robert Terry, secretary-treasurer; Wendell Stover, delegate, and Dan Woodson, alternate delegate.

Washington

Dr. M. M. McDowell spoke on "Medical Emergencies" at the Nov. 10 meeting of the Washington County Medical Society. Nurses from the Washington County Hospital were special guests.

Whitley

Drs. Thomas Hamilton and Jerome Wait spoke on "Coronary Artery Disease" at the Dec. 8 meeting of the Whitley County Medical Society. Thirteen members attended.

Association News

THE EXECUTIVE COMMITTEE

Dec. 16, 1959

Meeting called to order at 4:30 p.m.

Roll call showed the following present: Don E. Wood, M.D., chairman; Wendell E. Covalt, M.D.; Earl W. Mericle, M.D.; Guy A. Owsley, M.D.; Maurice E. Glock, M.D.; Okla W. Sicks, M.D.

Frank B. Ramsey, M.D., editor of *The Journal;* Robert Hollowell and Ralph Hamill, attorneys, and James A. Waggener, executive secretary.

Guest: Mr. Reuben Dalbec, American Medical Association.

Minutes of the meeting held Nov. 11, 1959 were approved on motion of Drs. Covalt and Mericle.

Membership Report

Number of members as of November 30, 1958		4,178
1959 members as of November 30, 1959:		
Full dues paying	3,558*	
Interns	39	
Residents	174	
Council remitted	39	
Senior	396	
Military	43	
Honorary	1	
Total 1959 members as of November 30, 1959		4,250
Gain over last year		72
Number of members December 31, 1958		4,201
Delinquent members as of November 30, 1959		6
Number of AMA members as of November 30, 1958		4,038
1959 AMA members: Dues paying	3,382	
Exempt, but active	733	
Total 1959 AMA members as of November 30, 1959		4,115
Gain over last year		77
Number of AMA members as of December 31, 1958		4,052
Delinquent AMA members as of November 30, 1959		13
(The above paid 1958 AMA dues but not 1959)		
Number who have paid state dues but not AMA dues in 1959		122
		135

* Includes 8 *new* members at $30.00.

Headquarters Office

The secretary reported the fact that the field men had been busy since the last meeting of the Executive Committee concentrating all their efforts in discussing the Forand Bill before county medical societies and hospital staffs.

The secretary presented a quotation on personal property insurance and upon motion of Drs. Mericle and Covalt the secretary is to purchase necesary insurance after a recommendation as to types and amount is supplied by Mr. Hollowell, the attorney.

Treasurer's Office

The treasurer reported on the investment transactions handled by him since the last meeting of the Executive Committee and also supplied each member of the committee with a copy of the auditor's report for the first nine months of 1959.

Legislative Matters

National

Dr. Wood informed the members of the committee of the meeting held immediately prior to the meeting of the Executive Committee with his Commission on Legislation. He briefed them on the plans of the commission to carry on a campaign against the Forand Bill, and told of the commission's plans to hold a dinner meeting the evening of January 11, at which time it is intended that Dr. Louis M. Orr, president of the American Medical Association, will address the business leaders in the state of Indiana.

Dr. Wood also informed the committee that the Commission on Legislation had discussed the request of Judge Luther M. Swygert of the United States Federal Court for the establishment of a panel of expert witnesses by the medical association for use by the federal judges, and that Dr. Otis Bowen, a member of the commission, would appear before the Council for discussion of this proposal. The secretary was instructed to make copies of the materials concerning this proposal for distribution to members of the Council.

1960 Annual Convention

Oct. 2-5, 1960, French Lick

Discussion of the 1960 and 1961 annual conventions was deferred until the time of the meeting with the Convention Arrangements Committee and the heads of the specialty organizations.

Organization Matters

Medicare contract. The secretary presented a supplemental agreement modifying the Medicare contract for the period of Jan. 1 to March 31, 1960, having the effect of restoring much of the program which was discontinued in October, 1958. The supplemental agreement was approved for signature by the president and secretary, subject to approval by the attorney, upon motion of Drs. Glock and Covalt.

"Dollars for Dooley." A letter was read from the Maricopa County Medical Society, Phoenix, urging the doctors to establish a "Dollars for Dooley" campaign in Indiana. Upon motion of Drs. Owsley and Covalt the president was requested to write an article for the News Letter upon this subject.

A request for a contribution of $25.00 to the Indiana Farm City Committee was presented and the contribution was approved on motion of Drs. Glock and Owsley.

A letter was read from Carl J. Rudolph, M.D., South Bend, complimenting the association on its stand and a resolution asking the Joint Commission on Accreditation to attempt to reduce the doctor's paper work.

A letter regarding a delegate to the United States Pharmacopeial Convention was read and by consent it was agreed that no delegate will be sent.

The minutes of the interim meeting of the Executive Committee of the North Central District Blood Bank Clearing House were read. The secretary informed the committee that the Clearing House had repaid the $1,000.00 loan.

A letter from Dr. Robert K. Webster regarding the Anderson polio immunization situation was read for the information of the committee.

New Business

The president and the secretary discussed the welfare situation of Lake County and a letter from Dr. Harry K. Stimson on this subject was read. Upon motion of Drs. Owsley and Covalt the president was authorized to attempt to arrange a meeting between the state and county welfare directors on this matter.

The Journal

Dr. Ramsey discussed the fact that the director of the Mental Health Division of the State of Indiana had talked with him about the possibility of using the association mailing list for the purpose of sending a questionnaire to all of the members of the association to obtain their suggestions and interest in a postgraduate program on mental health, to be held at the Indiana University School of Medicine. It was suggested that the University had such a mailing list and perhaps this list could be used.

Future Meetings

Sixth Regional Meeting of Committee on Disaster Medical Care of the AMA Council on National Defense, Drake Hotel, Chicago, Saturday, Jan. 23, 1960. Upon motion of Drs. Owsley and Mericle the secretary and the chairman of the sub-committee on Civil Defense were authorized to attend.

By consent it was agreed that the president should attend the annual Blue Shield Professional Relations Conference at the Drake Hotel in Chicago, February 1-3, 1960.

Medico-legal Conference, Drake Hotel, Chicago, May 20-21, 1960. Upon motion of Drs. Mericle and Covalt, the attorneys and the secretary are to attend.

The committee then adjourned to meet with the Commission on Convention Arrangements, representatives of the specialty organizations, and section chairmen.

Roll call showed the following present:

Executive Committee: Don E. Wood, M.D., chairman; Wendell E. Covalt, M.D.; Earl W. Mericle, M.D.; Guy A. Owsley, M.D.; Maurice E. Glock, M.D.; Okla W. Sicks, M.D.

Robert Hollowell and Ralph Hamill, attorneys; Frank B. Ramsey, M.D., editor of the *Journal;* James A. Waggener, executive secretary.

Commission on Convention Arrangements: Jack G. Weinbaum, M.D.; Jesse C. Benz, M.D.; James M. Leffel, M.D.; Robert Harris, M.D.; Max Long, M.D.

Section Chairmen: Section on Surgery, Ted L. Grisell, M.D.; Section on Medicine, V. Brown Scott, M.D.; Section on Anesthesiology, Paul Littlefield, M.D.; Section on Obstetrics and Gynecology, Mahlon F. Miller, M.D.; Section on Radiology, John R. Lionberger.

Specialty Organizations: Indiana Academy of General Practice, Harry Pandolfo, M.D.; Indiana Neuropsychiatric Association, Clifford L. Williams, M.D.; Indiana Association of Pathologists, Lester H. Hoyt, M.D.; Indiana Chapter of American Academy of Pediatrics, William M. Browning, M.D.; Indiana Division of International College of Surgeons, Harry S. Rabb, M.D.; Indiana Trudeau Society, Donald F. MacLeod, M.D., and John Miller, M.D.; Indiana Society of Internal Medicine, E. Paul Tischer, M.D.; Indiana Chapter, College of Surgeons, Harold Trusler, M.D.; Indiana Society of Ophthalmology and Otolaryngology, John J. Flick, M.D.

Dr. Mericle reviewed the purpose of the meeting, pointing out that he felt there was danger facing medicine and the dilution of the parent organization by the specialty groups holding their meetings at times other than at the time of the state medical association meeting. He pointed out he felt the time was here for medicine to regroup and to go back to its original philosophy that all were physicians first, and he suggested that the group consider the feasibility of holding their 1961 annual meetings in conjunction with the Indiana State Medical Association annual meeting. He proposed that the association supply speakers on a fifty-fifty cost basis. This was discussed also by Dr. Owsley, president-elect.

The specialty groups also were offered the use of the new headquarters office building of the Indiana State Medical Association and the use of the association clerical staff to assist them in their work. The general consensus of opinion appeared to be that this was a most worthwhile suggestion and the representatives agreed to propose it to their respective organizations and to report their decisions to the headquarters office of the Indiana State Medical Association.

Upon motion of Drs. Owsley and Mericle the association also is to ask the voluntary health associations to hold their annual meetings at the same time as the Indiana State Medical Association meeting in 1961.

There being no further business the meeting was adjourned. The Executive Committee will meet again at 6:00 p.m., Saturday, Jan. 9, 1960.

A woman usually knows what's behind the headlines at breakfast time—her husband.—*Morrie Gallant, Quote.*

Some of the new cars are so classy the motor no longer purrs—it sneers.—*J. C. Salak, Quote.*

MEMO TO: I.S.M.A. Members

The JOURNAL is interested in full-length scientific papers and case reports for early publication. This is an open invitation to you to submit such work. Each paper is given careful consideration.

A few regulations regarding publication of papers are printed on the Contents page.

This announcement is made following a decision to increase the number of scientific papers published if sufficient material is available.

Lighter Vein

Even to a linguist the American idiom is frequently confusing. I had an amusing example of this when my wife and I rented a cottage in Arlington, Va. Next door lived an elderly couple from Holland. Both spoke several languages, and the husband, a dreamy intellectual, worked as a translator for a government department.

They belonged to once affluent military and political families of Holland, but when we knew them they were reduced to modest circumstances and they made a brave show at home on a do-it-themselves basis.

One Sunday morning I wanted to ask the old gentleman something, and to avoid disturbing him, waited until I heard him stirring about, hammering at some chore inside the house. I then went to the fence, near where his wife was watering flowers, and said: "I want to talk to your husband a moment. Is he handy?"

Just then there was another bang from the hammer inside, and a hideous sound of glass shattering. The wife put down her sprinkling can with a resigned air and shook her head.

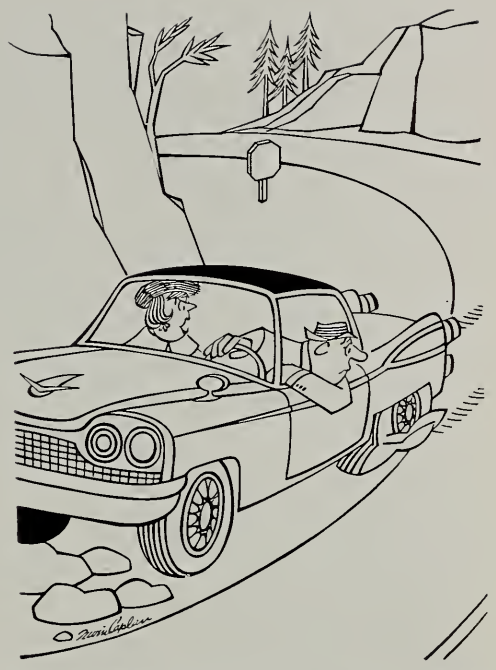
"Nay," she said sadly. "Not very."—*Ken Kraft, Quote.*

———

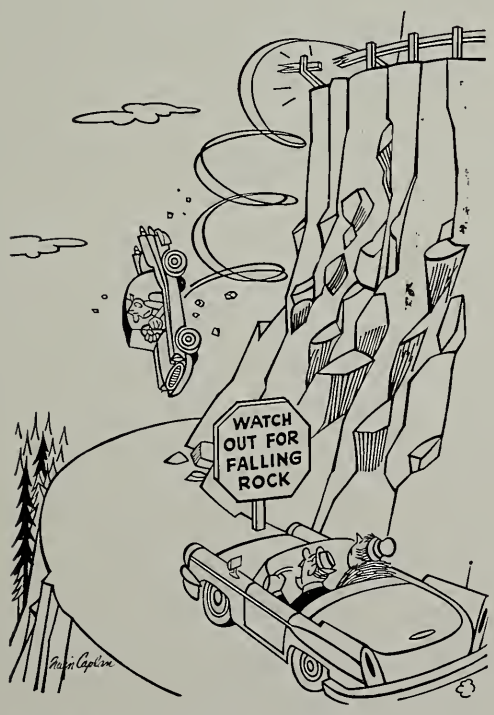
A beatnik figures he's real gone when he's only half there. —*Harold Goffin, Quote.*

———

If experience is the best teacher, the whole faculty should be fired.—*Franklin P. Jones, Quote.*



"I'm glad it's only a blowout . . . for a second I thought we'd broken the sound barrier!"



"Well, there's a switch for you!"



"After I cracked the fool thing I decided to title it 'Headache'!"

The Journal of the Indiana State Medical Association

MEDICAL ESSAY CONTEST

for

Interns and Residents of Indiana Hospitals

During the intern and resident year of 1959-60 The Journal is sponsoring a medical essay contest open to interns and residents of hospitals in Indiana. The subject matter will be limited to clinical experience observed primarily in the teaching hospital of the author. Presentations may contain up to 4,000 words and preferably should be illustrated with clinical pictures, graphs or tables.

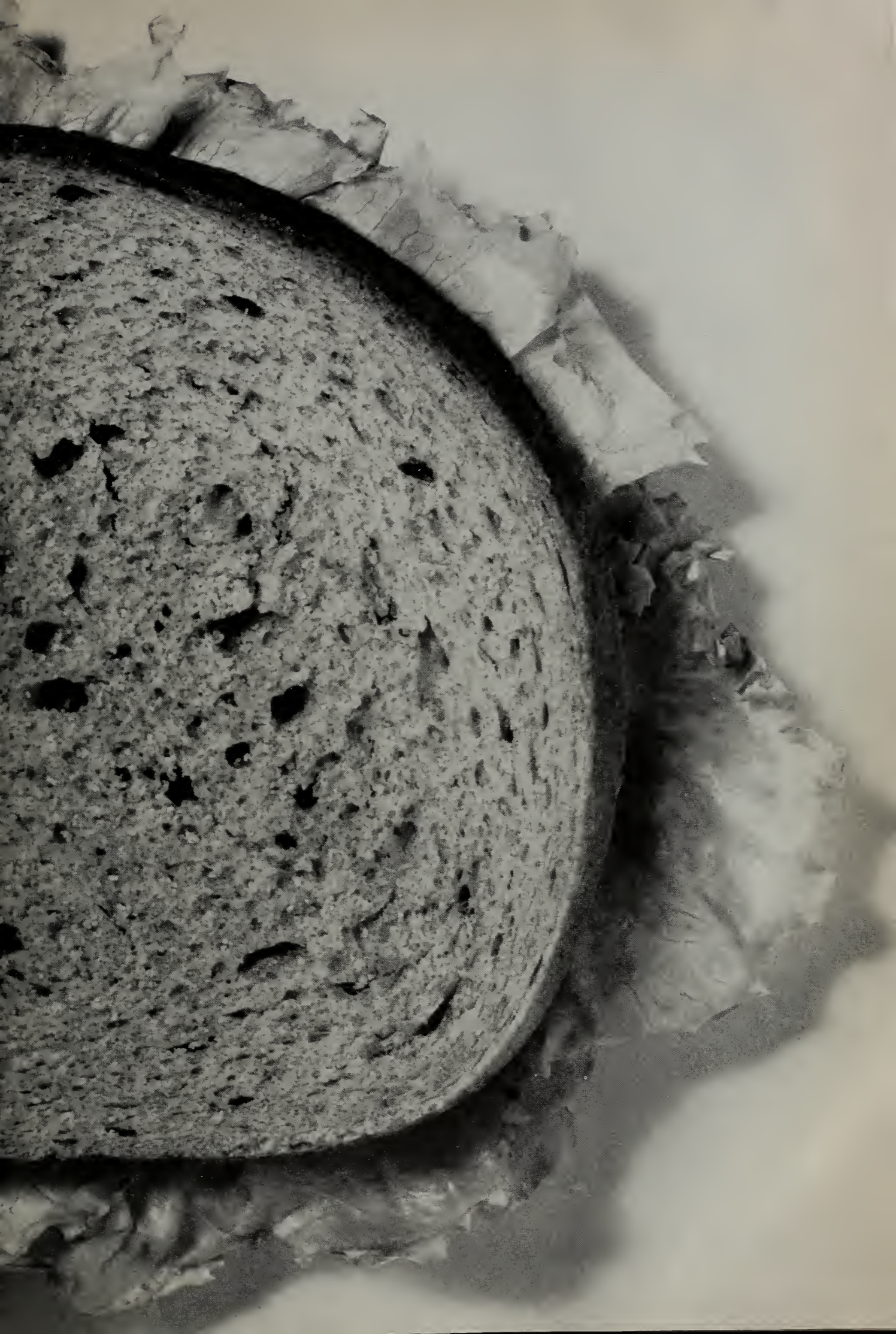
A first prize of $100.00, a second prize of $75.00 and a third prize of $50.00 will be awarded. All entries are eligible for consideration for publication in The Journal.

Manuscripts will be judged by a prize award committee selected by the Editorial Board of The Journal and by the Dean, Indiana University School of Medicine.

Manuscripts should be prepared in accordance with the specifications outlined on the masthead page of The Journal.

Entries must be submitted prior to May 1, 1960.

The manuscript itself is to be identified only by the title. The author's name must not appear in the manuscript. Instead, a special title page bearing the title and the author's name and address should accompany the paper. Mail entries to Mr. James A. Waggener, 1021 Hume Mansur Bldg., Indianapolis 4.



The Journal

March 1960

of the INDIANA STATE MEDICAL ASSOCIATION

Office of Publication:
1019 Hume Mansur Building, Indianapolis, Indiana

$1.00 per copy
except Yearbook
$5.00 per year

Contents

SCIENTIFIC

Fluid Balance in Obstruction of the Large Intestine, W. D. Snively Jr., M.D., Evansville 427
The Preanesthetic Evaluation of the Surgical Patient, Cyril Taylor, M.D., Indianapolis 435
Anti-Emetics and Tranquilizers in Surgical Patients, Douglas J. Giorgio, M.D., Evansville 441
Caps, Gowns and Masks—Who Should Wear Them and of What Material Should They Be Manufactured, William R. Noe, M.D., Bedford 445
Re-evaluation of the Methods of Cleaning the Hands of the Surgical Team, Ambrose C. Estes, M.D., Bloomington 445
Overlooked and Misdiagnosed Fractures, Francis G. Zeier, M.D., Evansville 447
Radiologic Management of Carcinoma of the Uterine Cervix, H. H. Dunham, M.D., Bloomington 453
Carcinoma of Pancreatico-Duodenal Region, William C. von der Lieth, M.D., Vincennes 454
Management of Mucosal Perforation in the Course of Pyloric Myotomy, Frank Scott, M.D., South Bend 457
The Case of the Comatose Truck Driver, Arnold Lieberman, M.D., New York, N.Y. 460
Pathfinder: Do's and Don'ts in Transfusions 464
Condensed Cardiology: Dyspnea, Alfred F. Fasola, M.D., Indianapolis 466

EDITORIALS

". . . Cooperation Will Add Authority . . ." 472
Who Needs Forand Legislation? 473
New State Medical Journal 474
As L.A. Goes, So Goes the Nation 474
To Encourage Giving (From the Northwest) 475

SPECIAL FEATURES

Journal Offers $5 for Anecdotes 475
'M.I.' (Medical Intelligence), A. C. Offutt, M.D., Indianapolis 477
AMA President Meets Hoosier Leaders (story and pictures) 485
Political Medicine, editorial from Indianapolis News 489
Political Medicine or Personal Medicine, Louis M. Orr, AMA President 490
It's That Time Again, Louis M. Orr, AMA President 503
'The Old Folks at Home,' Emmett B. Lamb, M.D., Indianapolis 518
Memo Re: Outpatient Blue Shield Benefits, E. T. Edwards, M.D., Vincennes 524
Steel Workers Panel Medicine—Sooner or Later, E. T. Edwards, M.D., Vincennes 532

REGULAR FEATURES

Month in Washington 402
Fourth Estate 412
to the editor 424
Journal Medical Essay Contest 459
President's Page 479
The Woman's Auxiliary 481
Vervain (A Journal Special), Miki Wilson 482
A 1960 Goal: Selling the 'Preferred' Programs, Blue Cross-Blue Shield series 484
Wanted: Locations, Physicians 546
News Notes 552
Add 1, by corki 570
Deaths 573
Board of Health Report 576
AMEF 601
Advertiser's Index 612

BUSINESS

County and District News 574
Commission Meetings: Medical Education and Licensure 581
Association News: Executive Committee, Jan. 9, 1960 582
Council, Jan. 10, 1960 586

EDITORIAL AND ADVERTISING INFORMATION

All articles must be typewritten, double-spaced with margins of one inch.

Photographs should be printed on glossy paper. Negatives cannot be used.

Illustrations are desirable. Selection of illustrations submitted at discretion of editor and editorial board members. Cost of color illustrations must be shared by the author.

Contributors are responsible for all statements made in their articles. The editors and editorial board members may not be in agreement with all views expressed by authors, but it is desired to give all authors as great latitude as possible. However, the right is reserved to reduce in length or reject any article.

Articles are accepted for publication with the understanding that they are submitted for exclusive publication in THE JOURNAL of the Indiana State Medical Association.

Communications dealing with editorial matter should be sent to Frank B. Ramsey, M.D., Editor, 1802 North Illinois Street, Indianapolis 2, Indiana. All other communications should be sent to THE JOURNAL of the Indiana State Medical Association, 1019 Hume Mansur Building, Indianapolis 4, Indiana.

Advertising rates will be furnished on request. Copy must be received by the 5th of the month preceding month of issue. (Scientific manuscripts must be received at least two weeks earlier if geared for a specific issue.)

Entered as second class matter January 25, 1933, at the Postoffice at Indianapolis, Indiana. Copyright, 1960, by the Indiana State Medical Association. Published monthly at 1019 Hume Mansur Bldg., Indianapolis 4, Indiana.



ONE *and only* ONE

Timed AMO*dex* CAPSULE

PER DAY *will economically*

control appetite in weight reduction or relieve the nervous symptoms of anxiety and the underlying depression.

6-10 HOURS SUSTAINED THERAPY

Timed AMO*dex CAPSULES* (Testagar) furnish a controlled uniform action. The medications provide prolonged, continuous therapeutic effect from active ingredients over a period of 6 to 10 hours.

Following ingestion of one *Timed* AMO*dex CAPSULE*, small amounts of the medication are released immediately.

Each *Timed* AMO*dex CAPSULE* contains a daily therapeutic dose of:

Dextro-amphetamine hydrochloride . . . . . 15 mg.,
Amobarbital . . . . . 60 mg.

AMO*dex* ADVANTAGES

- HIGH-LEVEL ANOREXIGENIC ACTIVITY WITHOUT NERVOUS EXCITATION
- SMOOTH, UNIFORM ACTION
- THERAPEUTIC EFFECT LASTING 6 TO 10 HOURS
- ONLY ONE DOSE DAILY
- CLINICALLY ECONOMICAL TO THE PATIENT

PROTRACTED THERAPEUTIC EFFECT

Before the development of *Timed* AMO*dex* (Testagar) the usual dose of Dextro-amphetamine hydrochloride, for the control of appetite, was one 5 mg. tablet two or three times a day. The usual dose of Amobarbital ranged from 20 to 40 mg., two or three times a day. On such a dosage regimen the absorption of the drugs, after ingestion, takes place quite rapidly. The therapeutic activity occurs within one-half to one hour. When the therapeutic peak is reached, a gradual decline takes place. At this point, the patient should receive another dose of medication . . . the cycle is then repeated.

Patients frequently fail to follow the physician's instructions. They take medication at irregular intervals. When this occurs with drugs such as dextro-amphetamine sulfate, phosphate or hydrochloride, excitation may result. A balanced combination of Dextro-amphetamine hydrochloride, **the preferred salt,** plus a balanced daily dose of Amobarbital will give the expected therapeutic results *without* excitation.

Timed AMO*dex*, after ingestion, releases Dextro-amphetamine Hydrochloride and Amobarbital steadily and uniformly over a period of 6 to 10 hours. Therefore, the physician may dispense with the usual dosage schedule thereby *attaining better control of therapy*. The patient will receive the benefits of even and sustained therapeutic effects. Side reactions such as anxiety and excitation are greatly minimized.

ACTION AND USES

Timed AMO*dex CAPSULES* (Testagar) supply the antidepressant and mood-elevating effects of Dextro-amphetamine hydrochloride and the calming action of Amobarbital. *Timed* AMO*dex* elevates the mood, relieves nervous tension, restores emotional stability and the capacity for mental and physical effort.

INDICATIONS

Timed AMO*dex* is the preferred treatment in anxiety states and in the management of obesity. *Timed* AMO*dex* may also be used in the treatment of Depressive states, Alcoholism, Nausea and Vomiting of Pregnancy.

DOSAGE The Daily Dose of *Timed* AMO*dex* (Testagar) IS ONE CAPSULE ON ARISING OR AT BREAKFAST.

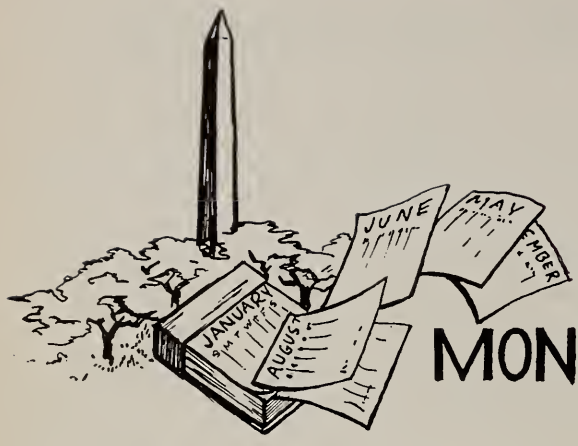
SUPPLIED Bottles of 100 and 1000 capsules, available at all pharmacies. Also supplied in half strength as *Timed* AMO*dex*, Jr.

Timed AMO*dex CAPSULES* are manufactured under these patent numbers:
2,736,682 — 2,809,916
2,809,917 — 2,809,918
Which provide prolonged, continuous therapeutic effect over a period of 6-10 hours

SAMPLES AND LITERATURE UPON REQUEST

Testagar & co., inc. 1354 W. Lafayette Blvd. Detroit 26, Michigan

This summary of what is happening in Washington is prepared by A.M.A.'s Capitol office and airmailed to *The Journal* on the ninth of each month preceding month of issue.



MONTH IN WASHINGTON

FEDERAL HEALTH INSURANCE SHOWDOWN—PROPONENTS PUSH HARD

Washington, D. C.–Congress appears headed for a showdown this session on legislation for the Federal government to provide medical care for aged persons.

The medical profession and allied groups stepped up their activities in opposition to such legislation as indications mounted that the issue was approaching a crucial stage. Several state medical societies planned to send delegations to Washington to personally express their opposition to their Congressmen.

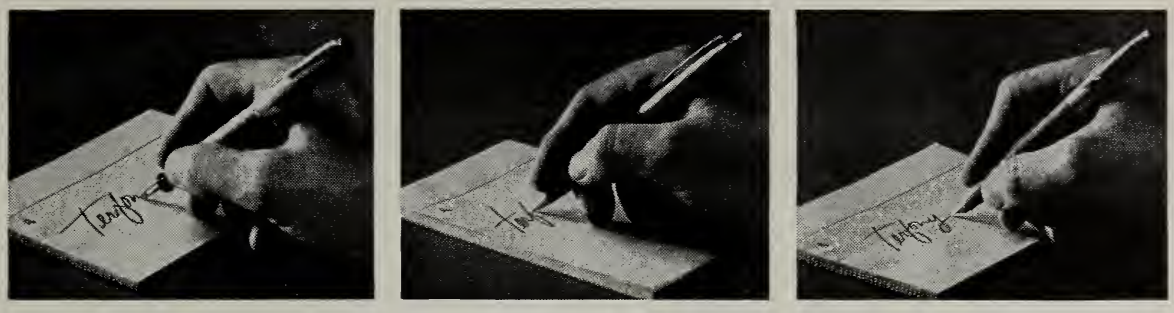
Pressure behind such legislation began to build up early in February.

The Eisenhower Administration announced it was working on three possible programs for providing health care for aged persons in cases of catastrophic--lengthy and costly--illness.

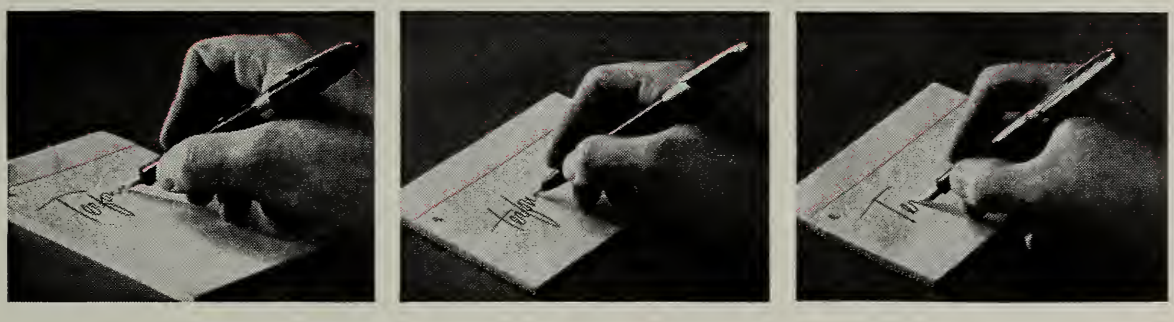
Without amplification, President Eisenhower told a news conference that there was under consideration "a possible change" in the Social Security Act "to run up the taxes by a quarter of a per cent to . . . make greater provision for the care of the aged." The President's statement that "there has been no conclusion reached in the administration" was backed up by Arthur S. Flemming, Secretary of Health, Education and Welfare, in a clarifying announcement.

Flemming said his department was working on two other approaches to what he called a serious problem in addition to the possible revision of the Social Security law mentioned by Mr. Eisenhower. The HEW Secretary said consideration also was being given to: 1) stepped-up Federal assistance under the Federal-state public assistance program, and 2) the Federal government supplementing voluntary insurance programs.

Continued



more and more physicians are prescribing this triple sulfa



TERFONYL

Squibb Triple Sulfas (Trisulfapyrimidines)

Clinical experience continues to prove that TERFONYL provides many special advantages fundamental to successful antibacterial therapy.

• specificity for a wide range of organisms • superinfection rarely encountered • soluble in urine through entire physiologic pH range • minimal disturbance of intestinal flora • excellent diffusion throughout tissues • readily crosses blood-brain barrier • sustained therapeutic blood levels • extremely low incidence of sensitization

SUPPLY: Tablets, 0.5 gm. • Suspension, raspberry flavored, 0.5 gm. per teaspoonful (5cc.).

SQUIBB *Squibb Quality—the Priceless Ingredient*

"TERFONYL"® IS A SQUIBB TRADEMARK

ADMINISTRATION OPPOSES FORAND BILL

Flemming again expressed opposition to the Forand bill which would increase Social Security taxes by one quarter of one per cent each on employers and employes to provide hospitalization, surgical benefits and nursing home care for Social Security beneficiaries. The Secretary said he wanted to "underline that the position of the administration is opposition to the Forand bill."

Flemming said he hoped to have an administration bill ready to submit in early April to the House Ways and Means Committee where the Forand bill is pending. The Committee is scheduled to take up in late March or early April proposed changes to the Social Security Act.

Proponents of the Forand bill—which is vigorously opposed by the American Medical Association and allied groups—were pointing their campaign toward securing the House Committee's approval of the legislation at that time.

The AFL-CIO, a main supporter of the Forand bill, urged labor union members to write to congressmen on the Committee urging them to vote for it. The AFL-CIO also distributed a pamphlet quoting a handful of physicians as supporting the legislation. But the labor organization didn't mention that the overwhelming majority of doctors oppose it.

SUBCOMMITTEE LAUDS SOCIAL SECURITY MEDICINE

The Senate Subcommittee on Problems of the Aged and Aging, headed by Sen. Pat McNamara (D., Mich.), issued on behalf of its Democratic majority a report stating that use of the Social Security program "is the most efficient procedure for providing" health care for older persons.

The AMA and the Subcommittee's Republican minority promptly disputed this conclusion. An AMA statement issued in Chicago said:

"The American Medical Association today sharply disagreed with the recommendation of the McNamara subcommittee regarding government medicine for Social Security beneficiaries.

"Dr. Louis M. Orr, Orlando, Fla., president of the AMA, said:

"'This is a politically inspired committee. Senator McNamara, Democrat from Michigan, has long supported political medicine. The fact is that at the seven subcommittee hearings held throughout the United States, observers heard little support expressed by the older citizens who attended the hearings for government medicine financed by additional taxes and administered through Social Security.'"

The Republican minority stated that testimony before the Subcommittee "proves that it is possible for elderly people to secure private insurance to provide hospitalization and surgical benefits without any intervention by public authorities."

Sen. John F. Kennedy (D., Mass.), a leading contender for the Democratic nomination for president, introduced legislation similar to the controversial Forand bill but broader in scope. The Kennedy bill would eliminate surgical benefits but would add diagnostic outpatient and home nursing services. ◄

INCREASES AND MAINTAINS BLOOD FLOW FOR 10-12 HOURS

THAWS ICY HANDS AND FEET Roniacol Timespan promptly increases circulation in cold fingers and toes,[1] resulting in "less ischemic pain, improved pulses and increased skin temperature."[2] Action: specific dilation of peripheral vessels.[1] Result: Roniacol increases blood flow to ischemic extremities.[3-5] Improved blood flow further minimizes the chance of ulcerations associated with peripheral arterial insufficiency.

EACH DOSE ACTS FOR 10-12 HOURS New, sustained-release Roniacol Timespan provides convenience for your patients as well as daylong or nightlong relief of cold, aching extremities—one Timespan in the morning precludes forgotten midday doses, another at night permits comfortable, uninterrupted sleep.

NO CONTRAINDICATIONS—NEGLIGIBLE SIDE EFFECTS Unlike sympathetic blocking agents, Roniacol is selective—produces no cardiac stimulation, no hypotension, no gastrointestinal stimulation[6,7]—may be used safely in the presence of gastritis, peptic ulcer or coronary disease. Of 264 patients on Roniacol Timespan, only thirteen experienced side effects—none of them major.[1]

RONIACOL TIMESPAN for intermittent claudication, night cramps, cold hands and feet, in such peripheral vascular conditions as generalized or cerebral arteriosclerosis, Buerger's disease, varicose and decubitus ulcers, Meniere's syndrome[8] and vertigo due to impaired cerebral circulation.

DOSAGE: One or two Roniacol Timespan tablets in the morning and at night.
SUPPLY: Tablets of 150 mg, bottles of 50. When prolonged effects are not desired, prescribe Roniacol Tartrate Tablets, 50 mg, or Roniacol Elixir, 50 mg per teaspoonful (5 cc).

REFERENCES: 1. Reports on File, Roche Laboratories. 2. W. D. Westinghouse, Personal Communication. 3. E. C. Texter, et al., **Am. J. M. Sc.**, 224:408, 1952. 4. M. M. Fisher and H. E. Tebrock, **New York J. Med.**, 53:65, 1953. 5. I. H. Richter, et al., **New York J. Med.**, 51:1303, 1951. 6. C. M. Castro and L. De Soldati, **Angiology**, 4:165, 1953. 7. R. M. N. Crosby, **Am. J. M. Sc.**, 225:61, 1953. 8. J. Dosdos and G. E. Arnold, **Eye Ear Nose & Throat Month.**, 38:1035, 1959.

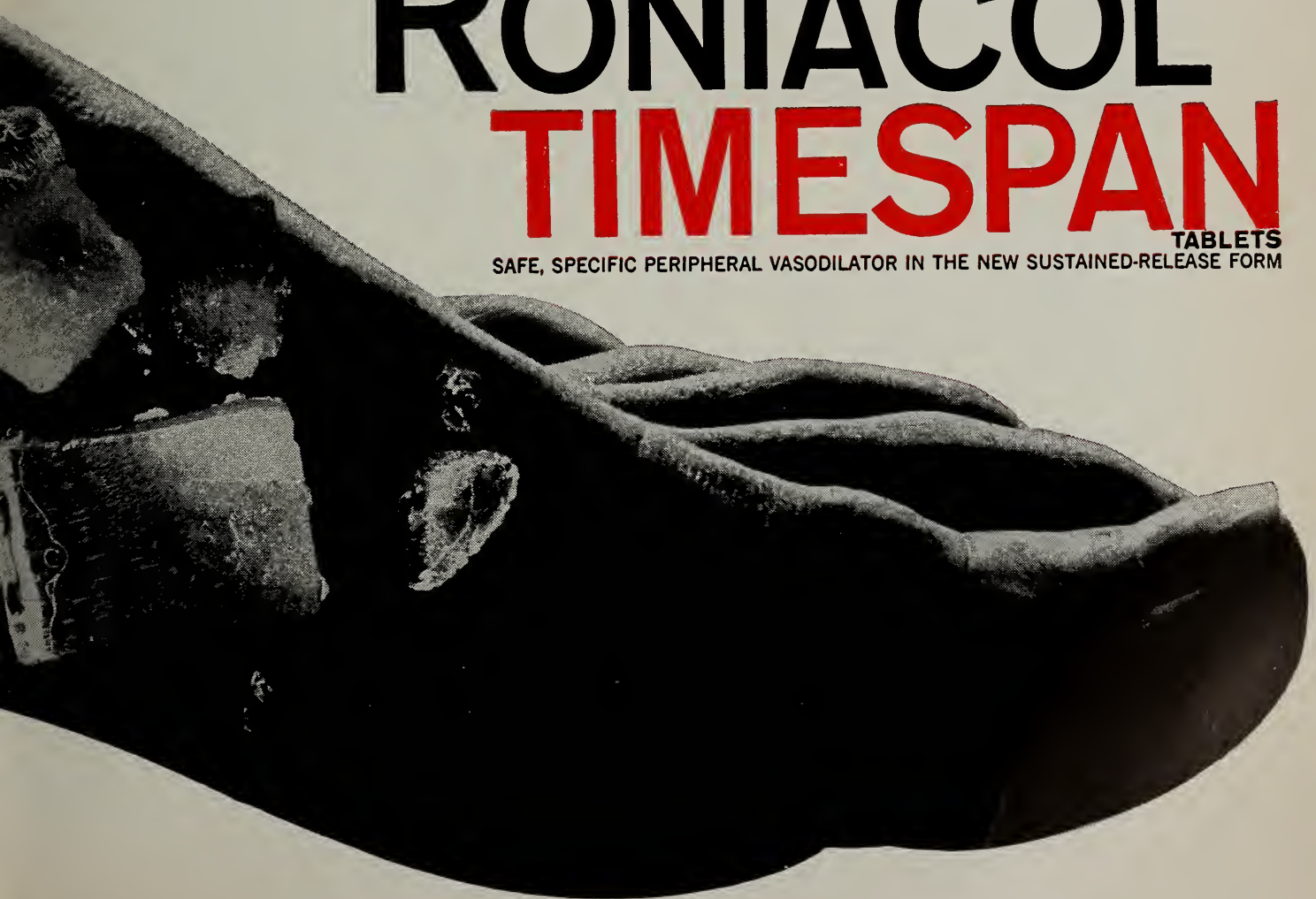
Roniacol®—brand of beta-pyridyl carbinol. Timespan®

ROCHE **ROCHE** LABORATORIES • Division of Hoffmann-La Roche Inc • Nutley 10, N. J.

RONIACOL TIMESPAN

TABLETS

SAFE, SPECIFIC PERIPHERAL VASODILATOR IN THE NEW SUSTAINED-RELEASE FORM





LOOKS AT MEDICINE

This section of THE JOURNAL is devoted to the presentation of opinions which appear on the editorial pages of the public press, and which are of interest to the medical profession. Its function is to review comments which may be favorable or unfavorable to medicine. Members are invited to submit editorial clippings for this column.

Medical Benefits to Elders Should Be Based on Need

Every election year since 1950, Congress has "sweetened" Social Security benefits. With a $4 billion surplus to shoot at, liberals are a cinch to make a big try again this year.

Congress is toying with many ways to broaden SS benefits. Some solons would cut the eligibility age from 65 to 60. Others would lower or abolish the disability age limit, now 50. The most avid spenders would simply boost all benefits by 10%.

Of all proposals, the "sweetener" deemed most likely to succeed is the Forand bill, which gives SS beneficiaries "free" medical, hospital and nursing home care.

Conservatives strongly oppose the Forand bill. It would cost a billion the first year, more thereafter. It would also raise the SS payroll tax which is already scheduled to reach 9% by 1969.

Doctors call the Forand Bill socialized medicine's "opening wedge."

But the bill has humanitarian aspects and widespread vote appeal. Many congressmen will be loathe to oppose it lest they be accused next fall of forsaking "poor, sick old folks."

Knowing this, liberals figure to make the Forand bill (or a reasonable facsimile) their objective—for the simple, realistic reason that it has the best chance to pass.

Even without considering the high cost, we think any bill which blankets SS beneficiaries with medical benefits is highly objectionable.

Certainly no rich, prosperous nation should neglect the medical needs of elders who cannot help themselves. But there is considerable doubt that a large number of SS beneficiaries are in genuine, distressing need.

The University of Chicago's National Opinion Research Center recently found only 9.6% of the over-65 group unable to pay a $500 medical bill. Of this 9.6%, many aren't eligible for Social Security payments.

Why, then, write medical blank checks for millions of elders who have no need—or right!—to mulct taxpayers?

What's needed here—as in most legislative controversies—is a fair, reasonable, practical compromise that will aid elders in genuine need without squandering taxpayers' money on those who aren't.

Can that be done? Yes—and quite simply.

At present, the Department of Welfare gives old-age assistance to elders who lack sufficient means to subsist. All who qualify for old-age assistance automatically get medical care, as well.

There are, however, many borderline cases—elders whose SS checks give them just enough to subsist, but not enough for medical care. Since they cannot qualify for Welfare's old-age assistance they cannot get Welfare's medical care.

It would be a simple matter to broaden Welfare regulations to give these borderline elders medical care—and Welfare already has the administrative machinery to screen them.

Further, under present laws, Welfare can recover from old-age recipients who die and leave property. (Surprisingly, almost half of those drawing old-age assistance own property, usually their homes.) We particularly like that part of the Welfare law because it rightly penalizes neglectful heirs who have palmed their parents off on taxpayers.

In the same way, part of the cost of medical care given needy elders could be recovered. Such

Continued on page 412

SOMA RELIEVES PAIN in a unique way by modifying central perception of pain without abolishing natural defense reflexes.

SOMA RELAXES MUSCLE SPASM . . . approximately 8 times more potent than meprobamate or mephenesin.

PHYSICIANS' REPORTS: "Marked pain-relieving effects of the new drug [SOMA] were seen in conditions involving muscle spasm and stiffness, whether acute or chronic. Relief from pain was usually rapid and sometimes dramatic." (90 patients.)
Kuge, T.: Submitted for publication.

"In 86 percent of the patients there were excellent or good results. . . . Relief of pain was noted by the patients' statements, by the diminished need for analgesic drugs, and by improved sleep." (154 patients.)
Wein, A. B.: The Use of Carisoprodol in Orthopedic Surgery and Rehabilitation. Proceedings of the Symposium on The Pharmacology and Clinical Usefulness of Carisoprodol. Wayne State University Press, Detroit, 1959, p. 156.

In a double-blind study, SOMA was reported to be "clinically effective to a highly significant degree." (92 patients.)
Cooper, C. D., and Epstein, J. H.: The Clinical Evaluation of Carisoprodol by a double-blind technique. Ibid. p. 97.

Notable safety—extremely low toxicity; no known contraindications; side effects are rare; drowsiness may occur, usually at higher dosage

Rapid action—starts to act quickly

Sustained effect—relief lasts up to 6 hours

Easy to use—usual adult dose is one 350 mg. tablet 3 times daily and at bedtime

Supplied—as white, coated, 350 mg. tablets, bottles of 50.
Also available for pediatric use: 250 mg. orange capsules, bottles of 50.

SOMA T.M.

(carisoprodol Wallace)

BIBLIOGRAPHY: 1. Berger, F.M., Kletzkin, M., Ludwig, B.J., Margolin, S. and Powell, L. S.: J. Pharm. Exp. Ther. *127*:66 (Sept.) 1959. 2. Leake, Chauncey D.: Proceedings of the Symposium on The Pharmacology and Clinical Usefulness of Carisoprodol, Wayne State University Press, Detroit, 1959, p. 8. 3. Kestler, Otto: Ibid. p. 143. 4. Proctor, Richard C.: Ibid. p. 122. 5. Berger, Frank M., Ibid. p. 25. 6. Goodgold, Joseph, Hohmann, Thomas and Tajima, Toshihiro: Ibid. p. 66. 7. Gammon, George D. and Tucker, Samuel: Ibid. p. 70. 8. Baird, Henry W. and Menta, Dominic A.: Ibid. p. 85. 9. Cooper, C. David and Epstein, Jerome H.: Ibid. p. 97. 10. Korst, Donald R., Gerard, R. W., Miller, James G., Small, Iver F., Graham, I. J. and Winkelman, Eugene I : Ibid. p. 104. 11. Friedman, Arnold P.: Ibid. p. 115. 12. Trimpi, Howard D.: Ibid. p. 150. 13. Wein, Arthur B.: Ibid. p. 156. 14. Olds, James and Travis, R. P.: Ibid. p. 39. 15. Hess, Eckhard H., Polt, James M. and Goodwin, Elizabeth: Ibid. p. 51. 16. Phelps, Winthrop M.: Ibid. p. 131. 17. Spears, Catherine E.: Ibid. p. 138. 18. Hyde, L. P. and Hough, Charles E.: Ibid. p. 166. 19. Spears, Catherine E. and Phelps, Winthrop M.: Arch Pediat., *76*:287 (July) 1959. 20. Phelps, Winthrop M.: Arch. Pediat., *76*:243 (June) 1959. 21. Friedman, Arnold P.: Paper presented at Scientific Meeting, New York State Society of Industrial Medicine, Inc., New York, Sept. 30, 1959. 22. Frankel, Kalman: Ibid. 23. Fransway, Robert L.: Ibid. 24. Kuge, T.: Unpublished reports.

Literature and samples on request WALLACE LABORATORIES, New Brunswick, New Jersey

Fourth Estate

Continued from page 408

a program would not unduly burden already-strained taxpayers who can ill-afford the billion-a-year which the Forand Bill's blanket benefits will cost.

—*News Dispatch*
Michigan City
Jan., 1960

Not So Fast, Warns AMA

The Authoritative *Journal* of the *American Medical Association* in its Dec. 12 issue takes vigorous exception editorially to the recent report of Surgeon General Leroy E. Burney of the US Public Health Service bracketing lung cancer and smoking.

In his statement, published earlier in the *Journal,* Dr. Burney declared that research evidence implicates smoking as the principal cause of the increase in this disease and advised that the best protection is to quit. Plainly, the AMA does not go along with this view.

"A number of authorities who have examined the same evidence cited by Dr. Burney," says the AMA editorial, "do not agree with his conclusions. Although the studies reveal a relationship between cigarette smoking and cancer that seems more than coincidental, they do not explain why, even when smoking patterns are the same, case rates are higher among men than among women and among urban than among rural populations."

The editorial goes on to point out that: "Neither the proponents nor the opponents of the smoking theory have sufficient evidence to warrant the assumption of an all-or-none authoritative position."

It is the *Journal's* advice to its physician readers that "until definitive studies are forthcoming" they can best fulfill their professional responsibilities by keeping posted on lung cancer research developments and advising their patients on the basis of their own best judgment.

"The Public Health Service can best meet its obligations," concludes the AMA in a highly ethical slap on the wrist, "by collecting and disseminating data from all sources and making known to the health and medical professions its evaluations of such data."

Continued

Tested . . . and proved . . .

ORAL therapy in diaper rash!



Convenient . . . simply open a capsule and add the contents to the baby's daily formula, or to fruit juice or water. No lotions . . . no rinses . . . no ointments . . . just oral therapy.

Send for samples and literature.

S. F. DURST & CO., INC.
Philadelphia 20, Pa.

Effective therapy! Thousands of pediatricians and general practitioners prescribe Pedameth for ammonia dermatitis—and they continue to prescribe it. Clinical tests have proved its effectiveness. Pedameth is safe because it contains only dl-methionine (0.2 Gm.) one of the essential amino acids. When Pedameth is administered, the pH of the urine is lowered and an as-yet-unknown antibacterial agent appears in the urine. Pedameth works . . . it's the safe, effective, convenient answer to ammoniacal diaper rash.

Prescribe

PEDAMETH®

(dl-methionine DURST)

Incremin®

Lysine-Vitamins Lederle

with iron Syrup

for the undersized underweight child



build appetite

with
B complex
vitamins

prevent nutritional anemia

with ferric pyrophosphate,
a form of iron
exceptionally
well-tolerated

promote protein uptake

with the
potentiating effect
of l-Lysine on
low-grade
protein foods

in taste-tempting cherry flavor

Average dosage, 1 teaspoonful (5 cc.) contains:

l-Lysine HCl	300 mg.
Vitamin B_{12} Crystalline	25 mcgm.
Thiamine HCl (B_1)	10 mg.
Pyridoxine HCl (B_6)	5 mg.
Ferric Pyrophosphate (Soluble)	250 mg.
Iron (as Ferric Pyrophosphate)	30 mg.
Sorbitol	3.5 Gm.
Alcohol	.75%

Bottles of 4 and 16 fl. oz.

Lederle LEDERLE LABORATORIES, a Division of AMERICAN CYANAMID COMPANY, Pearl River, New York

Fourth Estate

Continued

The emphasis in the preceding paragraph is ours, and doubtless superfluous in writing to the medical profession. But we think it is important that the lay reader appreciate the recklessness of Dr. Burney's ill-founded public statement.

—Kentland Enterprise
Dec. 31, 1959

Federal Health Bill

It will be interesting to note how Indiana congressmen vote on the Forand bill which proposes that the federal government pay medical benefits to recipients of social security.

This is a bill that congressmen ought to oppose, for two strong reasons. One is that a growing number of people 65 and older who want health insurance will be getting it through private programs. The other reason is that paying these benefits with federal funds will add billions of dollars to the national debt, and whether congressmen believe it or not one of these days the people who pay taxes are going to rebel against the tendency to saddle more and more taxes on them.

Not only are we paying heavily (in the form of taxes) for these additional benefits which Congress keeps voting, but we are leaving an increasing burden on our children and grandchildren. It's fine to have a good many things coming from the government, but it doesn't sit very well (or shouldn't) in one's conscience to be receiving those benefits at the expense of our children.

Take the Forand Bill. It would supply free hospitalization and nursing care for 190 days out of the year and push federal taxes upward by $1 billion to $2 billion the first year, and around $7 billion by 1960.

The American Medical Assn. has a selfish interest in health legislation, to be sure. But it has some things to say about the Forand bill that make pretty good sense. Dr. Louis Orr, president of the AMA, points out that the Forand bill does not help the indigent minority, because people on public assistance rolls, ineligible for social security, are not covered by it. He also notes that by the end of 1960 an estimated 60% of those 65 and over who want health insurance will have it through private programs, and a

Nation's Leading Designers and Builders of prefab "Medical Buildings"



An Erdman prefabricated medical building

• *designed to insure efficiency*

An efficient suite for medical use is not just a group of rooms. It has to be engineered to make the best use of space. Erdman prefabricated medical offices are individually designed for the selected building site and with your specific needs in mind, just as we have done for more than 275 doctors throughout the country.

• *prefabricated to save money*

Because of standardized plans, mass-produced parts and materials, and experienced craftsmen — Erdman saves much in costs, minimizes construction time and insures an ideal building.

If you are interested in a medical building, write Marshall Erdman and Associates, Inc., 5117 University Ave., Madison 5, Wisconsin.

Schering

Trilafon® perphenazine for the anxiety in the person overwhelmed by family illness...selective anxiety relief with minimal drowsiness or dulling

S-419





prescribe

NIPHYLLINE

the unique specific

This exclusive development is neutral in action, and ***specific in prophylaxis and treatment of angina pectoris.*** It is effective orally in about thirty minutes, for periods of 7 to 8 hours . . . and, even when given routinely, does not cause nausea or gastric upset. Niphylline is an efficient vasodilator and diuretic combining the effectiveness of Neothylline (soluble, neutral, stable derivative of theophylline) and pentaerythritol tetranitrate, substantially more effective than mannitol hexanitrate. Thus, the patient receives the benefits of both drugs without any annoying side effects.

Niphylline is safe, and well tolerated . . . exerts strengthening effect on heart muscles, and acts synergistically, remarkably reducing severity and frequency of cardiac attacks.

Indications: Relief and control of angina pectoris, cardiovascular symptoms, asthenia, coronary spasm with myocardial pain, prophylaxis and treatment of left ventricular insufficiency, cardiac dyspnea and oliguresis.

Dosage: One or two tablets, 3 or 4 times daily, or as directed by physician.

Supplied: Bottles of 100 and 1000 tablets.

Each tablet contains: Pentaerythritol tetranitrate, 10 mg., and Neothylline (dihydroxypropyl theophylline), 100 mg.

PM **PAUL MANEY**
LABORATORIES, INC.
Cedar Rapids, Iowa

Fourth Estate

Continued

further estimate is that by 1970, some 90% of those 65 and older will be covered by private insurance.

Why, then, should the government go into the health insurance business when private means are moving gradually to meet the need? Why should the government add to the already heavily taxed American citizenry when the government is unable even to pay off any of its staggering debt?

The British experiment with government-subsidized medicine offers a lesson for America. In a decade there has been no major hospital construction in Britain, the waiting list for surgical attention is said to total half a million, and a trend to private medical programs is reported.

In the light of this analysis, the vote of congressmen from Indiana, when the Forand bill comes up for decision, will be noted with special interest.

Kokomo Tribune
Jan. 17, 1960

For Your Future Health

Centuries ago when a *physician* wished to treat a patient with a certain *drug,* it was up to him to prepare that drug.

In the days of ancient Greece and Rome, medical men were their own pharmacists. To put it mildly, times have changed. Today, drug manufacturing is a basic and highly essential industry.

It is estimated that in the year 1959 alone, the industry will expend an estimated $190 million on research. To help practicing physicians keep abreast of advancement in drug therapy, the pharmaceutical manufacturers maintain a force of trained "detail men" in the field.

There are 15,000 of these individuals relaying information from industry research physicians to physicians in active practice.

To an increasing extent the drug manufacturer is becoming an ally of the medical profession—the practitioner or professor.

Usually the pharamaceutical manufacturer makes an important contribution in assembling facts which must quickly be put in the hands of the practicing physician and the medical educator.

One of the greatest problems facing both the medical profession and pharmaceutical manufac-

reaches all nasal and paranasal membranes *systemically*[1]



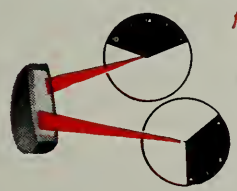
Pharmacologically balanced formula for prompt symptomatic relief

- in nasal and paranasal congestion
- in sinusitis and postnasal drip
- in allergic reactions of the upper respiratory tract

Triaminic*[2,3] *is safer and more effective than topical medication

- transported systemically to *all* respiratory membranes
- provides longer-lasting relief
- presents no problem of rebound congestion
- avoids "nose drop addiction"

Relief is prompt and prolonged because of this special timed-release action:



first — the outer layer dissolves within minutes to produce 3 to 4 hours of relief

then — the core disintegrates to give 3 to 4 *more* hours of relief

Each Triaminic timed-release Tablet provides:
Phenylpropanolamine HCl.....50 mg.
Pheniramine maleate.....25 mg.
Pyrilamine maleate.....25 mg.

Dosage: 1 tablet in the morning, midafternoon and at bedtime. In postnasal drip, 1 tablet at bedtime is usually sufficient.

Each timed-release Triaminic Juvelet® provides: ½ the formulation of the Triaminic Tablet.

Dosage: 1 Juvelet in the morning, midafternoon and at bedtime.

Each tsp. (5 ml.) of Triaminic Syrup provides: ¼ the formulation of the Triaminic Tablet.

Dosage (to be administered every 3 or 4 hours): *Adults* — 1 or 2 tsp.; *Children 6 to 12* — 1 tsp.; *Children 1 to 6* — ½ tsp.; *Children under 1* — ¼ tsp.

1. Fabricant, N. D.: E.E.N.T. Monthly *37*:460 (July) 1958.
2. Lhotka, F. M.: Illinois M. J.: *112*:259 (Dec.) 1957.
3. Farmer, D. F.: Clin. Med. *5*:1183 (Sept.) 1958.

the leading oral nasal decongestant...

Triaminic®

timed-release tablets and juvelets
also non-alcoholic, fruit-flavored syrup

SMITH-DORSEY • a division of The Wander Company • Lincoln, Nebraska

Fourth Estate

Continued

turer is lack of public appreciation of the giant strides that have been taken in medical care and drug therapy.

In the words of the president of a leading pharmaceutical company, "During the next decade the preservation of freedom as the proper climate for medical and scientific progress must be diligently worked for . . . . This requires the utilization of every opportunity to teach the advantages and accomplishments of our present system of medical care to the oncoming generations."

Princeton Democrat
Dec. 17, 1959

Aminotriazole

Science has been doing great things for us—prolonging life, making us more comfortable, knocking the daylights out of bugs which used to plague us. But science sometimes leaves us hanging on a limb.

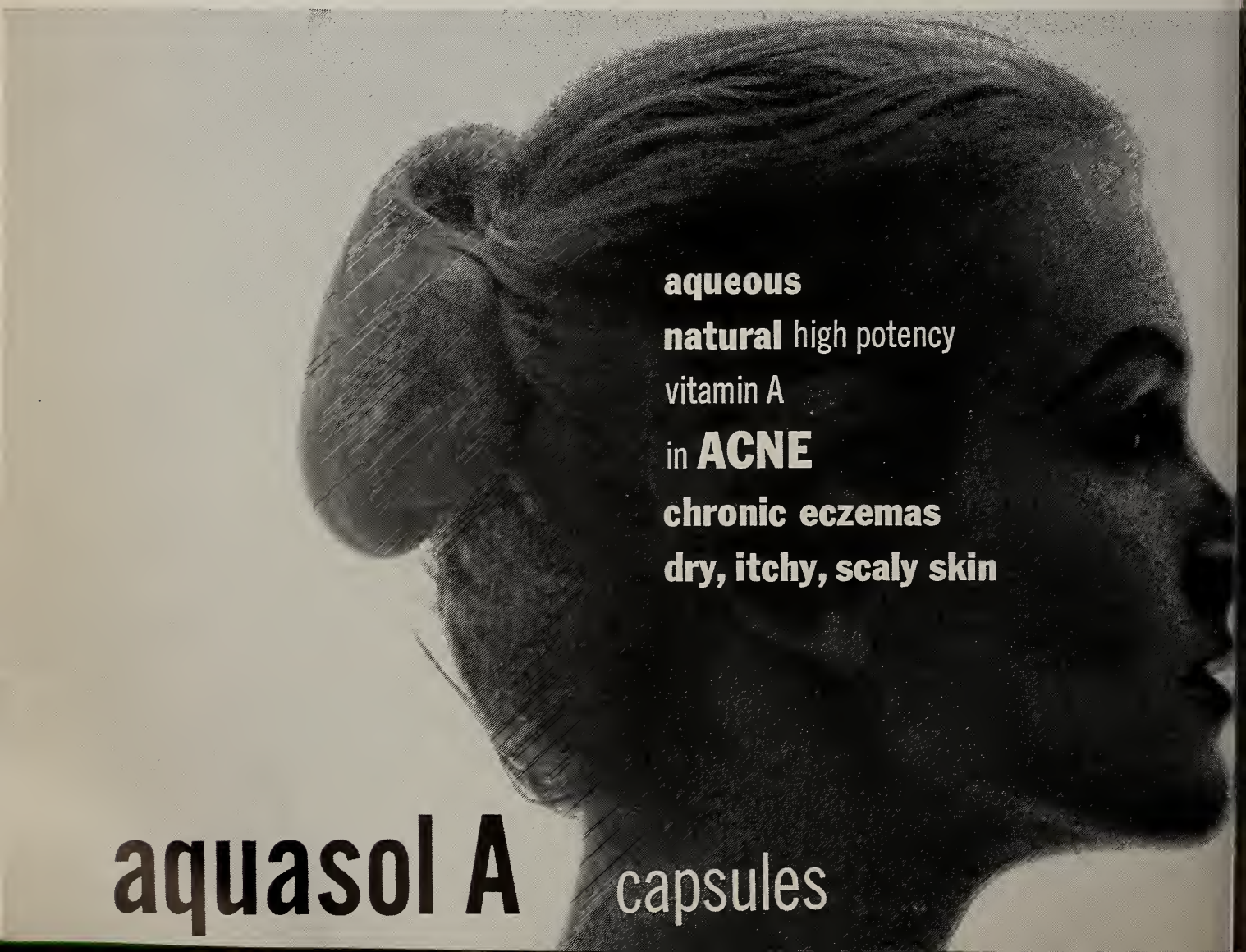
Dr. (honorary) Arthur Flemming, Secretary of Health, Education and Welface, advised us before Thanksgiving not to eat cranberries from bogs which has been doused with aminotriazole, a weed-killer. Later his department warned about the use of charcoal for coloring jelly beans and licorice, and the use of stilbestrol as a fattener in "caponettes"—a premium poultry item.

Now comes Dr. John H. Talbott, editor of the *Journal* of the American Medical Association, saying these Flemming actions created "undue alarm." Aminotriazole, he says, also is found in cabbage, turnips, broccoli and mustard. He suggests the charcoal in candies is no different than burned toast, and lightly brushes off the caponette incident.

Dr. Talbott's point seems to be that the law is "too categorical" in defining conditions under which chemicals are permissible in food.

Then there are the doctors in Utah whose research led them to the conclusion that the Christmas season is a depressant for many people, even can cause crying jags, dishonesty, overeating, hives and other ailments. The good doctors, however, don't suggest doing away with Christmas.

Like we say, science is probing so many things, and being so articulate about what it finds that sometimes we wonder what's good for us and



what might give us the heebie-jeebies, or worse.

Well, doc, tell you what we'll do: Until you fellows get together on some of these things, we'll risk a dab of cranberry sauce with our caponettes, now and then, and the lady at our house will continue to burn the morning toast. And if we seem a little relieved when the Christmas bills are paid, just lay it to a weak pocketbook; don't blame it on the season.

Indianapolis Times
Jan. 8, 1960

Socialism by the Back Door

Thanks to the sound judgment of the American people and the bitter experiences of nations like Great Britain in their experiments with the nationalization of medical services, the forces that have been laboring in behalf of socialized medicine in the United States have all but abandoned their direct attack. The American public, these forces have found, has benefited too much and too long from a system of free medicine ever to entertain any serious inclinations toward the regimentation and standardization that would inevitably accompany federalized medical services.

But the abandonment of the direct attack for socialized medicine has not meant the abandonment of the cause itself. For, as the new session of Congress begins its work, our national lawmakers find themselves wrestling with the Forand Bill, which, in essence, provides for the back-door approach to socialized medicine.

The Forand measure, to be specific, would make the beneficiaries of Social Security assistance recipients of free medical, hospital and nursing-home care. Any American on Social Security, the bill provides, would be entitled to 60 days of free hospitalization every year and to 120 days of free nursing-home care. Nearly half of every year, in other words, could be spent in bed at the expense of the Social Security Administration and the millions of Americans who contribute to its support.

At the moment there are 4.5 million men and women eligible to receive the medical and hospital benefits that the Forand Bill would make available. Yet to defray these expenses, no fewer than 76 million men and women are making regular contributions to the Social Security system. That inequity alone suffices to shake

aquasol A capsules

more readily, rapidly, completely reaches the affected tissues because there is

"greater diffusibility of vitamin A from aqueous dispersion into the tissues."[1]

aquasol A capsules — the most widely used of all oral vitamin A products, for these good reasons . . .

aqueous vitamin A is more promptly, more fully, more dependably absorbed and utilized.

natural vitamin A is more effective because it is directly utilized physiologically.

well tolerated — fish taste, odor and allergens are removed by special processing.

economical — less dosage is needed and treatment time is sharply reduced as compared to oily vitamin A.

three separate high potencies (water-solubilized natural vitamin A) per capsule:

25,000 U.S.P. units

50,000 U.S.P. units

100,000 U.S.P. units

bottles of 100, 500 and 1000 capsules

Samples and literature available upon request.

u. s. vitamin & pharmaceutical corporation

Arlington-Funk Laboratories, division
250 East 43rd Street, New York 17, N. Y.

1. Davidson, D. D. and Sobel, A. E.: J. Invest. Derm. 12:221, 1949.

Fourth Estate

Continued

the faith of many Americans in the proposal's soundness.

But even more questionable is the federalized, standardized brand of medical care the Forand Bill would create. Every American knows by now that medical care is the most personalized of all services. No two patients are alike; no two maladies are alike; no two treatments are alike. Who can believe, consequently, that a standardized, rubber-stamp kind of medical care would prove equally beneficial to 4.5 million Americans?

It is true, as the advocates of the Forand Bill maintain, that Americans are living longer—a circumstance attributable, incidentally, to the system of free medicine that the Forand Bill seeks to weaken. It is similarly true that an increasingly large percentage of the American population falls into the age category at which the Forand Bill is aimed.

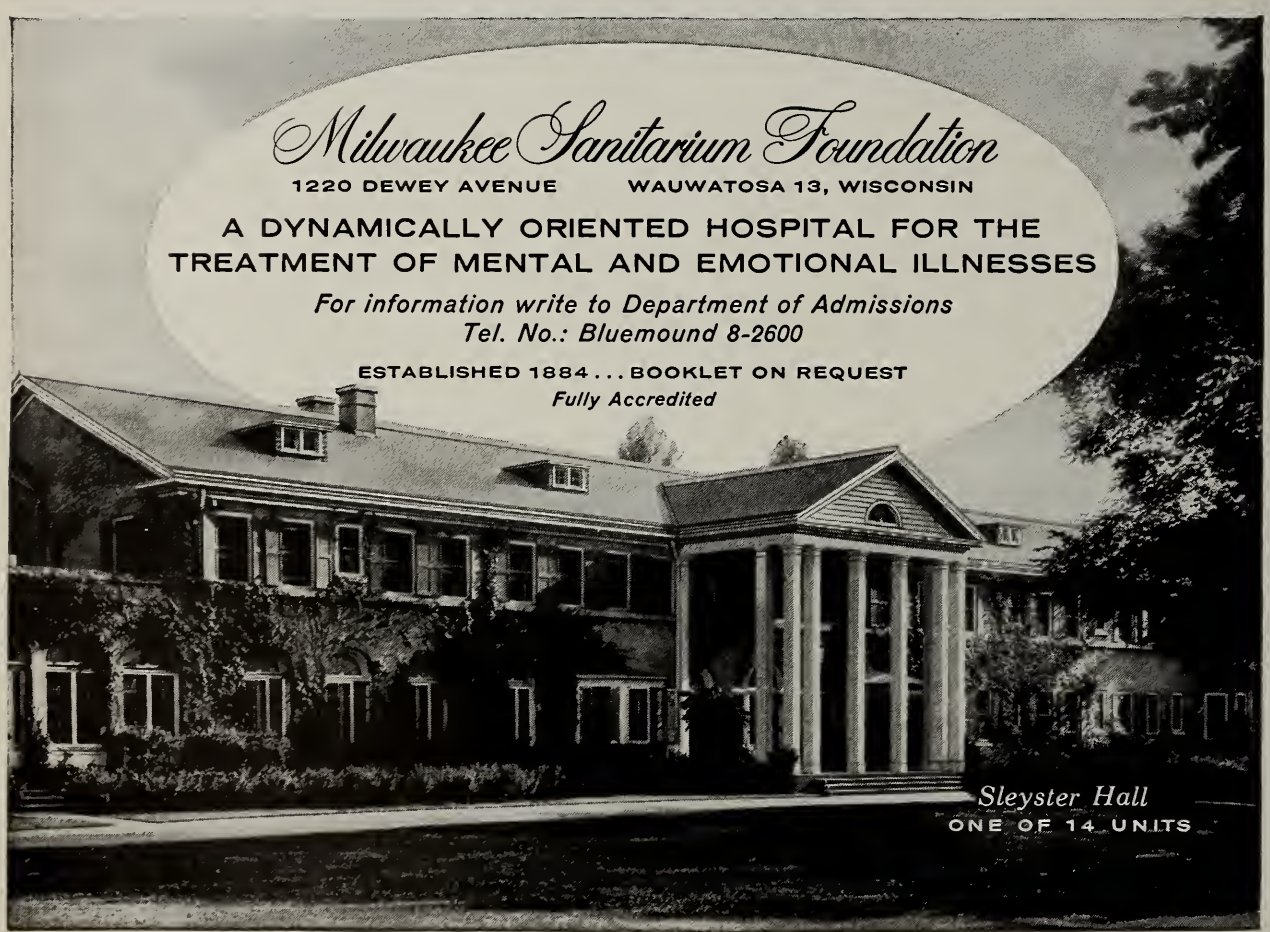
But we are far from an emergency situation in the availability of medical care for the aged and aging. A vast majority of the men and women presently receiving Social Security benefits are already receiving the medical and hospital attention they need and deserve. This attention is available through their own resources, through the resources of their families or through the resources of the communities in which they live.

There is, in brief, no sound medical reason for ushering in the socialization of medical services for this one segment of our population. This is particularly true in view of the likelihood that, once socialized medicine became available to one part of the American nation, it would ultimately become available to all other parts.

Of all the freedoms the American people enjoy, the freedom of choice in the field of medical care is one of the most precious and meaningful. That is why the forces of socialized medicine have made so little headway after two decades of effort. That is why the American people are almost certain to reject the Forand Bill with its backdoor approach to federalized medicine.

Anderson Herald
Jan. 14, 1960

Continued on page 424





This flaky pie crust, *crisp cookies, Chiffon cakes, biscuits can all be made easily with Wesson. Decrease the calories of pie by preparing with single crust and a fresh fruit or gelatin filling. It is delicious.*

FREE *Wesson recipes are available in quantity for your patients, showing them how to prepare these treats as well as main dishes, vegetables and salads with poly-unsaturated vegetable oil. Request quantity needed from The Wesson People, Dept. N., 210 Baronne St., New Orleans 12, La.*

Wesson satisfies the most exacting appetites. To be effective, a diet must be *eaten* by the patient. The majority of housewives prefer Wesson particularly by the criteria of odor, flavor (blandness) and lightness .of color. (Substantiated by sales leadership for 59 years and reconfirmed by recent tests against the next leading brand with brand identification removed, among a national probability sample.)

Wesson's Important Constituents

Wesson is 100% cottonseed oil . . . winterized and of selected quality

Linoleic acid glycerides (poly-unsaturated)	50-55%
Oleic acid glycerides (mono-unsaturated)	19-28%
Total unsaturated	75-80%
Palmitic and stearic glycerides (saturated)	20-25%
Phytosterol (predominantly beta sitosterol)	0.4-0.7%
Total tocopherols	0.09-0.12%

Never hydrogenated—completely salt free

Each pint of Wesson contains 437-524 Int. Units of Vitamin E.

to the editor:

December 26, 1957.

Dear Miss Wilson:

I have a feeling that you and your position constitute one of those situations in which things are simply taken for granted. I know that many of the doctors never even open their Journals and many more that never read them, as witness the fact that so many doctors don't know anything about the affairs of the Association.

I am sure you have a lot to do with the Journal. The covers are positively beautiful and don't even have the appearance of the common medical journal. I for one would like to congratulate you on the Journal, particularly the current issue.

Sincerely,
Robert K. Webster, M.D.
Brazil

(Thank you, Dr. Webster. Any improvement we have been able to accomplish on the *Journal* is the result of a combined staff effort. We all appreciate your kind words. C. W.)

January 26, 1959.

Dear Doctor:

I expect you have many comments on the new looks of the Journal. Here is another.

I took my Dec. number home the other night to read it and laid it on the library table. My wife saw it and said:

"What's that magazine?"

I said, "That's the state medical Journal."

The Mrs. said, "You mean that is a medical journal? I never saw one like that. It's really pretty."

Sincerely,
James B. Maple, M.D.
Sullivan

(Dr. Maple is necrologist for the *Journal*.)

Fourth Estate

Continued from page 420

Of Politicians and Pills

There is an interesting and odd coincidence between the Kefauver hearings on drug price and a series of stories which say Congress will "liberalize" Social Security next year. The fact that 1960 is an election year will have no effect whatever on Congress, except to insure the tastiest kind of political goodies for as many people as possible.

Senator Kefauver's hearings have one obvious intent. He wants to prove that the price of drugs for older citizens is too high, that the drug manufacturers are making too much money and that "something should be done." Lower prices for drugs or higher Social Security payments seem to be the "somethings" which appeal most to Senator Kefauver at the moment.

There is one point which the average citizen might mull over in the meantime.

Senator Kefauver forced drug manufacturers to admit that the cost of raw material for pills is mighty low, almost dirt cheap, when compared with the product purchased by the public. Along that same line, there are times when many citizens wonder whether the raw material of the average politician justifies the last cost to the public of the finished product. Of course, there is doubtless a great expense in finding and developing politicians, such as Senator Kefauver, too.

Indianapolis Star
Dec. 12, 1959

COOK COUNTY
GRADUATE SCHOOL OF MEDICINE

INTENSIVE POSTGRADUATE COURSES
STARTING DATES — SPRING, 1960

Surgical Technic, Two Weeks, April 18, May 16
Blood Vessel Surgery, One Week, May 9
Surgery of Colon and Rectum, One Week, May 2
General Surgery, Two Weeks, May 2
Gallbladder Surgery, Three Days, April 18
Surgery of Hernia, Three Days, April 21
Surgery of Hand, One Week, April 18
Pediatric Surgery, One Week, April 25
Internal Medicine, Two Weeks, May 2
Board of Surgery Review, Part II, Two Weeks, May 16
Gynecology, Office and Operative, Two Weeks, April 18
Obstetrics, General and Surgical, Two Weeks, May 16
Diseases of the Chest, One Week, May 23
Breast and Thyroid Surgery, One Week, May 23

Numerous other courses will be offered by the Divisions of Internal Medicine, Surgery, Gynecology, Obstetrics, Urology, Radiology and Dermatology. Circulars available upon request.

TEACHING FACULTY—ATTENDING STAFF OF COOK COUNTY HOSPITAL

Address:
REGISTRAR, 707 South Wood Street, Chicago 12, Illinois

Life started in the ocean—It is still at its healthiest when water and salt are in balance.

Fluid Balance in Obstruction Of the Large Intestine

*W. D. SNIVELY, JR., M.D.**
Evansville

FIGURE 1 symbolically portrays obstruction of the large intestine. Consideration of the intestinal secretions is of great importance in any discussion of fluid balance in obstruction of the large intestine. In the normal, healthy adult these secretions amount to over eight liters daily. They include:

- Saliva 1,500 ml.
- Gastric juice 2,500 ml.
- Bile 500 ml.
- Pancreatic juice 700 ml.
- Intestinal juice 3,000 ml.

These are the quantities secreted in health. They may well be increased in intestinal obstruction. Their importance can scarcely be overemphasized.

Clinical Events Producing Fluid Imbalances

The patient with obstruction of the large intestine is a likely candidate for derangements of the body fluids. Let us review the several clinical events which may produce imbalances in such patients. First of all (Figure 2), eating and drinking decreases or stops altogether.

Second (Figure 3), blood may be lost through bleeding into the gut, into the bowel wall, into the mesentery of the gut or into the peritoneal cavity. Besides actual blood loss, there may be extensive pooling of blood in the capillaries of the mesentery. This can occur in simple or strangulating obstruction. If surgical procedures are carried out, further blood loss may be anticipated. Blood loss through hemorrhage is especially serious when strangulating obstruction has occurred.

Severe plasma deficit (Figure 4) occurs even more frequently. Nearly half of the total plasma volume can be lost after four hours of a strangulating obstruction. Plasma may be lost into edema of the bowel wall. The fluid of such edema usually consists of about half plasma and about half interstitial fluid. Plasma may also be lost into the peritoneal fluid.

In addition to losses of plasma, water and electrolytes (Figure 5) may be lost through:

- Excessive perspiration
- Gastric or intestinal drainage
- Vomiting
- Failure of absorption of intestinal juices with excretion into the dilated bowel

Finally, excesses of water and electrolytes (Figure 6) are gained through injudicious therapy and through malfunction of the organs of body homeostasis.

Specific Imbalances of Water and Electrolytes

In discussing somewhat specifically, imbalances of water and electrolytes, I would like to employ a simple graphic method of delineating the major imbalances. On Figure 7 you will note

* Medical Director, Mead Johnson and Company, Evansville.



FIGURE 1

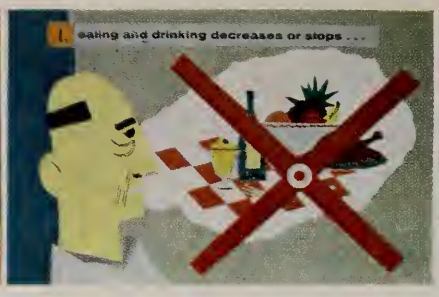


FIGURE 2

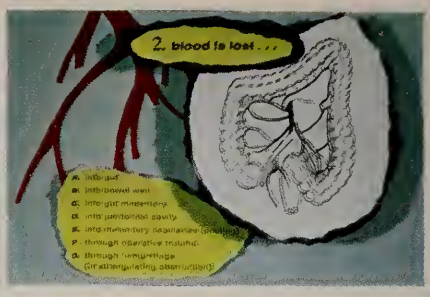


FIGURE 3

various properties of extracellular fluid represented: volume, electrolyte concentration (by which we refer chiefly to the sodium and chloride concentration of extracellular fluid), potassium content, calcium content, base bicarbonate content and carbonic acid content. Finally, at the far right, we have represented the distribution of extracellular fluid between plasma and interstitial fluid. The top row of beakers symbolize the normals for each of these values. The middle row illustrates excesses and interstitial fluid to plasma shift. We will employ these symbols in discussing specific imbalances of the extracellular fluid.

First (Figure 8), we will discuss an imbalance that occurs with great frequency in intestinal obstruction:

Extracellular Fluid Volume Deficit

Many factors may combine to produce extracellular fluid volume deficit in bowel obstruction. The deficit may be of sufficient magnitude to cause an acute weight loss of as much as twelve percent of the body weight. The deficit is caused by decreased intake of water and electrolytes, losses of these substances through vomiting, and losses through secretion of intestinal juices into the dilated, obstructed bowel. The symptoms include dryness of the skin and tongue, lack of moisture in the axilla and in the groins, and loss of skin turgor. There may be a body temperature drop, lassitude and decreased urination. Characteristically, the hematocrit, hemoglobin and red blood cell count are elevated because the loss of water and electrolytes leave the formed elements of the blood in a smaller volume of plasma. Extracellular fluid volume deficit frequently develops early in acute obstruction.

The opposite imbalance (Figure 9) may occur:

Extracellular Fluid Volume Excess

This imbalance may be produced when a patient is given excessive quantities of isotonic solution of sodium chloride for several days following operation. The symptoms include:

- Heavy eyelids
- Hoarseness
- Shortness of breath
- Moist rales in the lungs
- Engorgement of peripheral veins
- Bounding pulse
- Pitting edema
- Rapid weight gain

The hematocrit, hemoglobin and red cell count are decreased because of the plasma volume expansion.

Electrolyte Concentration Deficit

This imbalance (Figure 10) is prone to occur in hot weather and when an unrestricted quantity of water not containing electrolytes is drunk. It is frequently seen when gastric or intestinal suction tubes are functioning and the patient is either not drinking or is drinking plain water. Symptoms include weakness, anorexia, lethargy, apprehension, nausea, abdominal cramps, depressed urination, projectile vomiting, disorientation and coma. Edema may be present and one may observe fingerprinting when the thumb is pressed over the sternum. The level of sodium in the plasma is usually below 137 milliequivalents per liter and the specific gravity of the urine is characteristically below 1.010.

Another imbalance which may develop (Figure 11) is:

Electrolyte Concentration Excess

When a patient stops eating and drinking, particularly in hot weather or febrile states, he loses more water than electrolytes. He may do the same thing when he has a profuse watery diarrhea. The result is an electrolyte concentration excess of the extracellular fluid. Such an excess may also be observed when isotonic solution of sodium chloride, which provides no free water for body metabolism, is given without



FIGURE 4

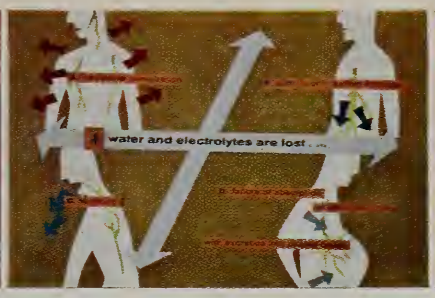


FIGURE 5



FIGURE 6

ARTWORK BY CARLOS SIERRA-FRANCO

adequate quantities of electrolyte-free solutions, particularly when a hypotonic fluid such as perspiration or watery diarrhea is being lost from the body. The symptoms of this imbalance include elevated body temperature, depressed lacrimation, dry, sticky membranes, flushed skin and excitement. The tongue is rough and dry. Salivation is depressed. Thirst and hypotension are frequently present. Weakness and depressed urination are observed.

The plasma sodium is usually above 147 milliequivalents per liter. Plasma chloride plus the plasma bicarbonate ions total about 135 milliequivalents per liter. The specific gravity of the urine is characteristically above 1.030.

One of the deficits most frequently seen in intestinal obstruction is:

Potassium Deficit
(Figure 12)

The normal daily intake of potassium is about 100 milliequivalents. Almost all of this is excreted in the urine. Since the body reserves amount to about 3,400 milliequivalents of potassium, depletion may occur fairly soon after operation if no potassium is given. Since replacement of lost potassium can readily be accomplished, there is little excuse for depletion. Administration of 20 to 50 milliequivalents of potassium per day following operation will prevent depletion.

Clinical findings in potassium deficit include weakness, anorexia, muscle irritability and hyperactive tendon reflexes. The muscles are soft, like half-filled water bottles. Silent intestinal ileus may occur; so may gaseous distention of the intestines. Tremor may be observed. As potassium deficit becomes more severe muscle paralysis occurs and tendon reflexes are decreased or absent. The electrocardiograph shows low voltage, flattening of the T waves and depression of the ST segment. The potassium level of the plasma is usually below four milliequivalents per liter. The opposite imbalance to potassium deficit may be seen:

Potassium Excess
(Figure 13)

Such an excess is observed when there has been extensive tissue damage, when excessive potassium has been given or when there is impaired renal function. Grahame observed that when patients with acute obstruction of the colon suffered from potassium excess, they also had small bowel distention. Since these patients also manifested elevated levels of non-protein nitrogen, he concluded that kidney failure was an important factor in the potassium excess. Clinical findings in potassium excess include nausea, intestinal colic, diarrhea and decreased urination.

The electrocardiograph in potassium excess reveals high T waves and depressed ST segments. Later, the T waves disappear and heart block has its onset. The plasma potassium is characteristically above 5.6 milliequivalents per liter. Another imbalance (Figure 14) is:

Calcium Deficit

An acute deficit of calcium has been noted in strangulating obstruction of the small intestine. It is not of frequent occurrence in large bowel obstruction. Massive repeated transfusions of blood may precipitate it. It is characterized by tetany, abdominal cramps, numbness and muscle cramps. The electrocardiograph shows prolongation of the Q-T interval. The plasma calcium is usually below 4.5 milliequivalents per liter.

Base Bicarbonate Excess

Primary base bicarbonate excess (metabolic aikalosis) (Figure 15) is often observed when gastric juice has been lost in considerable amounts in vomiting. The lowering of the chloride level of the extracellular fluid, caused by loss of chloride in gastric juice, causes a compensatory rise in bicarbonate since the anions of

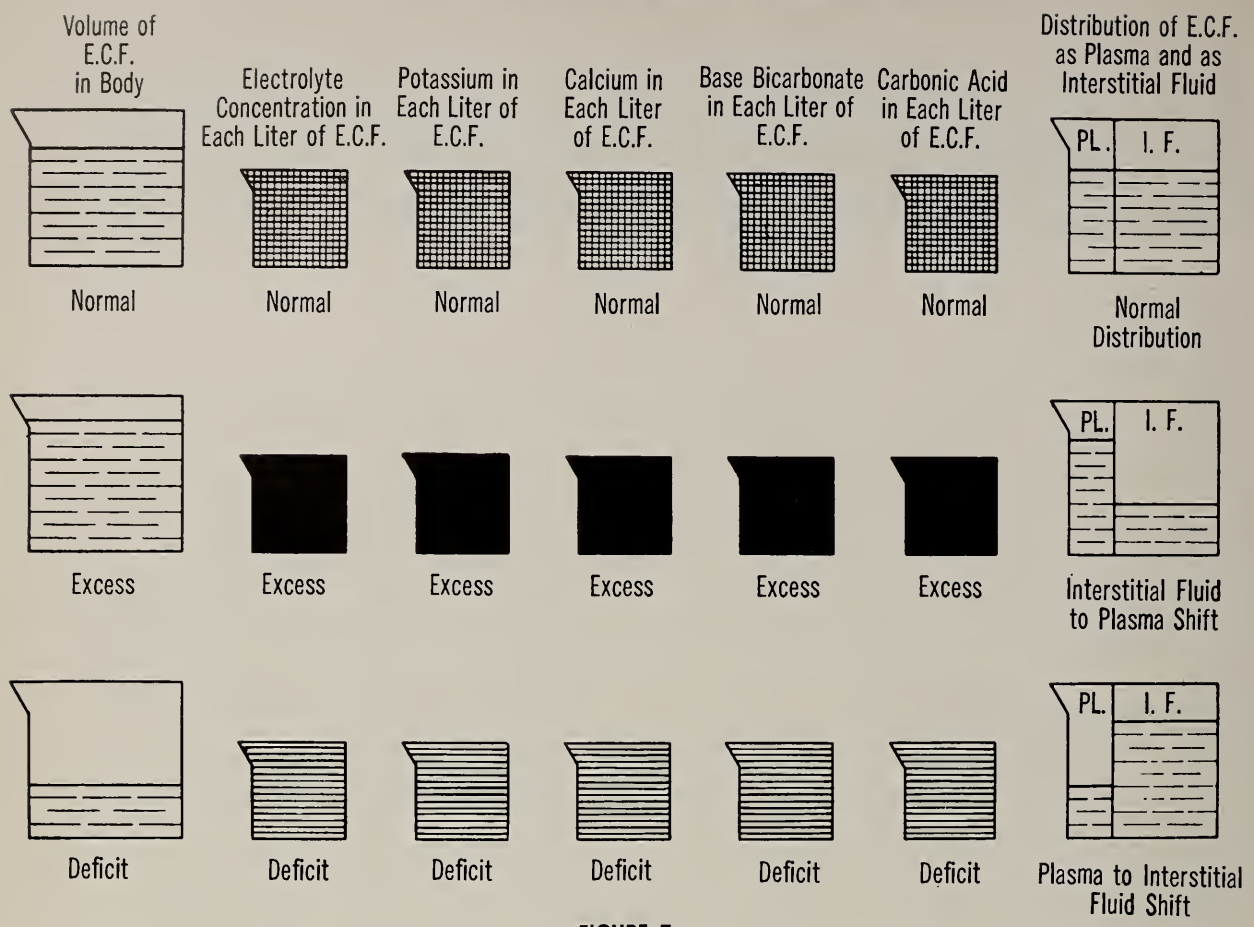


FIGURE 7

a fluid must always equal the cations. Since potassium is also present in gastric juice and since other losses of potassium frequently occur in intestinal obstruction, base bicarbonate excess is often combined with potassium deficit (Figure 16).

Here we have manifested an interesting and not completely explained phenomenon: A potassium deficit acts to maintain a base bicarbonate excess. If chloride is given in an effort to replace bicarbonate, the chloride will be excreted in the urine, resulting in a paradoxical acid urine in the presence of metabolic alkalosis. Correction of the imbalance will not be achieved unless potassium is given with chloride. When both chloride and potassium are given, bicarbonate is displaced and excreted in the urine.

Therapeutic Considerations

If the patient cannot void, an inlying catheter should be employed. The admission specimen of urine should be examined to rule out diabetic acidosis and renal colic since these conditions can mimic intestinal obstruction. Blood should be drawn immediately for determination of sodium, potassium, chloride, bicarbonate content and nonprotein nitrogen. A blood sugar determination may reveal unsuspected diabetes. The serum amylase may be elevated with acute intestinal obstruction, presumably because of back pressure in the duodenum.

The patient previously in good health with early acute simple bowel obstruction (or acute obstruction of the colon) requires little or no preoperative correction with blood, plasma, water or electroyltes. One to two liters of 5% dextrose in water may suffice. Correction of estimated blood or plasma deficits is of first importance. If the patient has not been eating or drinking, but has no pre-existing water and electrolyte deficit, he can be maintained by infusion of 2.5 liters of a Butler type of balanced solution for each 24 hours. If he has a deficit of up to 5% of acute weight loss, ideal restitution would consist of approximately four liters of a Butler type of balanced solution for the first 24 hours. If his acute weight loss is up to 10% or more of body weight, then approximately five liters of a

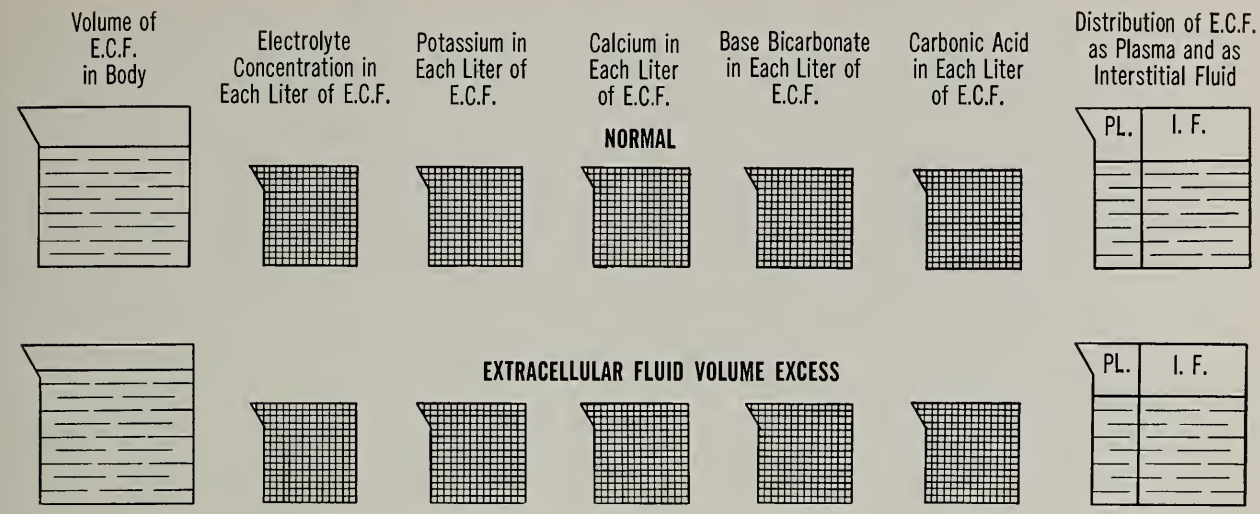


FIGURE 8

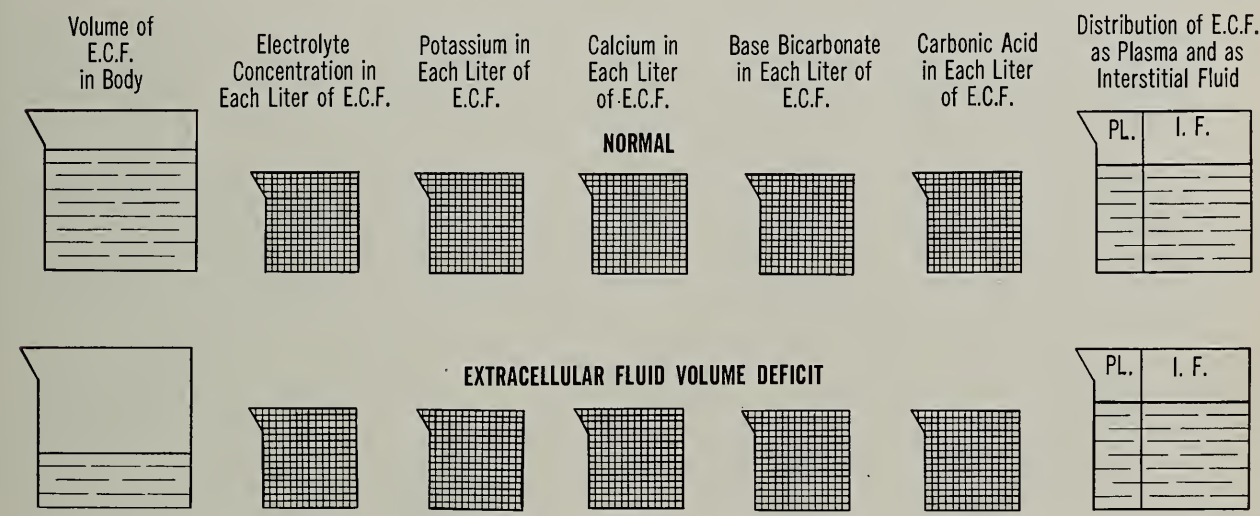


FIGURE 9

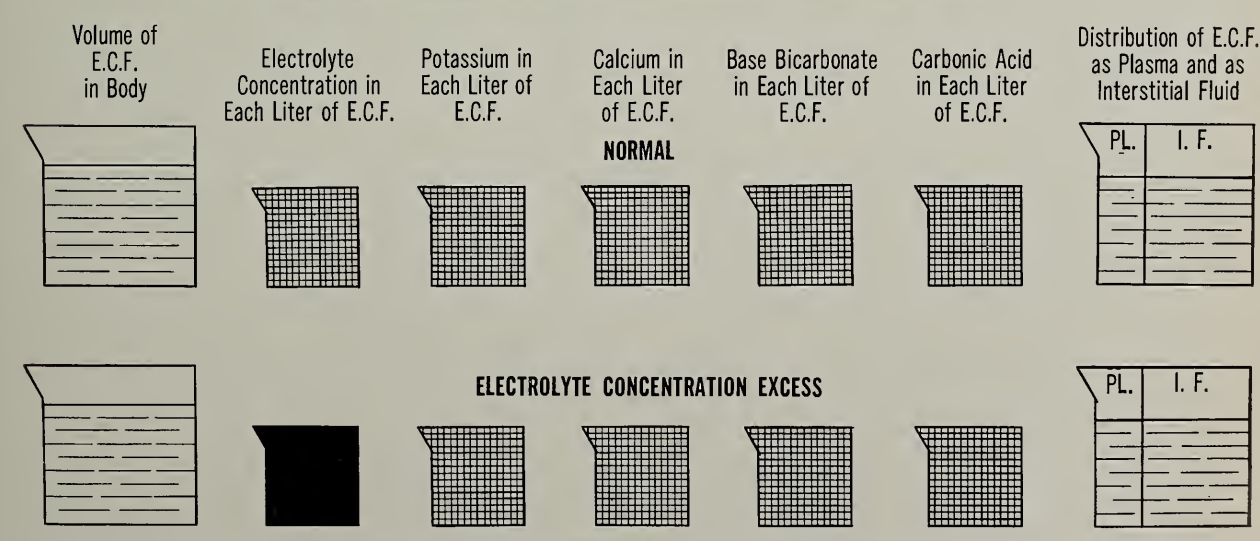


FIGURE 10

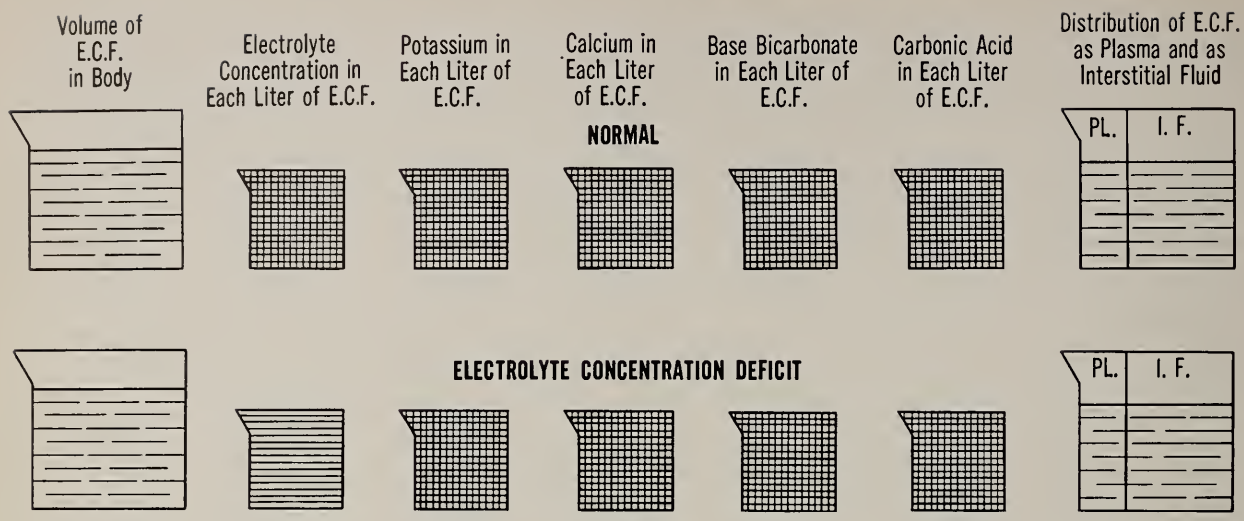


FIGURE 11

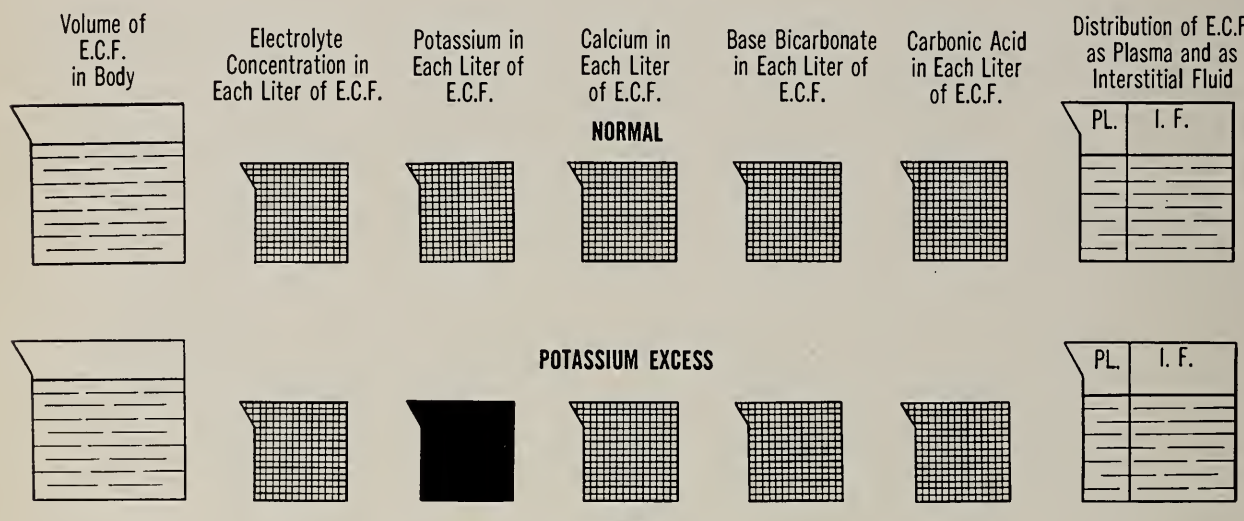


FIGURE 12

Butler type of balanced solution should be given during the first 24 hours. These suggestions presume, of course, adequate time before operation is required. They also assume a patient of average size.

Actually, we prefer the use of body surface area as a yardstick for dosage of water and electrolytes. The basic rule we follow is as follows:

- For maintenance: 1,500 milliliters per square meter of body surface per day
- For maintenance plus correction of a moderate pre-existing deficit: 2,400 milliliters per square meter of body surface per day
- For maintenance plus correction of a severe pre-existing deficit: 3,000 milliliters per square meter of body surface per day

The solution employed is a Butler type of balanced solution. One can roughly employ this scheme of dosage by considering that a small adult will have 1.5 square meters of body surface, an average sized adult 1.75, and a large adult two square meters of body surface. For more accurate dosage, body surface area nomograms are readily available from commercial manufacturers of solutions.

Usual rate of administration is three milliliters per square meter of body surface per minute, or about five milliliters per minute for an average sized adult.

In general, losses from enterostomy drainage, vomiting, diarrhea or pooling in a distended bowel should be replaced with an equal volume of a solution approximating in composition and

CHART FOR RECORDING ANALYSIS OF IMBALANCES IN EXTRACELLULAR FLUID

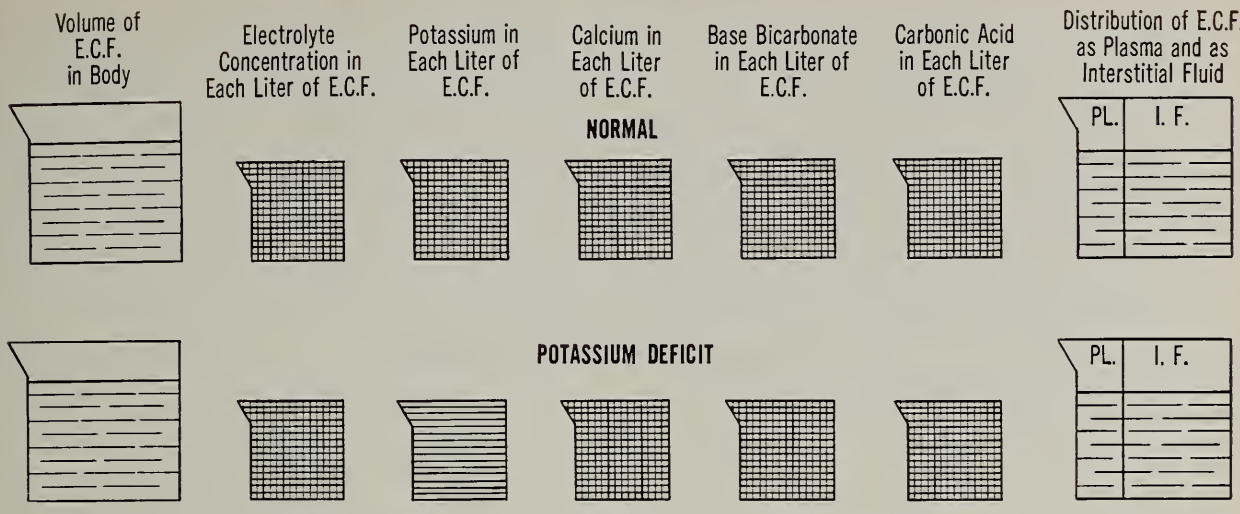


FIGURE 13

CHART FOR RECORDING ANALYSIS OF IMBALANCES IN EXTRACELLULAR FLUID

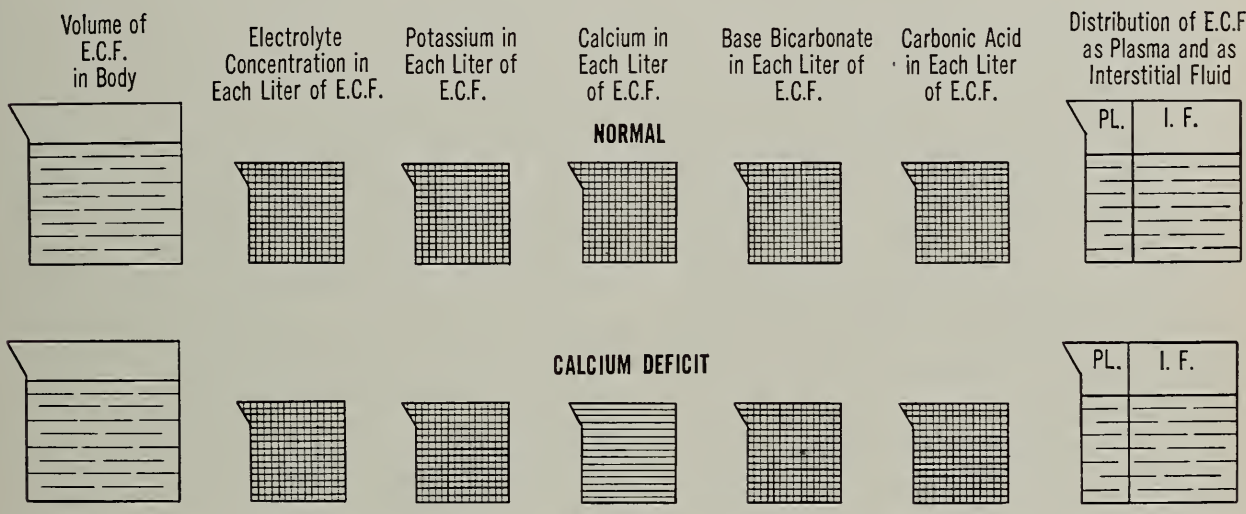


FIGURE 14

CHART FOR RECORDING ANALYSIS OF IMBALANCES IN EXTRACELLULAR FLUID

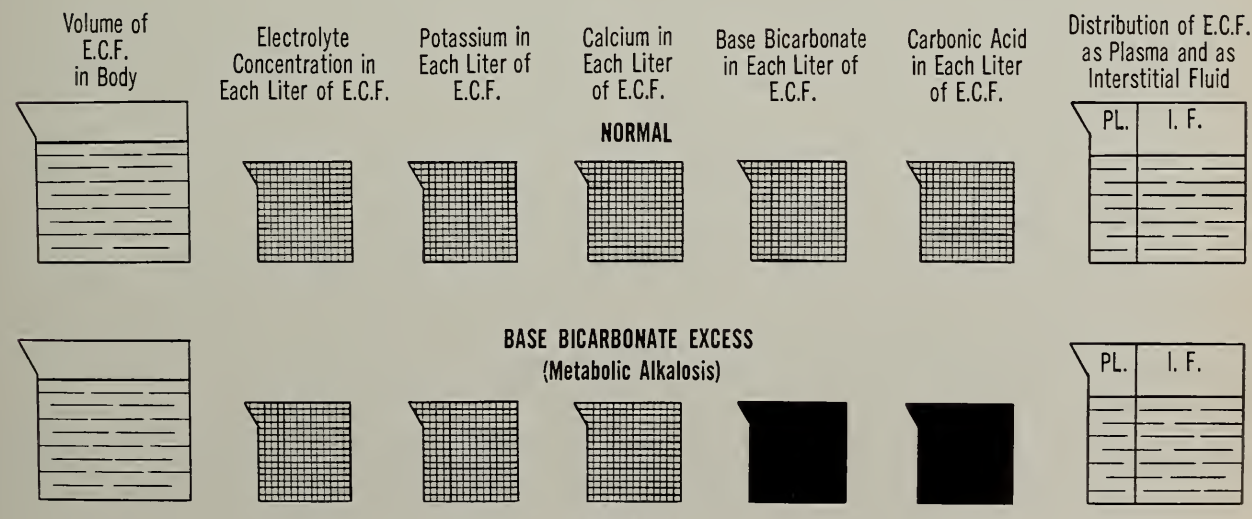


FIGURE 15

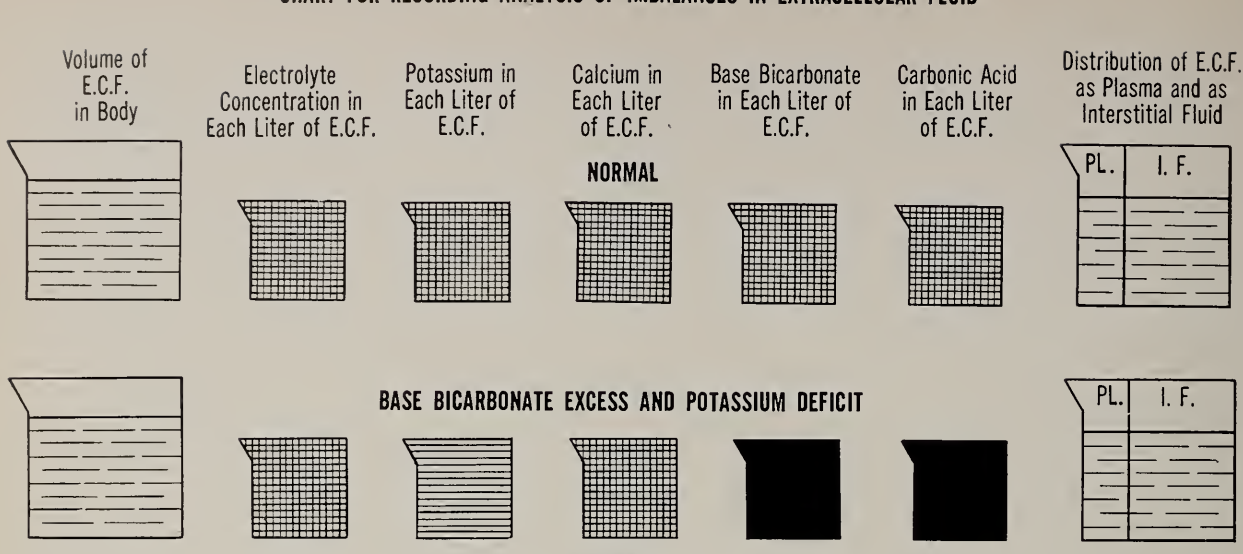


FIGURE 16

concentration the secretion lost. Thus, losses of gastric juice should be replaced with a gastric replacement solution, intravenously administered. Losses of intestinal juices should be covered by infusions of duodenal or intestinal replacement solutions. Fox's solution is excellent for this purpose. Lactated Ringer's solution can be employed, although it is unduly low in potassium. We employ the same general rules postoperatively as preoperatively in regard to provision of maintenance, correction of deficits and repair of concurrent abnormal losses.

As convalescence progresses, attention should be paid to correction of deficits of protein, calories and vitamins. If the intestinal tract is not yet ready to receive food, solutions containing protein hydrolysate, alcohol and dextrose are extremely useful.

The carbohydrate is usually incorporated in amounts of 50 to 100 Gm per liter of solution, that is, in 5 or 10% concentration.

Inspection of the solution reveals that it contains a total of 75 mEq of cations and 75 mEq of anions per liter. This type of solution has a total electrolyte concentration of about one half the electrolyte concentration of extracellular fluid or normal saline.

The solution thus provides *free water* to replace the essentially electrolyte-free water lost as insensible perspiration. The free water also aids the kidney to perform adequately its excretory and regulatory functions.

The solution provides both cellular and extracellular electrolytes. It is referred to as a balanced solution because it is so formulated that when it is used to correct a fluid volume deficit it provides electrolytes, in such quantities that the homeostatic mechanisms can retain those required for normalization of body fluid electrolyte composition and excrete electrolytes which are not needed. At the same time it provides carbohydrate to combat ketosis and tissue breakdown.

The "Butler type of balanced solution" referred to in the text has approximately the following composition:

Cations	sodium	40 mEq.
	potassium	35 mEq.
Anions	lactate	20 mEq.
	chloride	40 mEq.
	phosphate	15 mEq.

REFERENCES

Hendricks, E. D., Greene, L. F.: The Conservative Management of Acute Renal Insufficiency, *Proc. Staff Meet., Mayo Clin.*, 29:205-210, April 21, 1954.

McCarty, W. R.: The Management of the Acute Abdomen, *Med. Clin. North America,* 41:789-797, May, 1957.

Noer, R. J.: Intestinal Obstruction, *Postgrad. Med.,* 20:268-275, Sept., 1956.

Shapiro, S. W., Mason, E. E.: Ileus as a Cause of Volvulus of the Sigmoid; Review of Results of Management, *Surgery,* 41:512-521, March, 1957.

Snively, W. D., Jr., Sweeney, M. J.: *Fluid Balance Handbook for Practitioners,* Springfield, Illinois, Charles C. Thomas, 1956.

Snively, W. D., Jr., Sweeney, M. J.: Therapy of Imbalance of the Body Fluids, *GP,* 18:74-85, Aug., 1958.

Welch, C. E.: *Intestinal Obstruction,* Chicago, Year Book Publishers, Inc., 1958. ◄

Exact surgical risk is not determinable. However, study of patient by anesthesiologist before operation makes it possible to avoid or minimize complications.

The Preanesthetic Evaluation Of the Surgical Patient

CYRIL TAYLOR, M.D.
Indianapolis

THE EVALUATION of the surgical patient by the anesthesiologist is as important a step in the anesthetic procedure as the administration of the anesthetic. An incomplete knowledge of the patient's history and physical condition is one of the major causes of difficulties arising during anesthesia. Possession of this fundamental information may allow the anesthesiologist to anticipate many of these difficulties —and take the necessary steps to avoid them. The evaluation of the patient provides information so that the anesthetic procedure may be planned to fit individual requirements of the patient, and serves as a basis for estimating surgical or anesthetic "risk."

The term "risk" implies a prognosis in regard to the eventual outcome of a surgical procedure. This prognosis depends upon many factors, some of which can not be foreseen, but which may have a profound effect upon the outcome. The breakdown of the sterile routine, a carrier of pathogenic bacteria amongst the patients attendants, inadequate post-operative care by the house staff and nurses, are just some of the factors which are not expected, but which might have an unfavorable influence on the end result of the surgical procedure. On the other hand, difficulties may be anticipated which do not materialize. It is not surprising that it is difficult to make an accurate prognosis.

Physical Status Classification

The American Society of Anesthesiologists has suggested that patients should be classified according to their physical status, and whether surgery is an elective or an emergency procedure, and not according to "risk." These two factors are the least variable (Table I). This numerical classification does facilitate statistical analysis and is the classification demanded by most anesthetic record sheets. One of the most important factors influencing the prognosis is the ability and experience of the physicians attending the patient. Skillful preparation of the patient preoperatively, and an experienced surgical team, are essential to salvage a patient in very poor physical condition. An inexperienced surgeon or anesthetist can convert the simplest of surgical procedures into a dramatic fiasco.

The problem sometimes arises as to which group of physicians is best suited to evaluate a patient preoperatively. Evaluation entails a complete examination, preparation and an assessment of the physical condition which may be performed competently by the internist or general physician. The surgeon is best suited to evaluate

---

Revised from paper presented before the Indiana Chapter of the International College of Surgeons, Indianapolis, May 6, 1959.

Assistant professor, Department of Anesthesiology, Indiana University Medical Center, Indianapolis.

Class 1	A patient who has no organic disease or in whom the disease is localized and causes no systemic disturbance.
Class 2	A patient exhibiting slight to moderate systemic disturbance which may or may not be associated with the surgical complaint and which interferes only moderately with the patient's normal activities and general physiologic equilibrium.
Class 3	A patient exhibiting severe systemic disturbance which may or not be associated with the surgical complaint and which seriously interferes with the patient's normal activities.
Class 4	A patient exhibiting extreme systemic disturbance which may or not be associated with the surgical complaint, which interferes seriously with the patient's normal activities, and which has already become a threat to life.
Class 5	A patient who is operated upon in an emergency who would otherwise be in Class 1 or 2.
Class 6	A patient who is operated upon in an emergency who would otherwise be in Class 3 or 4.
Class 7	The rare person who is moribund before operation, whose pre-operative condition is such that he is expected to die within 24 hours even though not subjected to the additional strain of operation.

TABLE I

surgical aspects of the case. The physician, who has the experience to estimate the probable response of the patient to the immediate stresses of anesthesia and surgery, is the anesthesiologist.

An experienced anethesiologist has been trained to observe and understand the minute-to-minute responses of the patient on the operating table and has spent many hours since the completion of his training performing this task. He understands which problems may be anticipated, which precautions should be taken and which drugs and anesthetic technics will be most suitable in his hands for the particular patient. It is surprising to learn that on occasions his opinion is given only cursory consideration, and that some internists and surgeons will attempt to dictate his technics. The evaluation of the patient entails teamwork and consultation, with each participant offering the benefits of his special knowledge and experience.

Screen for Defects

Process involved in the evaluation of the surgical patient includes the screening of the patient in order to assess his physical condition and to demonstrate those defects which may have a significant effect on the proposed management of the patient. These abnormalities may be a direct result of the surgical condition, or may be unrelated to it. Careful preparation of the patient must be undertaken to remedy or ameliorate these defects so that the patient enters the operating room in his optimal condition. Attempts to remedy these defects during surgery, when they have become a problem, is unsatisfactory and usually denotes that adequate preparation has not been carried out. Emergency surgery does not always allow the full time necessary for complete evaluation and preparation. It must be appreciated that the emergency surgical procedure is liable to be associated with more problems and difficulties, and the outcome is likely to be less satisfactory than the same surgical procedure performed electively. Some preparation is both possible and essential in all but a few emergency procedures.

Preoperative assessment cannot offer a highly accurate prognosis, but if the limitations are recognized it can serve as a useful guide. The value which can be derived by the anesthesiologist in the estimation of the probable response by the patient to surgery and anesthesia and in the planning of the anesthetic procedure is of a much higher order. A careful consideration must be made of the probable effects of anesthesia and surgery on these pathologic conditions, and also the effect of these conditions on the proposed surgical and anesthetic technics.

Medical History Important

Medical history, as in other fields of medicine, is of paramount importance. Information may be obtained which is not available from physical examination or diagnostic tests. The patient's response to previous anesthetic and surgical procedures may be available from the patient, from his medical attendants or from his past medical records. Any previous difficulties, such as un-

toward reactions to anesthetic drugs, or technical problems, such as the difficulty in maintaining a natural airway or intubating his trachea, should be noted. Periodic diseases, such as asthma, may now be in abeyance, but may recur during anesthesia.

Previous drug therapy is of interest since some of these drugs may be required during the procedure. A knowledge of any reactions to these drugs and the dose schedules may be quite significant. The recent administration of the tranquilizers, particularly the Rauwolfia compounds and chlorpromazine, may produce severe hypotension during anesthesia. The alcoholic is notoriously difficult to anesthetize, and delirium tremens may develop during the emergence or postoperative period.

The physical appearance of the patient is often very informative. Negro patients are liable to be subjected to unrecognized anoxic insults because of the difficulty in recognizing cyanosis. Problems in maintaining satisfactory airways can be anticipated in obese patients, and in those patients with inflammatory lesions or with tumors involving the anatomical airway. Preanesthetic respiratory obstruction will invariably become worse when general anesthesia has been induced. Patients with Ludwig's angina can present rapid and often fatal respiratory obstruction if anesthetized in a routine manner. In this group of patients it is often necessary to ensure an adequate airway before the induction of anesthesia. Technical difficulty in performing endotracheal intubation can be expected in patients with trismus, and may be suspected from the configuration of the jaw and neck of some patients. The state of hydration, pallor, dyspnea, the state of consciousness and the respiratory pattern are some of the visible signs which aid the anesthesiologist in the performance of his proposed task.

Cardiovascular Disease Problems

Considerable difficulties are liable to occur in patients with cardiovascular disease during and after surgery. An adequate myocardial reserve may be necessary to overcome the pathophysiologic insults to which the patient may be exposed. Hypoxia, hypotension and hypercarbia are very poorly tolerated by this class of patient. Abnormal coronary arteries may not be able to dilate as a compensatory mechanism in the presence of hypoxia and hypotension, and hypercarbia may provoke dangerous cardiac arrhythmias. Technics such as high spinal, hypoxic mixtures of nitrous oxide and oxygen and any general anesthetic technic in which ventilation can not be supplemented are ill advised. These patients require adequate blood replacement during major surgical procedures, and yet great care must be taken to avoid overtransfusion with blood or intravenous fluids. The myocardium is significantly depressed by all general anesthetic agents except during light levels of anesthesia. This effect is more marked in the patient with a diseased myocardium and in the presence of such disease deep anesthesia must be avoided. Fortunately these patients usually require only light levels of anesthesia to provide satisfactory surgical conditions.

Evidence of recent acute phases of the cardiac disease indicates that the patient should receive full medical treatment before elective surgery is performed. In those patients with recent myocardial infarction, it has been recommended that it is desirable to defer surgery for at least six months.

Maintain Blood Pressure Level

Presence of hypertensive cardiovascular disease or cerebrovascular disease are particularly significant during anesthesia, and an attempt must be made to maintain the blood pressure at a level which is normal for that individual patient. Presence of arrhythmias, such as atrial flutter and fibrillation, if adequately treated, will not be of as great importance as the underlying cardiac disease. Most anesthesiologists prefer to avoid those anesthetic drugs which are reputed to enhance myocardial irritability when cardiac arrhythmias are present. Presence of heart block introduces a special problem in that an Adams-Stokes episode may develop during anesthesia. This will present itself with the signs of cardiac arrest. The cardiac pacemaker and the necessary drugs, such as Isuprel and molar lactate solution, must be available and ready for immediate use. Continuous electrocardiographic monitoring is mandatory throughout the procedure. At this medical center it is our practice to use continuous electrocardiography during surgery on all patients with significant cardiovascular disease.

Pulmonary diseases present problems which are not confined to the response of the patient to anesthesia and surgery, but may cause difficulties in the technic of administering anesthesia. Emphysema, bronchospasm, copious pulmonary

secretions and those conditions which cause a decrease in the area of functioning alveolar epithelium may all hinder the absorption and elimination of the volatile and gaseous anesthetic agents.

Induction of anesthesia may be prolonged and difficult and the patient will awaken very slowly when anesthesia has been terminated. Intravenous agents can be administered with ease, but care must be taken to ensure that the depression of respiration, which they cause, has been overcome before the patient is allowed to ventilate spontaneously without assistance following surgery.

Compensations for Defects

During anesthesia the use of oxygen-rich mixtures, positive pressure breathing and endotracheal intubation and aspiration can usually compensate for these defects, and for the further respiratory depression caused by the anesthetic agents. During this period, when the patient is anesthetized, his difficulties may be so markedly improved by these measures that his condition is more satisfactory than prior to surgery. Similar measures may be necessary during the postoperative period to avoid the serious pulmonary complications which may develop in these patients.

Spinal and regional anesthesia are not always a simple solution to these problems. In the patient with impaired respiratory efficiency, the intercostal paralysis, which may accompany these technics, may remove the margin of safety, so that respiratory insufficiency reaches a dangerous level. High and medium spinals share with general anesthesia an approximately equal incidence of postoperative pulmonary complications. Local anesthesia and regional anesthesia, which do not cause intercostal paralysis, may be suitable for certain types of surgical procedures on patients with pulmonary disease. Asthma may be just a nuisance to the patient, but the development of an asthmatic attack during anesthesia is frequently difficult to overcome, and the effects may be disastrous. Regional or local anesthesia or ether anesthesia are considered to be the technics of choice. The thiobarbiturates and cyclopropane are usually avoided. These precautionary measures do not preclude the development of an attack. Patients with a notable element of bronchospasm should be prepared with bronchodilators before surgery.

Protect Lungs

Presence of large amounts of secretions or pus within the tracheobronchial tree can be very dangerous. These secretions may pour into healthy portions of the lung as the patient is anesthetized or during surgical manipulation. Protection may be offered by extensive preparation prior to surgery, and if the pus is localized to one lung, as in a lung abscess, by isolating the healthy lung with an endobronchial tube early in the anesthetic procedure. The common cold may progress beyond the confines of the nasal cavity, particularly in a patient whose resistance is impaired by the stress of the postoperative period. This may predispose to atelectasis and pneumonitis, and coughing in the postoperative period may cause wound dehiscence.

In children, coryzal signs and symptoms may be the precursor of a more serious acute infection which may become manifest during the postoperative period. It may endanger not only the patient, but also the other occupants of the surgical ward. Elective operations on patients with acute coryza is an unnecessary hazard and should be avoided.

Abnormalities of the blood are next in importance. An adequate circulating blood volume and hemoglobin concentration is desirable during all anesthetic procedures. This state may be obtained with adequate drug therapy, without blood transfusions, if time allows. A value of 9-10 gm of hemoglobin per 100 cc of blood is usually taken as the dividing line, recognizing that any given value represents an arbitary figure. In minor surgical and diagnostic procedures some judgment is necessary.

Balance Dangers Carefully

The dangers of awaiting the effect of hematinic drugs, the dangers of blood transfusion and the danger of anesthesia in an anemic patient, must be carefully balanced against each other. A low circulating blood volume and hemoglobin concentration may be hazardous. Hemoglobin is obviously essential as the major vehicle for the carriage of oxygen to the tissues. Anemia may produce an anemic hypoxia of vital organs, such as the brain, heart, liver and kidneys, and may cause impairment of the normal function of these organs during anesthesia. Patients with a low blood volume are liable to develop severe cardiovascular collapse following the induction of anesthesia, and small amounts of blood loss may

precipitate severe shock. These hazards are more real and frequent than those associated with carefully prepared blood transfusions.

The concept of avoiding blood transfusions in a patient who is bleeding, so that his blood pressure should not be elevated above shock levels and cause further bleeding, is very dangerous in patients who are to be subjected to anesthesia and surgery. The patient with advanced carcinoma, severe malnutrition, liver disease, chronic infection and weight loss usually has a low blood volume. The estimation of the adequacy of a blood volume from the hemoglobin and hematocrit values are notoriously unreliable, and blood volume studies may be required.

Spinal and regional anesthesia, which may cause extensive paralysis of the sympathetic nervous system, are unsuitable in patients with hypovolemia. The compensatory mechanisms invoked against shock are thus abolished and severe vascular collapse may occur. The hemorrhagic tendency following the use of the anticoagulant drugs or in certain blood diseases should be treated appropriately. Spinal or regional technics should be avoided, if correction is not possible preoperatively, as inaccessible hemorrhage may be initiated during the manipulation of the needle.

Consider Renal Disease

Renal disease must be considered in its effect upon renal function. Poor renal function is of serious importance in the surgical patient. Anesthesia may cause further depression of renal function, which is in direct proportion to the depth of anesthesia. This depression is usually temporary, but particularly if this is associated with hypotension and hypoxia it may progress during the postoperative period. Many of the anesthetic drugs, other than the gaseous and volatile agents, are eliminated at least in part through the kidneys. These drugs must be used carefully, if at all, in patients with poor renal function.

A diseased liver may be an important consideration in determining the technic of anesthesia, and its function may be further impaired by surgery and anesthesia. Chloroform and vinethene are known to have caused hepatic necrosis, but it has been shown that even with these drugs, hypoxia, hypotension and malnutrition are the most significant factors in the etiology of the hepatic necrosis. Barbiturates do not cause liver damage. This class of drugs, like some of the other drugs employed during anesthesia, are metabolized by the liver. These drugs can be used safely, but they have to be administered with care.

Lesions of the gastrointestinal tract may have a profound effect upon the physical condition of the patient. Cachexia, anemia, hypovolemia, malnutrition and severe fluid and electroylte disturbances may occur. Intestinal obstruction and gastrointestinal hemorrhage create serious difficulties, because of the large amount of fluid or blood which can be vomited during general anesthesia. The material which is vomited may be aspirated into the trachea and literally drown the patient. Use of a Levin tube or even a Miller-Abbot tube does not completely remove this danger. Intubation of the trachea under topical anesthesia before general anesthesia is induced, or rapid endotracheal intubation immediately following the induction of anesthesia, will protect the trachea from the gastrointestinal contents.

Delay in Gastric Emptying

Presence of food in the stomach can be suspected if the patient has eaten recently, but it must be remembered that there may be a considerable delay in gastric emptying time following trauma or pain. Delay in performing surgery, the use of regional anesthesia, or the protection of the tracheobronchial tree with an endotracheal tube is advisable in these circumstances. In the acute surgical conditions of the gastro-intestinal tract, a delay of one or two hours to remedy electrolyte, fluid and blood deficits is usually possible and is most desirable.

Endocrine disorders are not infrequent complications encountered in the surgical patient. The abundant use of the adrenal cortico-steroids has made impending adrenal failure a fairly common syndrome. Patients who have had a recent course of therapy with these drugs must be assessed critically to determine whether preoperative replacement therapy is necessary. Possible occurrence of acute adrenal failure during surgery or during the postoperative period must be appreciated. The patient with diabetes should be as well controlled as is possible before undergoing surgery. Ether causes a marked increase in the blood sugar level, and is more likely to produce prolonged postoperative vomiting than the other anesthetic agents. Regional technics and nitrous oxide barbiturate anesthesia are the methods usually chosen to anesthetize the diabetic

patient. The hypothyroid patient usually requires smaller amounts of anesthetic drugs, and the thyroid crisis is a possible hazard in the poorly prepared hyperthyroid patient.

Nervous System Abnormalities

Abnormalities of the nervous system are mainly of interest in their effect upon the selection of the anesthetic technic. Use of regional technics are contraindicated in patients with organic nervous disease, insanity or emotional instability. Recovery from certain nervous diseases, such as anterior poliomyelitis, which may have involved the muscles of respiration, may leave a marked degree of respiratory insufficiency. These patients present some of the problems of the patient with severe pulmonary disease and may require management in a similar manner.

Modern concepts, drugs and anesthetic technics which are available to an anesthesiologist allow the majority of seriously ill patients to survive the immediate stress of anesthesia. The whole surgical team is aware of the patient's poor physical condition, and the meticulous care and attention which is given to these patients is one of the prime factors in achieving this result. It is indeed very rare that an anesthesiologist will refuse to anesthetize a patient if the surgeon feels that surgery offers a hope to save a life. Anesthesia is only one of the many factors which influence the final outcome. The fact that the patient will probably survive the anesthetic should not allow us to forget that the sick patient still has many other bridges to cross before recovery is complete. The gamble which one may take when surgery is the only hope of saving life cannot be accepted for any other reason.

A thorough evaluation of the surgical patient is important even though a highly accurate prognosis is not possible. It will permit logical planning of the medical surgical and anesthetic management of the case, and in this way is bound to improve the eventual outcome of surgery.

REFERENCES

1. Maher, C. C., Flack, H. A., Smyth, G. A.: Medical Evaluation of Surgical Risks, *Surg. Clinics of No. Am.,* 1181-90, October 1958.
2. Oech, S. R., Dripps, R. D.: Judgment in Anesthesia, *Surg. Clinics of No. Am.* 1205-13, October 1958.
3. Saklad, M.: Grading of Patients for Surgical Procedures, *Anesthesiology,* 2:281-284, 1941. ◄

Blue Plans for the Elderly

Coverage for Senior Citizens have been a constant aim of Blue Shield nationally, and although many plans are now providing such coverage, numerous current campaigns geared to the enrollment of as many of the aged as possible were recently inaugurated in many areas throughout the country.

During September, the Blue Shield Plan of Indiana, continuing its coverage for the 65 and over group, particularly stressed that all "elderly citizens" not presently protected by the benefits of health insurance should enroll in the Indiana Plan. In October, Maryland Blue Shield dropped its age limit in order that all qualified senior citizen applicants might be afforded coverage. Texas Blue Shield encouraged those 65 and over to enroll on a non-group basis during October, and from Nov. 15 through Nov. 28 the Blue Shield Plan of Kentucky will conduct its over 65 enrollment campaign.

As evidenced from these endeavors, and from the many plans that are now in effect, it is clearly evident that Blue Shield, nationwide, is striving to provide prepaid medical care for as many of "our elderly citizens" as possible.—*Blue Shield Newsletter,* November, 1959.

Anti-Emetics and Tranquilizers In Surgical Patients

Some drugs combine well with anesthetic agents . . . some don't!

DOUGLAS J. GIORGIO, M.D.
Evansville

THE TRANQUILIZERS are called ataraxics from the Greek word ataraxia, meaning peace of mind. I'm not sure whether it means peace of mind for the patient or the doctor. Few drugs have swept into prominence so quickly as the tranquilizers. Yesterday the doctor prescribed a vacation for his emotionally upset patients. Today he prescribes a chemical vacation. Tons of tranquilizers are prescribed yearly. We appear to be using them in hospitalized patients to lead them back to reality and in the office patient to draw him away from reality and now even to lead steers to the slaughter house as this item from *Newsweek* indicates:

"Everyone knew, or thought he did, that the best milk comes from contented cows. Why not steaks from serene steers? This week, half a dozen drug manufacturers came up with similar answers to the question: tranquilizers for beef cattle that not only make the arduous journey from the pasture to the stockyards pen seem like a deluxe vacation cruise, but, also, somehow put weight on them.

"At an international animal feed symposium in Washington, the drug companies also claimed that a dollar shot of one of their new products would tenderize the ultimate table product by reducing bleed-out time and the amount of toughening oxygen and nitrogen in the flesh.

"Whether or not the diner would really ever taste the difference, tranquilizer-wise Madison Avenue was sure to have a ball with carefree cuts from happy heifers."

Presented before the Joint Meeting of the Indiana and Kentucky Chapters of the American College of Surgeons at French Lick, Indiana, May, 1959.

Tranquilizer Classification

The simplest classification I could find is by Scheele and Benson. They have grouped them into major and minor divisions with the phenothiazines (Thorazine, Sparine, Pacatal, Compazine, Trilafon, Vesprin and Phenergan) and the reserpates (Serpasil, Moderil and Harmonyl) in the major division. In the minor division are included the alkanediols (Miltown, Equanil and Ultran) and the diphenylmethanes (Atarax, Suavatil and Frenquel). Other classifications and divisions mentioning all the chemical groupings, generic and trade names of all the agents and combinations available would take more time than I have been allotted.

The group we have become most interested in anesthesia are the phenothiazines and the popular ones at present are Phenergan (promethazine), Compazine (prochlorperazine), Sparine (promazine) and Thorazine (chlorpromazine). These tranquilizers represent an entirely new type of drug because they produce calmness without hypnosis. The action seems to be a depression at the hypothalamus and the sympathetic level. We are using them in premedication, during certain phases of anesthesia and during the recovery period.

We are using them as premedicants to anesthesia because they have a potent sedative action with no significant respiratory or circulatory de-

pression. They also exhibit variable anti-emetic properties and a synergism with the barbiturates and narcotics and most anesthetic agents. A careful selection of these drugs, in combination with our usual premedication, in smaller doses can assist in approaching an ideal in anesthesia in which the patient may be permitted to have a restful, undisturbed sleep the night before anticipated surgery. On the morning of operation he may be rendered ataraxic and amnesic for preoperative preparation. Then sedation, subhypnosis or deep sleep can be induced smoothly without subjective discomfort and with minimal physiological disturbance.

Reduce Requirements

With these drugs, due to their synergism with our anesthetic agents, we reduce the requirements needed for general anesthesia. The ultrashort acting barbiturates must be given more slowly and in smaller divided doses. An overdose of a general anesthetic, whether barbiturate or inhalation, will easily cause an apnea and must be treated by assisted respiration with an adequate airway. During surgery we must be ever aware of a hypotensive crisis, even though they seldom occur with the small doses of the tranquilizers used for premedication. The patient will respond readily to our usual vasopressors and lightening of the anesthetic level. By the same token we can treat the hypertensive episodes we occasionally meet during cyclopropane anesthesia, infusion of succinyncholine, or overdoses of vasopressor drugs, with small intravenous doses of Thorazine.

In the recovery room there is less vomiting, as a rule. The occasional patient who does vomit can be given small doses of Compazine or Sparine and relief will be quite rapid. The average stay in the recovery room may be slightly prolonged, the effects of the hypnotic and the muscle relaxant drugs may wear off promptly while light analgesia, ataraxia and depression of the vomiting center may persist for several hours, or until the acute disturbances caused by anesthesia and the surgical trauma have subsided. There is less need for post-operative sedation and this should be given in small divided doses to prevent a relapse into general anesthesia.

Many and varied complications are listed with the use of the tranquilizers, ranging from dizziness and drowsiness through hypotension, jaundice and a granulocytosis, but none of these more serious ones are met with when the small doses needed for premedication are used. Needless to say, it is important for the anesthesiologist to be informed if, and for how long, the patient may have been a regular user of a tranquilizer so he can more safely plan his anesthetic procedure.

The proper balance of the ataraxics with other premedication, appropriate use of drugs to maintain a light hypnosis, and to provide sufficient analgesia, muscle relaxation and reflex supression during the anesthesia, and minimal post-operative sedation is rapidly improving the anesthetic management of the patient. ◄

916 S. Burkhardt Rd.
Evansville

The Worth of Man

We are in conflict with a communistic ideology which treats men as pawns of an economic system. If we are to survive, we must convince ourselves that our free society gives man a higher value. And we must demonstrate this higher worth that other people of the earth will discover it. Nor is it enough to say that American wages and standards of living are higher. These may only be due to marketability. We cannot depend on our modern market to make the worth of a man. We must make the man of sufficient worth to support the market.

Ralph W. Sockman
"What Are We Worth?"
Arkansas Methodist

Caps, Gowns and Masks—

Who Should Wear Them And of What Material Should They Be Manufactured

WILLIAM R. NOE, M.D.
Bedford

FOR MANY YEARS the wearing of caps, gowns and masks has been recognized as a vital part of hospital sterile technic. Our purpose is to re-evaluate this phase of the technic as it applies to the prevention of hospital-transmitted resistant staphylococcal infections—wounds or otherwise.

It is not only necessary to prevent transmission of infection from one patient to another, but it is also equally important to protect our medical personnel.

In a sense we have in recent years developed a less fearful attitude toward infections with the advent and general usage of the sulfonamides and antibiotics. As a result of this less fearful attitude, combined with the indiscriminate use of these drugs, our hospitals are faced with a new and deadly serious problem. It is spotty, to be sure, but it is serious in some hospitals—it is undetected in some and absent in others. We, as physicians, must shoulder the major portion of blame for this catastrophe.

It is obvious why hospitals are confronted with this problem. Infected patients are concentrated in hospitals where professional people can easily transfer infection while contaminating themselves at the same time.

A world-wide medical effort *must,* in a preventive sense, be put forth to recognize the problem and take the necessary precautions if we are to provide the public with safe hospital service. Complacent attitudes of all personnel must be changed. Unless close attention is paid to the already-learned exacting details of hospital sterile technics, control of resistant staphylococcal infections is doomed to failure.

Two points come to mind when one considers the subject of caps, gowns and masks.

(1) First, I wish to mention material and design. Cotton fabrics are generally used in their manufacture. The material is closely-knit, is easily washable and sterilized and is inexpensive and probably the best material available. The problem of static electricity is nonexistent. Gowns must be designed to fit loosely to allow freedom of motion. Caps should snugly cover all the hair-bearing area of the scalp. This prevents danduff and other foreign material from dropping onto and thereby contaminating surgical wounds, etc.

Presented before the Joint Meeting of the Indiana and Kentucky Chapters of the American College of Surgeons at French Lick, Ind., May, 1959.

In spite of being gowned and capped, however, loose minute body debris can still traverse the material. This is particularly prone to occur if the gown is wet or if the sleeves above the gloves become moistened with blood or tissue juices during operative procedures.

(2) The face mask is manufactured of multilayers of loosely woven cotton cloth to permit some respiratory air exchange and this is necessarily so. Cellophane inserts are advocated and worn by some—but air exchange has to occur around the edges and, therefore, makes for discomfort. Herein has arisen a degree of controversy as to the effectiveness of the face mask. As you all know, some surgeons have long since discarded it.

Numerous studies have been made as to the effectiveness of the mask. Experiments have been carried out by exposing blood agar plates to talking and silent personnel. In the first instance no masks were worn—in others 1 and 2 masks were worn. From colony counts on these agar plates, it appeared that there was no advantage in wearing 2 masks over 1, nor was one mask much improvement over none. When silence was the rule, the lowest colony counts were obtained and masking did not seem to improve it.

We can arbitrarily state, then, that masks, when worn, are effective in preventing contamination (surgical wounds or otherwise) in direct proportion to the coughing, sneezing and talking of the person wearing it. In various studies over the country, from 20 to 80% of hospital personnel were found to be nasal carriers of the staphylococccs. Airborne contamination can then be minimized by taking the following measures:

(1) All personnel should be banished from the operating room where it is known that an acute or active staphylococcic infection exists. This is to include those individuals with acute upper respiratory infections because of sneezing and coughing. Masks may not be effective in controlling staphylococcal nasal carriers.

(2) Daily bathing or showering by operating room personnel should be part of their personal hygiene before beginning work in the operating room. This is to rid the skin of loose and hair-clinging debris which, of course, is contaminated with bacteria.

(3) Ward blankets, linens and street clothing should be eliminated from the operating room and not even allowed in the operating suite. This material is notoriously heavily contaminated with staphylococcic organisms.

(4) We should insist on a drastic reduction in the amount of activity in the operating room during surgery. All operating room personnel should refrain from unnecessary entrances and exists. Unnecessary conversation should be stopped. This is justifiable because of the proven added opportunity for airborne staphylococcal contamination as well as being distracting to the surgical team.

All of us need to look at ourselves now and then and see if we are doing our utmost to protect our patient. We need to develop a sense of surgical conscience in the operating room, and a sense of medical conscience in the rest of the hospital.

In summary, caps, gowns and masks are only as effective in the preventive control of resistant bacterial infections as we who wear them. At the proper time and place they must be worn, for their presence is a constant reminder of our responsibilities.

Let "silence" be the rule and "thinking" prevail. Any other approach to the problem must be considered flagrant disregard for the safety of our patients. ◄

Edgewood Clinic
Bedford

Scrubbing of hands should be done with great care. At best it is none too good.

Re-evaluation of the Methods of Cleaning The Hands of the Surgical Team

AMBROSE C. ESTES, M.D.

Bloomington

THIS MATTER of pre-operative scrubbing of the hands is dull at best until an "unexplained" infection occurs in a clean case.

In the past several years most of us are scrubbing with 3% hexachlorophene detergent soap without any type of germicidal rinse—whether alcohol, zephiran or iodine base.

Although it has been suggested by a number of studies that a 10-minute hand scrub is not necessary, it is equally true that meticulous care is required to scrub all areas of the fingers, especially the webs and creases.

Accepted procedure is:

(1) to lather the hands and arms with hexachlorophene soap and proceed to care for the nails with a sterile nail stick.

(2) Then, rinse off the lather.

(3) A brush is then used for three to six minutes. The surgeon's judgment here is valuable, especially for the first scrub of the day, or if greater surface contamination is considered likely.

The literature is of some help here. In comparison of the effectiveness of:

(1) ordinary cake soap, as compared with (2) detergent-hexachlorophene, and (3) liquid soap-hexachlorophene, the original bacterial counts were compared with counts taken immediately after scrubbing and also after an average operating time of two hours.

The detergent-hexachlorophene produced the most effective degermation in the three- to six-minute period of scrubbing and further reduced the bacterial count immediately following the operative period. This is in marked contrast to the findings following the use of a 10-minute scrub with bar soap and an alcohol dip, for with this procedure the bacterial count increased under the gloves during the operation to as much as 79% of the original count. A zephiran hand dip did not produce a further degermation. An alcohol dip should never be used following hexachlorophene preparations because the alcohol inactivates the hexachlorophene deposited on the skin.

In summary, these reports seem to show that consistent use of hexachlorophene has a carry-over effect (i.e., pre-scrub bacterial counts are markedly reduced in succeeding scrubs). This is not duplicated with alcohol rinses or ordinary soap scrubs.

Recently, Frisch *et al* have investigated Virac, an iodine preparation, which in a controlled study has given better bacterial control than

Presented at the Joint Meeting of the Indiana and Kentucky Chapters of the American College of Surgeons at French Lick, Indiana, May, 1959.

hexachlorophene. However, the matter of carry-over effect was not checked.

Walter has studied the matter of using G-11, or 3% hexachlorophene soap, for all daily hand care—in addition to surgical scrubs—and has reported that this reduces pre-scrub bacterial counts consistently and thus the efficacy of the hand cleansing.

One fact all investigations have established is that bacterial counts rise *almost to pre-scrub levels* after two hours despite the hands being encased in intact rubber gloves! One might assume these bacteria are brought up in sweat from hair follicles and skin creases and, of course, have multiplied in a warm environment. I could find no study in which a second short scrub was done prior to closure of the wound, although the above information might suggest such practice as being wise.

In summary, then, I believe three points are worth emphasizing:

(1) Hexachlorophene produces a carry-over effect of a lower bacterial count on the skin in successive scrubs, and

(2) the bacterial count rapidly rises on the surgeon's hands even under sterile gloves and suggests a source of wound infection during closure if the gloves aren't sound, and

(3) daily all-purpose use of 3% hexachlorophene soap is a proven method for reduction of pre-scrub bacterial counts for the surgeon's hands. ◄

121 East Kirkwood
Bloomington

Indiana Road Information at Your Finger Tips . . .

That's what motorists were promised recently as the Indiana State Police inaugurated a new telephone answering service to promote driving safety.

A current, recorded summary of the general situation may be heard by dialing Indianapolis *CHapel 1-6321* for the driving situation in the north half of the state. *CHapel 1-8244* is the number for the south half.

Col. Harold S. Zeis, State Police head, suggested that citizens memorize the two numbers or write them down for easy reference.

"Travelers may plan their trips in accordance with the conditions they will face," he pointed out.

The road information summaries are vital to street and highway accident prevention, Colonel Zeis said. Thousands of Hoosiers now motor long distances each day to their jobs in every part of the state. In addition, Indiana's geographical location results in a heavy movement of transient motorists.

The recorded bulletins will deal with general road conditions as observed by State Police troopers on patrol. Detailed information will be limited, unless an unusual situation develops.

Overlooked and Misdiagnosed Fractures

Correct diagnosis of fractures is very important. Here are suggestions to increase diagnostic efficiency.

FRANCIS G. ZEIER, M.D.

Evansville

FOR ONE reason or another fractures are occasionally overlooked and misdiagnosed. In order to promote the patient's earliest possible recovery from trauma, in order to avoid future reconstructive orthopedic surgical procedures, in order to prevent prolonged morbidity and crippling complications—in short, in order to render the best service to our patients—it behooves us to make accurate diagnoses of skeletal injuries. Patients are justifiably dissatisfied and disgruntled when their overlooked injuries lead to unnecessary prolonged suffering, loss of income or result in added expense at a later date.

The following is a series of overlooked or misdiagnosed skeletal injuries which have ultimately come to the attention of the author.

Case No. 1—is that of an elderly female who fell at home and injured her left hip. An x-ray examination was made in her community hospital immediately after her accident. It was interpreted as being negative. She was encouraged by her physician to walk in a walker and bear weight. The hip became progressively worse. Five weeks later, on examination by the author, x-rays showed a fracture of the neck of the femur with angulation and displacement (Figure 1). Fibrous union prevented reduction. The head of the femur was, therefore, replaced by an endoprosthesis.

Associated Fracture Found

Case No. 2—is that of a middle-aged man who was involved in an auto accident. There was an obvious fracture of the shaft of the femur clinically. X-ray examination by portable unit showed the fracture and portions of the shaft proximal and distal to the break (Figure 2). The fracture was treated by open reduction and Hansen-Street nail fixation. Two months later progress with regard to the femoral shaft fracture was excellent, but he was then complaining of discomfort in the region of the same hip. X-ray examination revealed an associated fracture of the neck of the femur, hitherto undiagnosed (Figure 3). This fracture fortunately was amenable to manipulation and Moore pin fixation with a satisfactory result.

Case No. 3—is one of a child's elbow fracture which was overlooked in spite of a good early x-ray film (Figure 4). The elbow was treated like

Presented before the Joint Meeting of the Indiana and Kentucky Chapters of the American College of Surgeons at French Lick, Indiana, May, 1959.



FIGURE 1

ANTEROPOSTERIOR view of left hip at five weeks. Earlier films considered negative for fracture.



FIGURE 2

MIDDLE THIRD of femur fracture. Film unsatisfactory because it does not depict the head and neck of the bone.

a sprain with a sling and a bandage. The elbow became comfortable but non-union with resultant deformity and dysfunction developed (Figure 5). The lateral epicondyle and capitellum were fractured off and displaced. Such a fracture must be perfectly reduced and adequately fixed, preferably with two Kirschner wires driven across the fragments for a satisfactory result. A good policy is to obtain films of the other elbow for comparison.

Case No. 4—is that of a mature white male who fell off a truck landing on his right hand, injuring the wrist. He was treated by "shots" and bandages for two weeks. When the swelling had subsided a short arm cast was applied and kept in place for eight weeks. He denied he had been given an anesthetic or that his wrist was manipulated. When first seen by the author, eight months after his injury, he was unable to use his right wrist and hand. X-rays revealed a carpal navicular fracture and a perilunar dislocation, with avascular necrosis of the lunate bone (Figure 6).

Second Element Found Later

Case No. 5—is that of a child's forearm injury. The original diagnosis was greenstick fracture of the shaft of the ulna. It was treated by plas-



FIGURE 3

SAME CASE as Figure 2 two months after injury. Intramedullary nail in place. Associated fracture of femoral neck just discovered.

ter cast immobilization for one month. It was not until the cast was removed that a dislocation of the radial head was discovered. The original and up-to-date x-ray films submitted by the treating doctor revealed a Monteggia's fracture (Figure 7). Both elements of this injury should have been treated initially by manipulative reduction, flexion at the elbow and supination of the forearm. Ultimately the ulna remodeled. The ruptured annular ligament was reconstructed with a fascia lata graft.

Case No. 6—is that of a hyperextension neck injury. The original x-ray (Figure 8) examination was reported "No evidence of fracture or dislocation." Because of the severe persistent symptoms the films were reviewed. A fracture of the neural arch of the second cervical vertebra with anterior spondylolisthesis of the body on the third cervical vertebra was discovered. An overlooked fracture at this level is potentially dangerous to life.

Case No. 7—is that of a middle-aged farmer who fell climbing over a fence, injuring his right shoulder. On the basis of the x-ray report, "the films are of inadequate detail, but there is no evidence of fracture or dislocation of the scapulohumeral joint" (Figure 9), the patient was treated for one month with a sling. When his shoulder did not improve his physician referred him for specialist care. Films of better diagnostic quality were then obtained, revealing a dislocated shoulder with displaced fracture of the greater tuberosity of the humerus. An open reduction and shoulder reconstruction had to be performed.



FIGURE 5
SAME FRACTURE as Figure 4, neglected, after 18 months.



FIGURE 4
ACUTE ELBOW fracture in child. Displaced lateral epicondyle fracture evident.

'Pleurisy' Is Rib Fracture

Case No. 8—is that of a middle-aged female who had cough and pain in the chest. She was treated at home for two weeks for pleurisy. On admission to the hospital a careful history uncovered the fact that she had fallen against her porch just before the pain appeared. An x-ray film (Figure 10) was then obtained showing two ribs to be fractured.

Case No. 9—is that of a 5-year-old boy who was struck by a car and sustained multiple injuries. There was an obvious fracture of the right clavicle. This was confirmed by x-ray. At a later date when a checkup x-ray examination was made (Figure 11), including the other clavicle on the same film, an unsuspected fracture of the left clavicle was an incidental finding.

Case No. 10—is that of a 14-year-old boy who complained of pain in the proximal third of the left leg. There was no history of injury. X-ray



FIGURE 6

RIGHT WRIST eight months post-trauma. Neglected fracture of carpal navicular and perilunar dislocation. Note avascular necrosis of lunate bone.



FIGURE 7

NEGLECTED MONTEGGIA fracture after four weeks of cast immobilization. Neither fracture nor dislocation were reduced.



FIGURE 8

FRACTURE of neural arch of C-2 with anterior displacement of body on C-3.

films revealed periosteal bone reaction on the posterior surface of the tibia (Figure 12). A bone tumor was suspected. Prolonged observation proved the condition to be a fatigue fracture.

Case No. 11—is that of a middle-aged female who had pain in her left foot for months. Chiropodists and physicians treated her with arch supports and shoe modifications. She obtained no relief. Ultimately an x-ray examination was

made (Figure 13). A March fracture of the second metatarsal bone was found.

Case No. 12—is that of a mature female who slipped on a rug and injured her left ankle. She was given definitive treatment by her family physician. Some time later she was admitted to a charity hospital and placed on the orthopedic service. X-ray films through her cast on admission showed fractures of the medial malleolus and the shaft of the fibula in good alignment, but there was gross diastasis of the ankle mortise (Figure 14). Open reduction and Webb bolt fixation were performed.

Summary

Each of the cases cited teaches a lesson. It seems trite to emphasize the virtues of a careful history and physical examination. The value of adequate x-ray films in quality, in quantity and in unlimited extent is poignantly obvious. Where there is a history of a fracture-producing accident, but where there is no evidence of fracture on initial x-ray films, re-examination by x-ray in 10 to 14 days may pay dividends. In the intervening time resorption of bone or displacement may occur, disclosing a fracture.

Lower left:

FIGURE 9

FRACTURE dislocation of right shoulder misdiagnosed because of poor quality of film.

Upper right:

FIGURE 10

FRACTURED ribs diagnosed as "pleurisy."

Center right:

FIGURE 11

CHECKUP X-RAY examination of treated fracture of right clavicle reveals unsuspected greenstick fracture of other clavicle as well.

Lower right:

FIGURE 12

FATIGUE FRACTURE of tibia thought possibly to be early bone tumor.





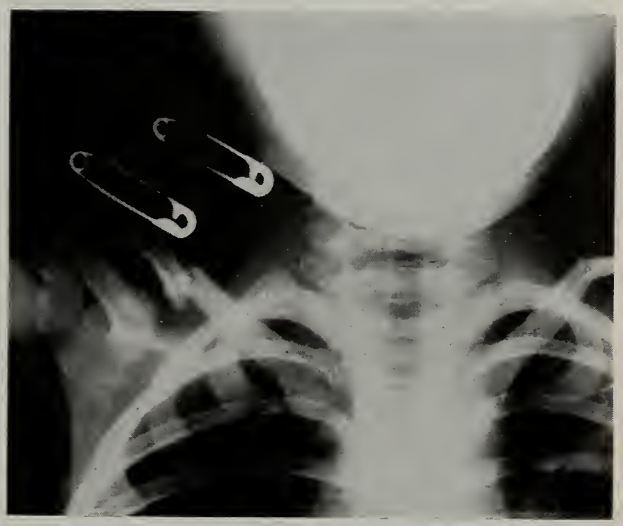






FIGURE 13

MARCH FRACTURE treated for months as "foot strain" or "metatarsalgia."



FIGURE 14

BOTH BONE fracture right ankle. Given definitive treatment by cast. Diastasis of ankle mortise overlooked.

Closer collaboration between the treating physician and the radiologist is recommended. Blind treatment of a severe injury from an x-ray report is hazardous. Too often the radiologist is at a disadvantage, having only a film on which to base a diagnosis; if he knew the clinical picture he would be guided to the injury and issue a more reliable report.

Finally, if we accept patients with complicated and serious injuries, we must train ourselves to interpret x-ray films, be conversant with the pitfalls inherent in each fracture problem, and always be aware of the possibility of anomalies, fatigue fractures, associated fractures and joint injuries. ◄

Welborn Clinic
Evansville

The most curable major form of internal cancer.

Radiologic Management of Carcinoma Of the Uterine Cervix

H. H. DUNHAM, M.D.

Evansville

ADEQUATE RADIATION therapy for carcinoma of the uterine cervix requires application of radium or Cobalt-60 to the primary tumor. This involves insertion of one of these materials into the cervical canal and uterine cavity, along with application to the vaginal cervix and vault. For this purpose various methods and devices have been utilized. Within wide limits no particular device nor plan of attack has shown unquestioned superiority over others. Some radiologists have supplemented radium with roentgen therapy applied transvaginally and some have even substituted this approach for radium or Cobalt. This variation is not in general use, however.

As a general rule, 90 or more milligrams of radium are utilized and the dose is generally in the neighborhood of 5,000 milligram hours, usually administered in a single application. Multiple, divided doses have demonstrated no clearly defined superiority and are not in general use.

Scarcely less important than treatment of the primary lesion as described, is the use of roentgen therapy to the entire pelvis delivered through external ports. Many, if not most, radiologists choose to defer radium therapy to the cervix until after a complete course of external irradiation has been delivered to the pelvis. This external therapy is usually delivered through 2 anterior and 2 posterior ports, each about 10 x 15 cm. In some cases lateral pelvic ports and gluteal ports are added. X-ray generated at 200-250 KVP is adequate, but 1 or 2 million volt generators or CO-60 therapy devices may be used. The aim is to deliver cancerocidal doses to the parametrial areas without exceeding the tolerance of normal tissues. In practice 150 or 200 r., measured in air, will be delivered to each of two pelvic ports in a treatment day. Treatment is protracted over a period of 4 to 8 weeks, administering treatment perhaps 5 times weekly.

Radiation therapy is attended by almost no immediate mortality, but there is usually some morbidity, especially lassitude, anorexia and diarrhea. In more severe cases there is nausea and vomiting and occasionally radiation proctitis results. This infrequently will require surgical treatment. sometimes a colostomy. The lesser side-effects are treated symptomatically and supportively.

The reasons for applying external radiation before administering radium are: (1) Secondary infection is reduced, (2) Excessive bleeding is checked, (3) A state of well-being results, and (4) Radium application is easier, more accurate and more effective.

Careful radiation therapy as outlined here results in 70-80% 5-year salvage rates for Stage I cases. For all stages combined, salvage rates are as high as 40 to 50% in some series. There is no other major form of cancer for which the prognosis is so good, regardless of the means of therapy employed. ◄

715 First Ave.
Evansville 10

Presented at the Joint Meeting of the Indiana and Kentucky Chapters of the American College of Surgeons at French Lick, Ind., May, 1959.

Carcinoma of Pancreatico-Duodenal Region

Whipple resection of pancreas accomplishes more good as indications are narrowed.

WILLIAM C. VON DER LIETH, M.D.

Vincennes

THE PROBLEM confronting the surgeon who operatively encounters an apparent carcinoma of the pancreatic or duodenal region is a challenging one. His first concern will be to establish an accurate diagnosis, and then to select a suitable form of therapy.

The nature of the pathological changes present may have been suggested by his pre-operative evaluation. Marked weight loss, a constant and progressive jaundice with epigastric pain boring through to the back may have suggested the presence of a carcinoma of the pancreas. A longer history characterized by recurrent bouts of pain may have indicated chronic or sub-acute pancreatitis. The finding of blood on duodenal intubation or through chemical analysis of stools coupled with a jaundice that temporarily lessened would have suggested an ampullary lesion. Commonly, however, the actual establishment of a firm diagnosis will depend upon operative findings.

These findings may be confusing. The commonly observed pancreatitis secondary to the obstruction of a part of the pancreatic duct system by an adenocarcinoma of the head of the pancreas will produce a combination of pathological changes difficult to interpret. This same combination of pathological states makes a biopsy difficult to interpret, particularly by frozen section technics.

Presented before the Joint Meeting of the Indiana and Kentucky Chapters of the American College of Surgeons at French Lick, Ind., May, 1959.

Proof Not Always Possible

A surgeon is understandably reluctant to perform a complicated, extensive, resectional procedure carrying a high immediate mortality without proof positive of the existence of a malignant tumor. But he may have to, if he hopes to obtain a cure. Aside from the difficulty in distinguishing on frozen section the microscopic changes of obstructive sclerotic pancreatitis from that of adenocarcinoma, there are other aspects of biopsy that are dangerous.

In this vascular organ, hemostasis may be quite difficult to obtain. Precipitation of acute pancreatitis by the trauma of biopsy is a hazard. The creation of a persistent pancreatic fistula has been frequently observed. The dissemination of tumor cells accelerating the spread of a malignant disease is another danger. Multiple needle biopsies have been advocated as a safe method of pancreatic biopsy. However, diagnosis by this method is not always satisfactory. It is of value only if positive for malignancy.

Carcinomas arising in the peri-ampullary tissues are usually easily biopsied from inside the duodenum, after exploratory duodenotomy. Biopsy of a regional node while dissecting to establish the extent of the tumor process occasionally provides a safer, more satisfactory method of tissue diagnosis. This sort of biopsy has its greatest use when you are dealing with an advanced malignant lesion, not resectable for cure. It is desirable at the completion of an otherwise futile laparotomy to at least be able to provide

the patient and his family with a definite diagnosis and accurate prognosis. For this reason even those men who are opposed to biopsies feel that in this particular instance a biopsy should be done.

Two Schools of Thought

There are two schools of thought as regards the need for positive evidence of carcinoma before proceeding with a radical resection. One group represented by Drs. Carlson,[1] Spjut and Ramos,[2] surgical pathologists, feels that the high immediate mortality rate for resection makes it desirable to obtain positive biopsies before proceeding. They admit that biopsies are difficult but feel that the risks inherent in biopsies are worth it.

The second group represented by Drs. Cattell and Warren of Lahey Clinic,[3] Drs. Dennis and Varco of Minnesota and Mayo Clinic[4] feels that pancreatic biopsies are often misleading or incorrectly interpreted and it is best to proceed on the basis of clinical judgment. Porter of Columbia University[5] is also an advocate of resection of small lesions confined to the pancreas without anticedent biopsies. He takes multiple biopsies of regional nodes before proceeding with resection and feels that the demonstration of lymph node involvement by carcinoma constitutes evidence of incurability rather than the need for wider *en bloc* dissection.

Particular attention is paid to the nodes along the hepatic artery; in the root of the small intestine; along the right gastroepiploic artery; along the middle colic vessels and the nodes behind the upper common and hepatic ducts. It is interesting to note that Porter advocates every effort be made to obtain a positive tissue diagnosis in cases that are not resectable, but he feels that primary intra-pancreatic tumors, when resectable, should not be biopsied. Use of anticholinergics and a Levin tube to diminish pancreatic stimulation after biopsy is a sound idea.

Operative Mortality

The operative mortality of pancreatic or duodenal resection in the reports of collected series usually ranges from 20 to 30%.[3,6,7] In some smaller series, particularly if recent cases are reported, the mortality is lower, but consistently over 10%. The complication rate is high with pancreatic fistula or leak the greatest cause of difficulty. Cattell and Warren[3] reported this complication in 24 of 88 cases.

Other complications are numerous and varied. Late sequelae had been described in survivors. Major gastrointestinal hemorrhage from marginal ulcers occurs, probably due to diversion of the major source of alkali in the gastrointestinal tract. Resection of at least 50% of the stomach is advocated to minimize this possibility. The late development of sprue and/or diabetes has also been described, thought to be due to late development of stricture of the pancreatic or jejunal anastomosis. These cases can be well maintained on substitution therapy.

Cures are few. Ampullary and distal common duct cancers carry a relatively favorable prognosis as compared to pancreatic carcinomas. Kaufman and Wilson[8] reviewed the American literature in 1955 and reported 36 five-year survivors following pancreatico-duodenectomy. Twenty-one of these cases were ampullary lesions and only eight were carcinomas of the head of the pancreas. Since 1955 a few additional cases have been reported.

I believe that most reported series include a significant number of advanced unfavorable tumors resected between 1940 and 1950 when a resectability rate of 1 in 3 was the general rule. The same surgeons might today consider some of these lesions non-resectable. By restricting our curative efforts to small lesions confined within the zone of proposed resection I'm sure a reasonable operative mortality and better survival record will be reported. Criteria of non-resectability would include distant and regional nodal metastases, invasion of adjacent viscera and major vessel involvement. The surgeon should be willing to bear responsibility for proceeding with resection of a clinically favorable lesion without positive biopsy.

14 North Third St.
Vincennes

BIBLIOGRAPHY

1. Carlson, R. I.: The Problem of Diagnosis at the Time of Operation in Tumors of the Head of the Pancreas. *Surg.*, 28:672, 1950.
2. Spjut, H. J., Ramos, A. J.: An Evaluation of Biopsy—Frozen Section of the Ampullary Region and Pancreas. *Ann. Surg.*, 146:923, 1957.
3. Cattell, R. B., Warren, R.: *Text—Surgery of the Pancreas.* Saunders, 1953.
4. Dennis, C., Varco, R. L.: Survival for More Than Five Years after Pancreatic-Duodenectomy from

Cancers of the Ampulla and Pancreatic Head. *Surg.*, 39:92, 1956.
5. Porter, Milton R.: Carcinoma of the Pancreatico-Duodenal Area. *Ann. Surg.*, 148:711-724, 1958.
6. Loggan, P. B., Kleinsasser, L.: Surgery of Pancreas. Results of Pancreatoduodenal Resection Reported in Literature from April 1, 1942 to June 30, 1949. *Int. Abst. of Surg.*, 93:521-543, 1951.
7. Miller, E. M., Dockerty, M. D., Wallaeger, E. E., Waugh, J. M.: Carcinoma in the Region of the Papilla of Vater. *Surg., Gyn. & Obst.*, 92:172, 1951.
8. Kaufman, L. W., Wilson, G. S.: Carcinoma of the Head of the Pancreas and Periampullary Region. *Am. J.M.S.*, 230:200-212, 1955. ◄

Answer to Excessive Blood Cholesterol Possibly Found

Stress-induced overactivity of the adrenal glands may be an answer to how the body translates high tension living into excessive amounts of cholesterol in the blood, according to two physician-biochemists at the National Heart Institute, Bethesda, Md.

A potent fat-mobilizing pattern of hormone activity has been found in dog experiments by Dr. Eleazar Shafrir, a visiting scientist from Israel, and Dr. Daniel Steinberg, chief of the Heart Institute's Metabolism Section. The pattern involves secretions of the inner core (medulla) and the outer "rind" (cortex) of the adrenal.

Overactivity of both parts of the paired prune-sized gland atop the kidneys has long been known to result from stress. Not noted previously, however, is the combined activity of the gland's "stress" secretions in increasing cholesterol and other fatty substances (lipids) in the blood.

The medullary hormone implicated was adrenalin, long known to be secreted by the inner adrenal during intense emotional excitement and to stimulate the body's mechanisms for coping with threatening situations. The cortical hormone was cortisone, well-known steroid secreted by the adrenal cortex in response to exposure (heat, cold, etc.), inflammatory conditions such as injuries and infection, and other forms of stress.

Adrenalin injections alone were found by the NHI workers to be capable of raising the blood cholesterol and other lipids in normal dogs. But when the dogs were deprived of their normal cortical secretions (by removing their adrenal glands) this effect of the adrenalin injections was lost. And when cortisone injections were used to "replace" the missing cortical secretions, the fat-mobilizing potency of the adrenalin was fully restored.

The fat-mobilizing action of this combination of adrenal "stress hormones," as seen in dogs, is strong enough to suggest the possibility of a direct cause-and-effect relationship between adrenal overactivity and the rise in blood lipids seen in various studies of men subjected to disturbing emotional experiences or sustained high-level job performance at a forced pace.

The dog studies are now being extended to volunteers at NHI to learn whether the pattern of "stress hormones" that raised the blood lipids of dogs has a similar effect in man.

The only time an operative perforation of the duodenum is dangerous is when it is not recognized.

Management of Mucosal Perforation In the Course of Pyloric Myotomy

FRANK SCOTT, M.D.

South Bend

IN DISCUSSING mucosal perforation in the course of a pyloric myotomy, three considerations should be emphasized. The first of these is the technic of performing the operation itself in order to avoid perforation. In other words, as with any complication, the best form of treatment is prevention. The point at which perforation usually occurs is at the duodenal end of the pylorus. At this point the pyloric tumor has a tendency to invaginate into the duodenum in such a way that some authors have described the anatomy as similar to the projection of the cervix into the vagina. This, therefore, may bring duodenal mucosa to an external position to the pyloric muscle at the pyloro-duodenal junction.

In addition, the transition of the pyloric muscle to the duodenal muscle layer is rather abrupt; the former, of course, being quite thickened, and the latter normally rather thin, thereby making the junction the hazardous point. In carrying out the myotomy, I have made it a practice to grasp the tumor between the thumb and index finger and lift it forward, thereby putting tension on the duodenum and minimizing the tendency toward invagination.

Presented before the Joint Meeting of the Indiana and Kentucky Chapters of the American College of Surgeons at French Lick, Indiana, May, 1959.

Starting the Incision

The incision for the myotomy is started over the distal end of the pylorus, but far enough from the duodenum to avoid the hazardous point. The incision is extended up onto the stomach. The distal portion of the myotomy is then completed by spreading the incision. By so doing, one can carefully watch the splitting of the remaining muscle fibers toward the duodenum to determine the adequacy of the myotomy and at the same time avoid perforation of the duodenal mucosa with the knife. No pointed instrument, of course, should be used to spread the fibers for fear of puncturing the mucosa.

The second consideration is that of recognizing a mucosal perforation when it does occur, inasmuch as failure to do so probably invariably results in peritonitis and death. Inadvertently opening into the lumen during myotomy is not in itself particularly dangerous, but rather it is the failure to recognize such an accident that is serious. Even though one feels sure that no such accident has occurred during the operation, it is a good practice to compress the duodenum between the thumb and the index finger and milk the stomach contents toward the pylorus under some pressure, watching for the escape of any fluid from the wound.

Suture the Perforation

The third consideration is what to do about a perforation should it occur. In going over my records, I discovered that I had had such an experience several years ago and that I closed the perforation with two interrupted inverting sutures of 5-0 chromic catgut on an atraumatic needle. The patient made an uneventful recovery. There is very little tension on the anterior duodenal wall just adjacent to the pylorus and the intraluminal pressure in this segment is relatively low. Therefore, closure of a perforation with two or three interrupted inverting sutures of fine suture material on an atraumatic needle should result in no complications.

Although it is probably unnecessary, there would be no objection to suturing a small slip of omentum over the defect. Suction with a small aspiration tip should be carried out while the perforation is being closed so as to prevent any undue soiling. I believe that a child who has had the mucosa perforated during the course of pyloric myotomy and who has been treated in the described manner, can follow the usual postoperative routine without special precautions except for close observation. ◄

122-124 N. Lafayette Blvd.
South Bend 1.

One of Seven Americans Has Impairment

Nearly one out of every seven Americans has a chronic or permanent health impairment, the Health Insurance Institute reported recently.

The institute, citing a U. S. National Health Survey, said that during a 12-month period there were, on the average, about 24 million impairments among the civilian, non-institutional population of the U. S., some 22 million persons were admitted to hospitals, and 47 million persons suffered injuries severe enough to restrict their activity or require medical attention.

Between 12 and 13 million impairments consisted of some form of limited motion, about six million impairments were some degree of hearing loss, and visual defects of varying degrees numbered about three million.

Blindness, defined in the survey as inability to read ordinary newsprint even with the help of eyeglasses, totaled about 960,000 cases. There were approximately one million cases of speech defects, and the miscellaneous group of impairments included almost 1.4 million.

Of all the 24 million impairments, 82% had been seen by a physician at some time, the institute stated. Paralysis and loss of limbs and extremities had been medically attended in practically all cases.

The Journal of the Indiana State Medical Association

MEDICAL ESSAY CONTEST

for

Interns and Residents of Indiana Hospitals

During the intern and resident year of 1959-60 The Journal is sponsoring a medical essay contest open to interns and residents of hospitals in Indiana. The subject matter will be limited to clinical experience observed primarily in the teaching hospital of the author. Presentations may contain up to 4,000 words and preferably should be illustrated with clinical pictures, graphs or tables.

A first prize of $100.00, a second prize of $75.00 and a third prize of $50.00 will be awarded. All entries are eligible for consideration for publication in The Journal.

Manuscripts will be judged by a prize award committee selected by the Editorial Board of The Journal and by the Dean, Indiana University School of Medicine.

Manuscripts should be prepared in accordance with the specifications outlined on the masthead page of The Journal.

Entries must be submitted prior to May 1, 1960.

The manuscript itself is to be identified only by the title. The author's name must not appear in the manuscript. Instead, a special title page bearing the title and the author's name and address should accompany the paper. Mail entries to Mr. James A. Waggener, 1021 Hume Mansur Bldg., Indianapolis 4.



The Case of the Comatose Truck Driver

ARNOLD LIEBERMAN, M.D.
New York, N. Y.

BACK IN THE twenties, the Cook County Hospital of Chicago had a "night senior" resident; he was on duty to take all calls from midnight until 8 a.m. This permitted the other residents an undisturbed night's sleep. Each resident spent about one night a month in this fashion. I had just finished helping the intern do a difficult forceps delivery when a call came in urgently requesting my presence in the admitting room. The night intern, the patrolman with his litter and the male nurse were all grouped together around the examining table within the curtained booth. On this table lay the unconscious form of a burly, almost completely naked man. There was the strong reek of cheap whiskey on his breath; he winced when pressure was applied to the supra-orbital notch but, except for a faint mumble, there was no other response.

The intern was almost apologetic: "When he was brought in, I thought he was just another drunk but then the picture does not seem to fit. The pupils are pin-point; the pulse and respirations are slow and strong; the stomach has been washed and there is no alcohol there to speak of and then—just look at this!"

The patient was turned on his side; the buttocks were caked with streaked blood; the gloved finger palpated a badly lacterated rectum; inside was something round and hard for all the world like the bottom of a round bottle . . .

The intern nodded confirmation to my look of amazement, "Yeah, it is! The flat film was taken before I called you."

A Black Stocking

The view box showed all of us the unmistakable outline of a small, intact Coca-Cola bottle; there was no air in the abdomen to suggest a peritoneal tear. Having just come from the delivery room, a vision of the Kielland forceps we had just used rose before me; it was sent for. There was no need for sterile precautions; the comatose form was put in the familiar posture seen in every delivery room, the blades slid into the rectum without difficulty; they locked and, without a hitch, gentle traction brought forth the slimy mess. The rectum had been badly torn and stretched and yet suture proved quite simple, also. We then took a closer look at the bottle; it was without a chip and a long, black feminine stocking had been wound

---

The second of an intermittent series of case reports. Dr. Lieberman formerly practiced in Lake County, Indiana. Artwork by Miki Wilson.

Cook County General Hospital in Chicago is one of the warld's really great and famous institutions. In December of 1959 Roger (the Terrible) Touhy lay on a slab in the morgue—the fourth of six brothers to be autopsied there for acute lead poisoning. In the Dec. 26, 1959 issue of the staid and proper J.A.M.A. (Vol. 171, No. 17, p. 2307) there was an article on "Foreign Body in the Rectum." The senior author of this well presented discussion (A. M. Vaughn) is a former Cook County Hospital resident surgeon. My thoughts went to a story now three decades old . . .

around it with a running knot. A small barium enema and a quick look through the fluroscope confirmed the fact of the success of the job just done.

The intern and I were rather exhilarated with the bizarre features of the case. As a matter of fact, a much later subsequent search of the literature failed to reveal to us a single report of a similar case. At the moment, however, we were still puzzled by the absence of alcohol in the gastric washings, by the pin-point pupils, and by the fact of the torn rectum (after being sewn up) feeling normally snug—not at all the characteristic relaxed musculature of the sodomy habitue.

We had worked without any anesthesia, but by now, two hours after admission, the man had begun to moan, whimper and toss around a bit. The blood pressure, pulse, respiration and other vital signs were all normal, so that the man was put into the emergency observation ward; the bottle with the stocking wound around it was put on a tray and very carefully saved.

Away Out in Cicero

The police report was bare but competently factual; the man had been found beside his truck away out in Cicero—Al Capone's bailiwick; he did not seem to have fallen out of his truck (the police were impressed with the fact that the driver appeared to have been LAID by the sidewalk). The firm owning the truck was a known front for some beer runners even if nothing illicit had been found in the load of the truck; also, a check by the owners revealed the fact that nothing was missing from the cargo. The patient turned out to be a normally married man, father of a family, of good repute and considered by his neighbors as being a sober, sedate person. He had been unemployed and had just started working for the firm in question.

The tests for alcohol in those days were very much in an experimental phase; still, they were totally negative, the gastric washings particularly showed no alcohol at all. By this time, the truck driver was waking up and exhibiting much pain; he did manage to give us a urine specimen even if the rectal discomfort was making him wince. Re-examination now showed the man to be out of any immediate danger; it also revealed an utterly terrified man cowering under his bed sheets, and obviously expecting further horrors at any moment.

This burly truck driver almost whimpered, "I don't know nuttin" to every question prob-

ing as to what had happened; his stubble covered chin was weak and receding but it *was* a bit incongruous seeing this huge hulk so totally intimidated by his recent experiences; his constant, furtive glances all around had the delusional, macabre quality of the paranoid schizophrenic.

Red Parallel Lines

Psychiatric consultation was requested. The new attending physician was young and energetic; I knew him well and trusted his judgment. After hearing the history and looking at the bottle and the long black stocking still enshrouding it, he grew quite thoughtful. This attending man had been at the sanity hearings of a couple persons suspected of several unsolved sex murders. He proceeded to the examination of the patient; as the patient was turned over, the attending man pointed significantly to a row of fine red parallel lines covering both buttocks and not noticed when masked by the dirt and overlying caked blood.

He leaned over to me and whispered, "Switch marks."

As we stood in the ward room, Dr. G--- at first hesitated and then spoke up, "You know, doctor! All those cases had black silk stockings *and* black full length gloves associated with them . . . I wonder??"

His voice trailed off as he gazed out of the window. Then, he wheeled around and gave me a calculating look, "Would you be game for something rather unorthodox?"

"Sir, anything you do I know is well thought through and I would be proud to be associated with you—I'm sure I'll learn something worth while."

And so our patient received a potent sedative injection; he was placed in a private room (we surely wanted no witnesses to a hypnotic seance). A half hour later, we were at his bedside. The technic was seemingly simple and the response very prompt! Within minutes of being told that he should look at a pencil and repeat the sentence, "I am asleep and feel no pain" over and over again, our patient passed into what later I learned is called the somnambulistic phase of hypnosis; he would respond to orders subconsciously but there would be no waking recall.

The story tumbled out quickly: a couple men had boarded his truck at a light; he had been ordered to drive to a certain neighborhood and park in a certain driveway; at gun point he had been taken inside.

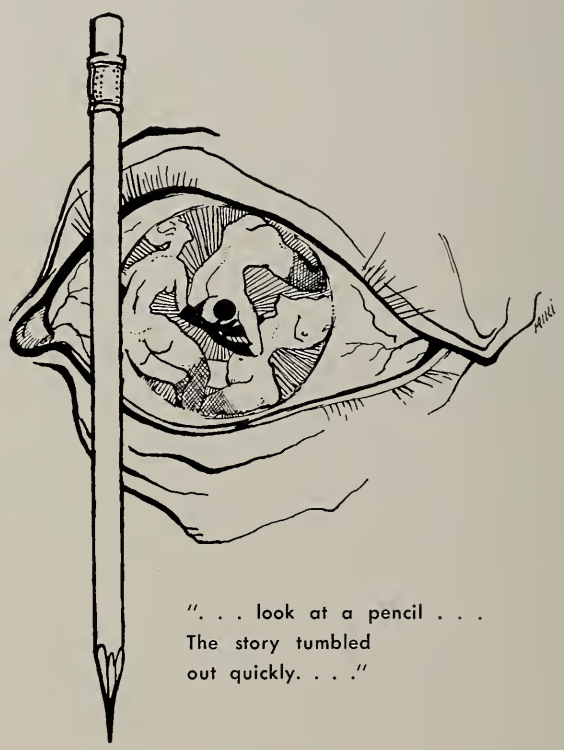
Private "Massage" Parlor

He entered a richly furnished, private "massage" parlor. The details of his ordeal were drab and gory besides being completely unprintable even in a medical journal having a general circulation.

The master of the household gave orders to the gunmen as to what to do with the hapless truck driver; he was jabbed with a hypodermic; he drank no liquor; he was switched over his bare bottom and genitals; he—and two women also present there and also naked—was sexually abused and assaulted. Anyways, let us gloss over the sadistic nausea of the gruesome recitatif told in the flat monotone so typical of the hypnotized subject.

Yes, everywhere were long black gloves and jet black stockings; yes, that is all the women and he were allowed to wear; yes, the women were abused abominably; yes, he fainted after the bottle began to be inserted rectally; yes, he remembers awaking in the hospital; no, he did not know the "master" at all; yes, he could find his way to that house again.

The psychiatrist had been talking quietly to the patient while I sat there with my mouth practically hanging open (this was the first time I had the privilege of seeing a master hypnotist at



". . . look at a pencil . . . The story tumbled out quickly. . . ."

work) . . . and then the attending psychiatrist paused and said to the patient—slowly and emphatically:

"Now repeat after me and remember to do this only once!! Tomorrow morning you will be discharged from this hospital. Have no fear; drive off in your truck; drive direct to the house where you had been detained but do NOT stop there—I repeat, do NOT stop there! Count *ten* more houses—remember, ten houses AFTER the house where you had been. Now, at this tenth house, on the same side of the street as the original house, you park your truck, get out and examine the right front tire; you kick it once, then get back in the truck and drive right to your home—that is all."

No Recall of Anything Unusual

The somnambulist repeated the sentences under the psychiatrist's direction until he was letter perfect. He was awakened without difficulty and told to go to sleep; this he did. That evening I saw him. He had no recall of anything unusual that day; he no longer seemed terrified; he did ask as to whether he could go home the next day. Very casually, he was informed that, if he felt well, there would be no objections.

He was discharged as promised. I asked no questions but I knew that a car trailed him—most discreetly—at a distance. Soon afterwards, a very fashionable home in a sedate neighborhood was subjected to a raid; the country rocked with the story although the really lurid details could not be more than hinted at even by the most uninhibited sheets. The defendant at the ensuing trial claimed that he was being framed by rival gang leaders. The evidence was too devastating to be shrugged off; not even all his money could bribe off an impending life term—or worse.



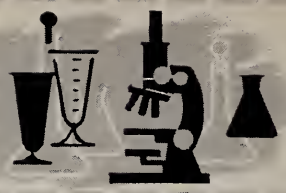
"Soon afterwards a very fashionable home in the sedate neighborhood was subject to a raid . . ."

And then—the Dons of the Mafia decreed HIS death. While out on bail, he was well ventilated by a blast from a "Chicago piano"; I saw the coroner's post at which some threescore slugs were mined out of the body. The truck driver was completely forgotten; he never knew that he "put the finger" on the infamous vice lord and gangster.

Venereal Disease Problem Still Not Solved

Since the introduction of the antibiotics, Health Information Foundation points out, the over-all death rate from syphilis has dropped from 12 persons per 100,000 population in 1943 to 2.2 in 1958. Nevertheless, an estimated million persons in this country still have the disease.

Path-finder
PUBLISHED UNDER THE AUSPICES OF THE INDIANA ASSOCIATION OF PATHOLOGISTS



Do's and Don'ts in Transfusions

THERE IS probably no area in the practice of medicine where the courts have shown so little sympathy for the doctors' position as in the field of blood banking. It appears that this situation will continue and probably become even more distressing to our profession. According to the courts, a bad result in this field "speaks for itself." If a hemolytic reaction occurs, an error has been committed and it only remains to show who is at fault.

Recently, after the occurrence of a hemolytic reaction, a decision has even been made against the doctor who ordered the transfusion on the basis that the need for a transfusion could not be established. Thus, no one is immune when a reaction occurs. The physician who orders the transfusion, the anesthesiologist, the hospital because of its nurses and aides, the pathologist and the laboratory technicians are all likely to be named in such a suit.

In the past 20 years much has been learned of blood group systems, methods of identification of rare antibodies and proper procedures for cross matching blood. However, hemolytic reactions continue to occur, and for a very simple reason which, we must admit, to some extent justifies the attitude of the courts concerning reactions. The truth is that most transfusion reactions do not result from failure to apply some special technic but rather incompatible reactions are usually the result of some simple human error. These include mislabeling of specimens, misidentification of the patient, and very commonly, simple failure of the individual who starts the transfusions to read the label on the blood.

Ask of Yourself

Ask yourself how recently you have personally read the blood bottle label and compared it with the information on the compatibility report from the laboratory. Or ask yourself, if you have delegated the responsibility for starting a transfusion to someone else, if you have personally impressed them with the great need for making such a comparison. Failure on your part in this simple duty may be disastrous for the patient's health and life, and also for your own reputation and financial security.

Failure of the laboratory to detect an incompatibility can and does occur. This too is often the result of a simple human error rather than technical incompetence. Such laboratory errors are most prone to occur when the procedure is being done under the duress of a "stat" or "rush" order. Everyone who pratices medicine should know enough about compatibility testing to realize that it is impossible to shorten a cross match procedure, and that to distract a technician who is doing this test by repeated phone calls from the doctor or heckling from the nurses for the blood is inexcusable. If the laboratory is to be asked to cross match blood, it must be given time to complete the test. If the emergency is so great as to require blood before the cross match can be completed, then the laboratory must be relieved of its responsibility and blood which has not been cross matched given to the patient. Such a genuine emergency which would require departure from routine in order to save a life would probably by its nature protect against a medico-legal action, *provided the emergency were genuine.*

Usual Procedure

In this regard, the usual procedure is to rush to the blood bank for a bottle of "O Negative" blood. If nothing is known of the patient this is acceptable in a dire emergency, but if the patient's blood type and Rh type has been estab-

lished this is foolish. The blood types (major group and Rh) can be rapidly done and if this information is established, blood of the patient's type should be given. "O Negative" blood given to a patient who is "A Positive," for example, is hazardous from two standpoints.

First, it may contain hyperimmune antibodies, active against A cells, which are not neutralized by Witebsky substance. If present in high titer they can cause hemolysis of the patient's cells. Second, "Rh Negative" blood is capable of sensitizing certain patients who are "Rh Positive" just as "Rh Positive" blood can sensitize patients who are "Rh Negative." Without going into the details of the sensitization, it seems enough to say that this is dangerous to such patients in the event of future transfusions, and in the case of female children or females in the reproductive period of life this sensitization may establish the basis for erythroblastosis in case of subsequent pregnancies.

Finally, apparent transfusion reactions should be promptly reported to the laboratory for investigation, since all such situations may not be transfusion reactions.

Technician Saves Situation

Recently, a patient entered a hospital as a septic abortion with hemorrhage. Blood was ordered and an alert laboratory technician at this point saved all concerned from a serious situation. This technician noticed, when she obtained the specimen for a cross match procedure, that the patient's serum was grossly discolored by hemolysis. A urine specimen was obtained which showed marked hemoglobinuria.

The pathologist then went to the bedside and told the patient that she might subsequently become jaundiced and have kidney failure, and that this would not be the result of the transfusion which she was to receive. A consultation to this effect was made in the hospital chart. Subsequently the patient did develop renal shutdown and finally had to be sent to a medical center for treatment with an artificial kidney.

If this technician had not made this observation of hemoglobinemia prior to the transfusion, you may be sure that everyone would have believed that the patient had a hemolytic reaction as the result of an inadequate cross match. The laboratory would have been unable to convince everyone that this was not an error in cross matching.

This patient, after her recovery, says that at the medical center the doctors expressed considerable doubt that she had not had a transfusion reaction and more than once tried to get her to admit that she received blood prior to the hemolysis. For a doctor to sign out a chart with a diagnosis of "hemolytic transfusion reaction" without laboratory confirmation is nothing less than a flagrant invitation for the patient to institute what may be an unwarranted but indefensible suit for damages against everyone involved in the patient's care, *including the doctor who signed the chart.*

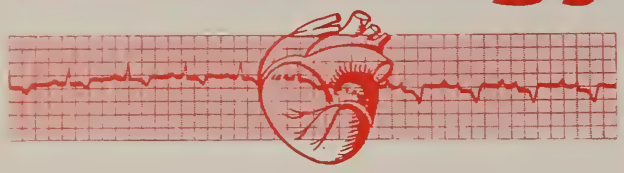
The Lessons We Know

The lessons to be learned from this have not all been told, but some we know:

1. Don't use blood unless indicated.
2. Do read the blood label and compatibility report.
3. Don't attempt to rush a cross match procedure.
4. Do give type specific blood rather than universal donor (O Negative) blood.
5. Don't diagnose a hemolytic transfusion reaction without laboratory confirmation.
6. Do report all suspected reactions promptly to the laboratory.
7. Don't discuss transfusion reactions before patients or relatives. ◄

Although the incidence of venereal disease is still high, 30 infants in this country died from congenital syphilis last year, while 3,460 would have died if the 1930 rate had continued, according to Health Information Foundation.

Condensed Cardiology



Presented as a regular feature of The JOURNAL, Condensed Cardiology is a series of short talks on cardio-vascular diagnosis and treatment, edited by the staff of the Robert M. Moore Heart Clinic of the Marion County General Hospital, Indianapolis.

Dyspnea

ALFRED F. FASOLA, Ph.D., M.D.

Indianapolis

RESPIRATORY MOVEMENTS during normal quiet breathing are carried out involuntarily Under these conditions inspiration is an active process requiring musclar effort to bring about enlargement of thorax. Expiration, on the other hand, is a passive process which brings the thorax to its rest position without muscular intervention. Eupnea is the term applied to the respiratory act when it is accomplished with ease and without conscious effort.

Dyspnea or labored breathing is the term applied to the respiratory act when the individual cannot meet the demands of the body with ease (*i.e.*: when the actual ventilation cannot provide the breathing capacity). The respiratory act becomes conscious and creates a desire for forceful respiration.

Dyspnea is a relatively subjective phenomenon. Because of this the evaluation of the degree of dyspnea is difficult, although several attempts have been made to quantitate this symptom.

The common causes of dyspnea are as follows: (1) dyspnea during severe exercise in the normal individual, (2) dyspnea of neurogenic origin may be due to either psychogenic overlay or to organic lesions involving the brain or respiratory muscles, (3) dyspnea due to hematogenous factors such as acidosis, anemia or arterial anoxia, (4) dyspnea due to pulmonary disease and lastly (5) dyspnea due to cardiac dysfunction.

Determining Dyspnea Degree

The present discussion will be confined to dyspnea of pulmonary and cardiac origin. With the present development of pulmonary function tests, it is possible to determine the degree of dyspnea at rest and during mild exercise, and to some extent to determine the phase of the respiratory cycle responsible for respiratory distress. Because of the multiple facets in the transfer of atmospheric oxygen to the lungs, pulmonary function cannot be assessed with one test. These tests are unable to provide either anatomical or biological diagnosis. Elaborate technical equipment and trained personnel are required for complete pulmonary function tests.

A detailed discussion of the tests is not within the scope of this paper. We will attempt to summarize the tests which are necessary to detect pathology at the various levels of the respiratory cycle and to point out differences between cardiac and pulmonary dyspnea.

The first phase of the cycle is concerned with transferring atmospheric air into the lungs (*i.e.*:

From the Robert Moore Heart Clinic, Indianapolis, Indiana.

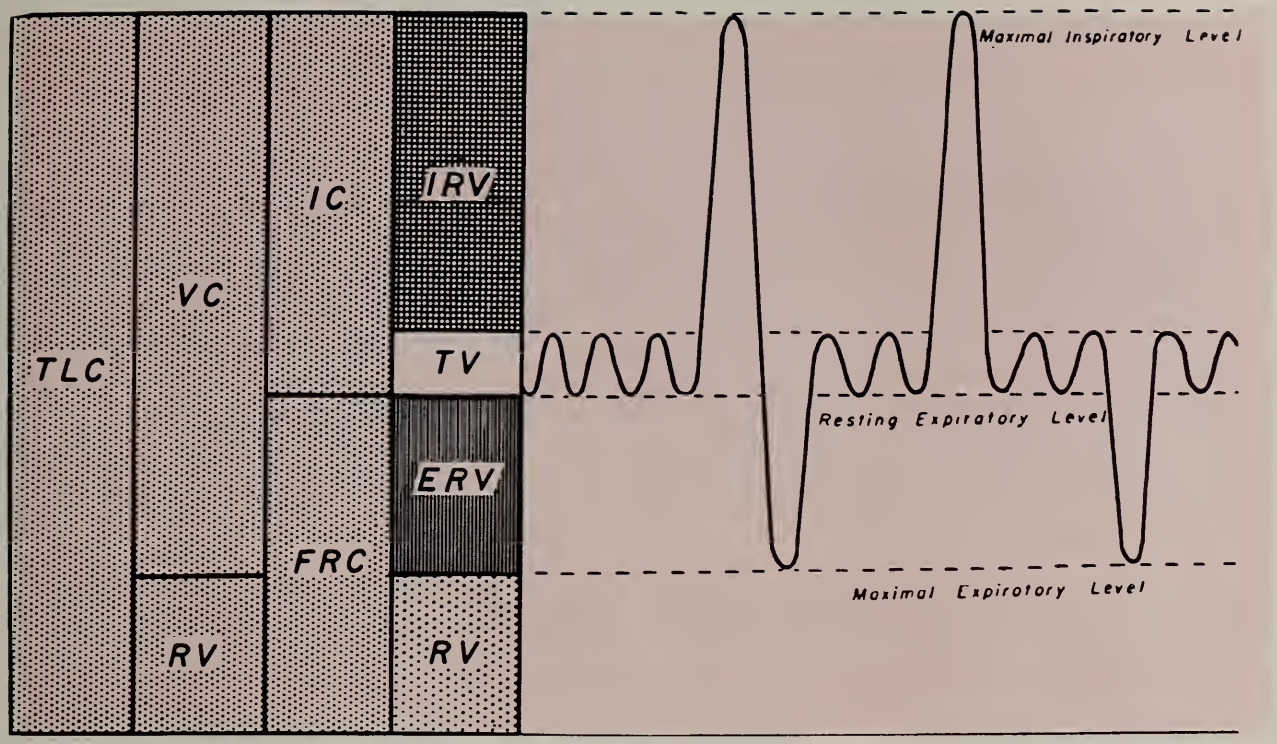


FIGURE 1

AFTER COMROE. Showing the division of the lungs into its component parts.

Legend
TV = Tidal volume
IRV = Inspiratory reserve volume
ERV = Expiratory reserve volume
RV = Residual volume
IC = Inspiratory capacity
FRC = Functional residual capacity
VC = Vital capacity
TLC = Total lung capacity

the ability of the lungs and thorax to function as bellows). This involves measurements of lung compartments, which are shown in Figure 1, vital capacity, timed vital capacity, maximal breathing capacity, residual volume, inspiratory and expiratory flow rate. All but residual volume may be determined with closed system respirometer. Residual volume may be determined by nitrogen washout method or helium method.

With these data, the pulmonary diseases may be divided into obstructive or restrictive pulmonary insufficiency.

Common Examples

Common examples of obstructive diseases causing dyspnea are chronic obstructive emphysema, asthma or neoplastic lesions causing obstructions of the tracheobronchial tree. A spirogram of a patient with asthma is shown in Figure 2. This shows decrease in vital capacity, increased timed vital capacity (normally 95% of vital capacity is expired in 3 seconds), decreased maximal breathing capacity and "air trapping" phenomenon characterized on the spirogram by a stepwise elevation of baseline during performance of maximal breathing capacity.

Restrictive pulmonary insufficiency is associated with lesions causing a decrease in lung parenchyma. Common diseases belonging to this category which give rise to dyspnea are the pneumoconioses, pulmonary fibrosis, pulmonary granulomatoses, large neoplastic infiltration or the extrapulmonary lesions such as kyphoscoliosis, pneumo-thorax and hydro-thorax.

The spirogram shows a symmetrical decrease in all lung compartments, normal timed vital capacity and either normal or disproportionate decrease in maximal breathing capacity. Because of the relatively low sensitivity of these tests, abnormalities of pulmonary function may not appear until large segments of lung parenchyma have been damaged. (Figure 3.)

The second phase is concerned with the distribution of inspired gases to the small alveolar sacs (intrapulmonary mixing). Diseases causing inadequate intrapulmonary mixing are air cysts, emphysematous bleb formation and bronchiolar obstruction.

The index of intrapulmonary mixing is determined by having the subject breathe pure oxygen for a period of seven minutes. The nitrogen remaining in the lungs (alveolar sample) at the end of this time should be less than 2.5%. Values as high as 10-12% have been recorded with severe emphysema.

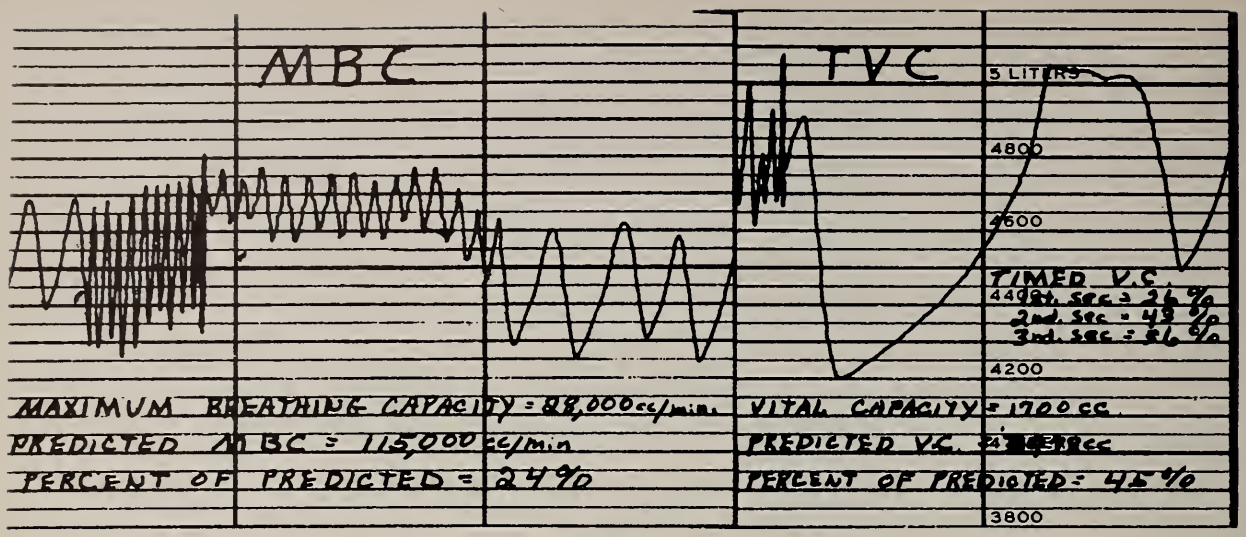


FIGURE 2

SPIROGRAM of patient with bronchial asthma and emphysema showing combined obstructive and restrictive pulmonary insufficiency. MBC = maximal breathing capacity, TVC =timed vital capacity. Obstructive disease is shown in the tracing by increased expiratory time (56% in 3 seconds) and decreased maximal breathing capacity (24% of predicted value). "Air trapping" is shown by stepwise elevation of baseline during performance of maximal breathing capacity.

Third Phase

The third phase of the cycle is concerned with diffusion of oxygen across the alveolar capillary membrane (Syndrome of Alveolar Capillary Block). Impaired diffusion is found in diseases causing interstitial edema, pneumonia, thickened alveolar-capillary membrane and fluid in alveoli. Alveolar capillary block has been described in sarcoidosis, beryllium granulomatosis, pulmonary scleroderma, diffuse metastatic lesions of the lung and asbestosis. Normally 10-30 cc of oxygen are transferred across the membrane/minute/mmHg pressure. Two gases (carbon monoxide and oxygen) have been used to calculate this value according to the following equation:

$$\text{Diffusion Capacity for } O_2 \text{ or CO} = \frac{\text{ml of } O_2 \text{ or CO transferred from alveoli to blood/minute}}{\text{Mean alveolar } O_2 \text{ or CO pressure} - \text{mean capillary } O_2 \text{ or CO pressure}}$$

The fourth phase of the cycle involves a correlation between the ventilation and perfusion of blood through the alveoli. Imbalance in ventilation-perfusion ratio is common cause of arterial anoxia and is found in emphysema, atelectasis, pulmonary embolism, asthma and fibrotic pulmoary diseases.

The process of respiration has as its main function the arterialization of venous blood. The fifth phase is concerned with the lungs' ability to perform this function. A cause of arterial

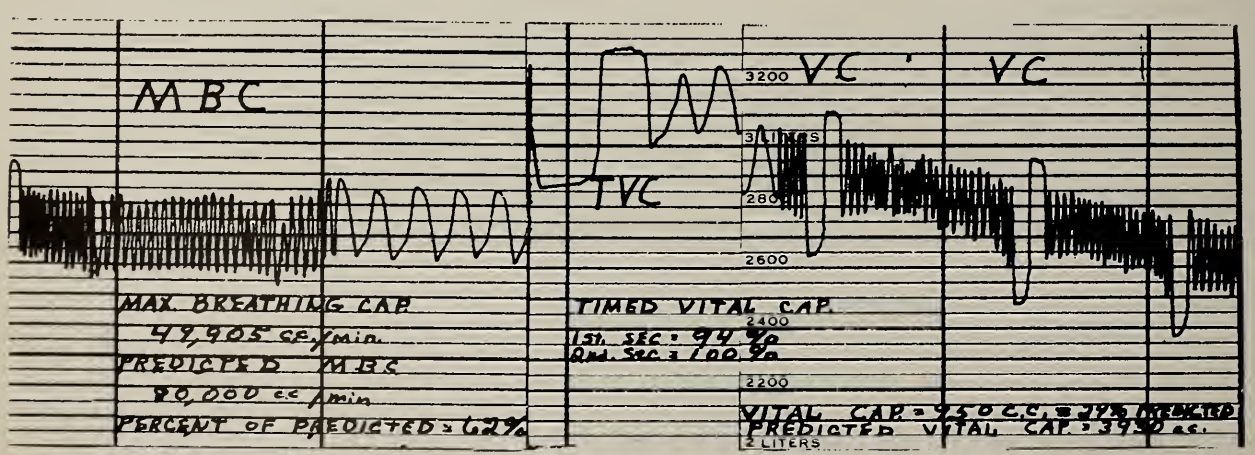


FIGURE 3

SPIROGRAM of patient with restrictive pulmonary insufficiency. This is shown by decrease in vital capacity (24% of predicted value) out of proportion to decrease in maximal breathing capacity (62%). No obstruction is present, as shown by patient's ability to expire 100% of vital capacity in 2 seconds.

anoxemia has been described above. Additional causes are right to left shunt, decreased partial pressure in the atmosphere, alveolar capillary block and hypoventilation. In addition to oxygen saturation, valuable information is gained from a study of pH and CO_2 tension.

From the standpoint of pulmonary function the degree of dyspnea can be related to breathing reserve according to the following equation:

$$\text{Breathing Reserve} = \frac{\text{Maximal breathing capacity—Resting minute ventilation x 100}}{\text{Maximal breathing capacity}}$$

Dyspnea is experienced when breathing reserve drops to approximately 60-70%.

Though dyspnea is not present at rest, it may be present during mild exercise. The Dyspnea Index is calculated according to the following equation:

$$\text{Dyspnea Index} = \frac{\text{walking ventilation (liters/minute)}}{\text{Maximal breathing capacity (liters/minute)}}$$

Ratio of 0.35 indicates onset of dyspnea. Severe dyspnea is indicated with values of 0.50.

Thus far we have dealt with obstructive and restrictive pulmonary insufficiency. A third category, congestive pulmonary insufficiency, exists in patients with cardiac disease characterized by left ventricular failure. In this category the emphasis shifts from the inadequate performance of the lungs to inadequate performance of the heart and circulation as the cause of dyspnea.

Orthopnea and paroxysmal nocturnal dyspnea are common symptoms with progressive left ventricular failure.

An Important Symptom

Orthopnea, dyspnea at rest in the recumbent position, is an important symptom of cardiac dyspnea. The recumbent position results in excessive cardiac filling and in pulmonary congestion. The relief of this symptom in the sitting position is thought to be due to: (1) lowering of the abdominal viscera which allows the diaphragm to descend easily during inspiration, (2) improvement in blood flow through the respiratory centers and (3) improvement of pulmonary congestion by adequate drainage of blood from the chest.

Acute shortness of breath may occur while the patient is asleep (paroxysmal nocturnal dyspnea). Inspiratory and expiratory effort becomes marked and simulates an acute asthmatic attack. This is believed, by some investigators, to be produced by a loss of pulmonary elasticity and reflex increase in pulmonary ventilation.

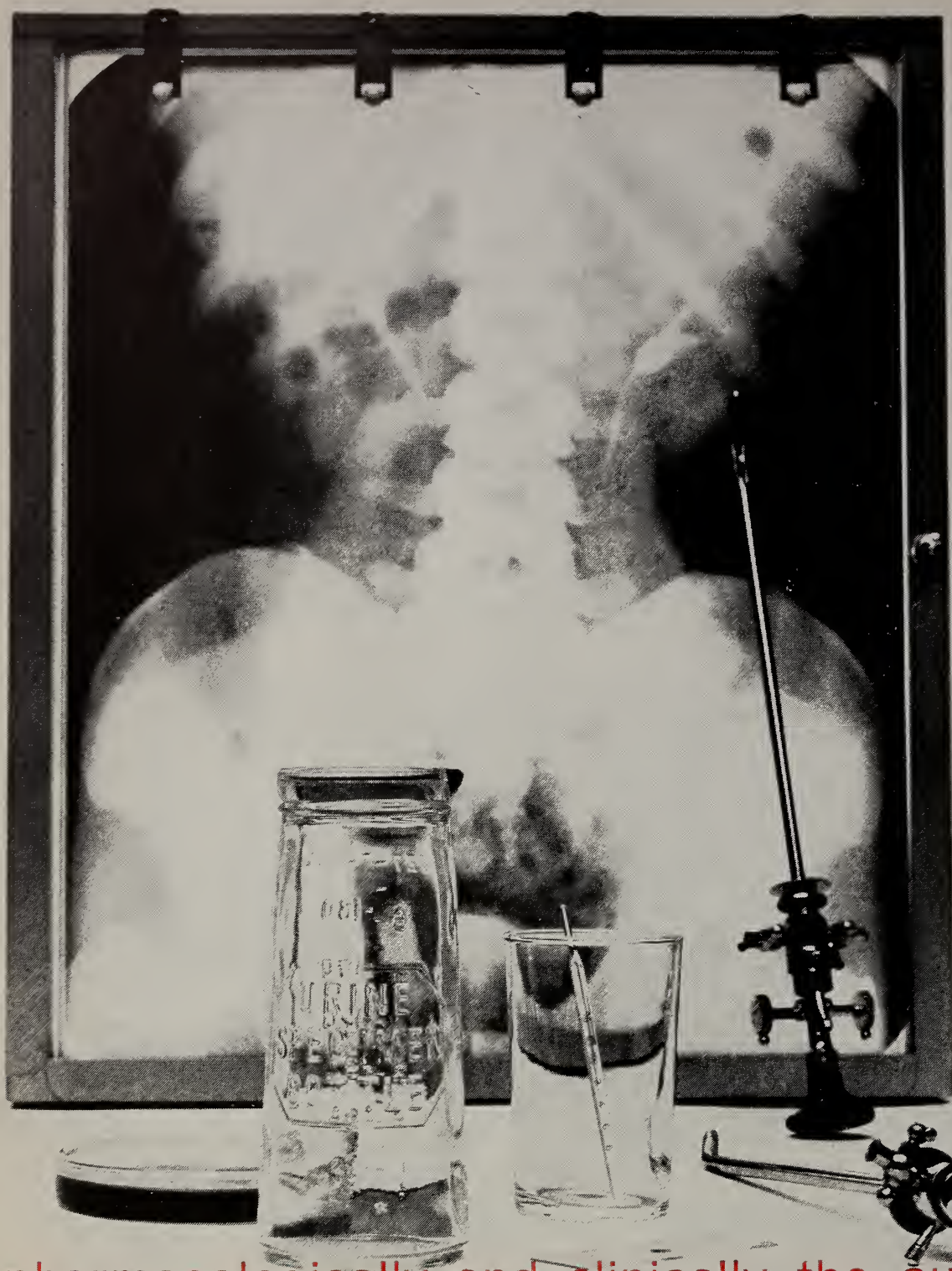
Early failure has as its dominant feature retarded blood flow, whereas pulmonary congestion is the dominant feature of more advanced cardiac failure.

Spirogram gives evidence of decreased vital capacity and decreased maximal breathing capacity. Data obtained by cardiac catheterization in mitral stenosis have shown a low, fixed cardiac output and decreased exercise tolerance.

Marked increase in intrapleural pressure has been recorded during inspiration and expiration in congestive failure, presumably due to increased pulmonary congestion. This is interpreted as increased effort of breathing and accounts for exhaustion and fatigue noted by these patients at rest or during mild exercise.

In summary, dyspnea is common to both pulmonary disease and cardiac disease, although the character of the dyspnea may be used to distinguish cardiac from pulmonary dyspnea. A number of pulmonary function tests have been described which indicate the presence of pulmonary disease as primary etiologic factor in dyspnea. A number of studies indicate that diminished blood flow is the important factor in early failure and pulmonary congestion as the factor producing symptoms in late left-sided failure. ◄

The rate of first admissions to mental hospitals for paresis, a complication of syphilis, has dropped from 4.7 per 100,000 population to 0.5 since the antibiotics were introduced. In spite of such figures, according to Health Information Foundation, the problems of venereal disease in the U. S. are far from solved, chiefly because of public apathy and ignorance.



when sulfa is your plan of therapy...

pharmacologically and clinically the outstanding

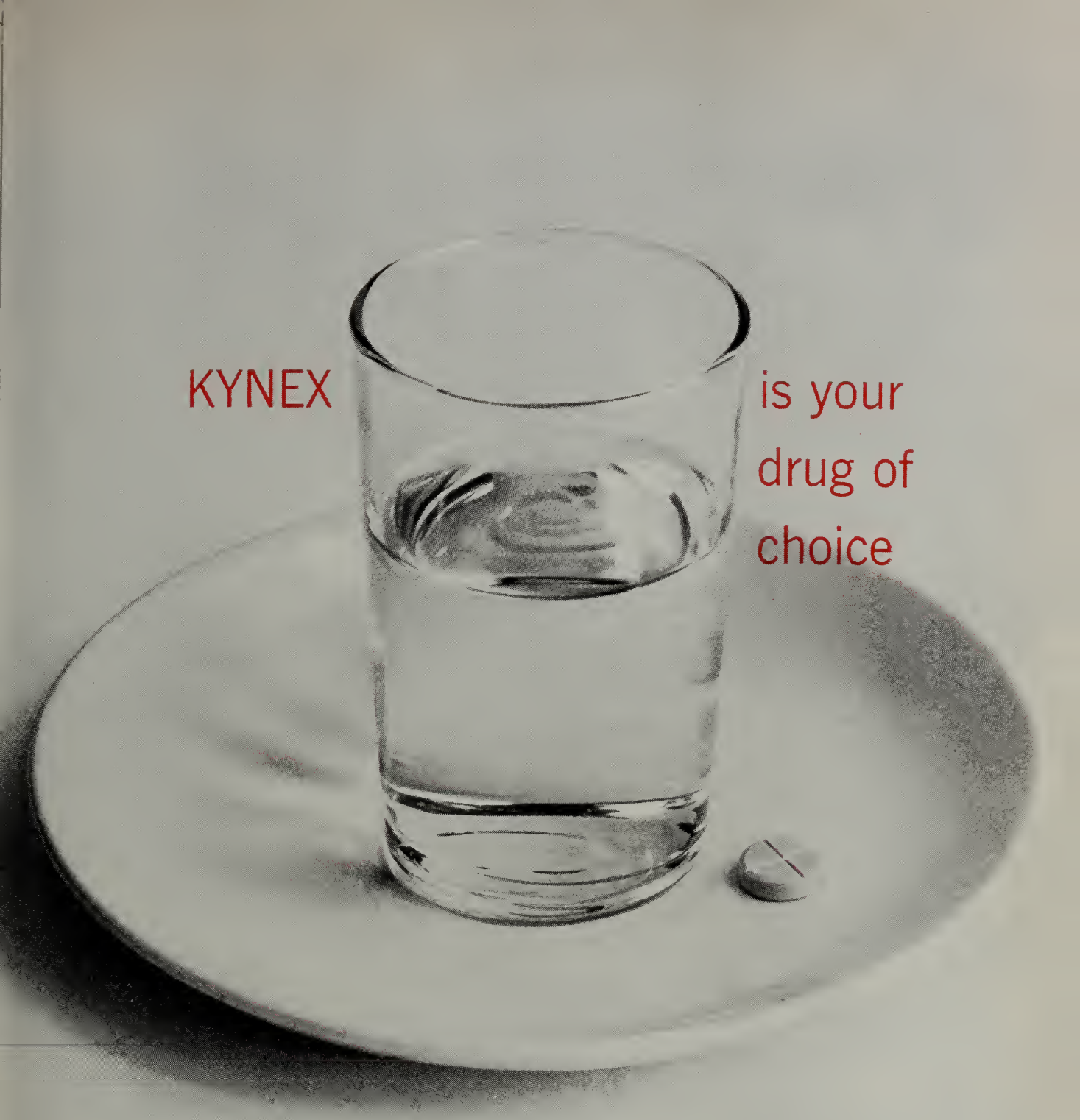
Rapid peak attainment — for early control — KYNEX® Sulfamethoxypyridazine reaches peak plasma levels in 1 to 2 hours[1,2] . . . or approximately one-half the time of other once-a-day sulfas.[2] Uninterrupted control is then sustained over 24 hours with the single daily dose . . . through slow excretion without renal alteration.

High free levels — for dependable control — More efficient absorption delivers a higher percentage of sulfamethoxypyridazine — averaging 20 per cent greater at respective peaks than glucuronide-conversion sulfas.[2] Of the total circulating levels, 95 per cent remains in the fully active, unconjugated form even after 24 hours.[3]

Extremely low toxicity[4] . . . only 2.7 per cent incidence in recommended dosage — Typical of KYNEX relative safety, toxicity studies[5] in 223 patients showed TOTAL side effects (both subjective and objective) in only six cases, all temporary and rapidly reversed. Another evaluation[4] in 110 patients confirmed the near-absence of reactions when given at the recommended dosage. High solubility of both free and conjugated product[6] obviates renal complications. No crystalluria has been reported.

Successful against these organisms: streptococci, staphylococci, E. coli, A. aerogenes, paracolon bacillus, Gram-negative rods, pneumococci, diphtheroids, Gram-positive cocci and others.

1. Boger, W. P.; Strickland, C. S., and Gylfe, J. M.: Antibiotic Med. & Clin. Ther. 3:378, (Nov.) 1956. 2. Boger, W. P.: Antibiotics Annual 1958-1959, New York, Medical Encyclopedia, Inc., 1959, p. 48. 3. Sheth, U. K.; Kulkarni, B. S., and Kamath, P. G.: Antibiotic Med. & Clin. Ther. 5:604 (Oct.) 1958. 4. Vinnicombe, J.: Ibid. 5:474 (July) 1958. 5. Anderson, P. C., and Wissinger, H. A.: U. S. Armed Forces M. J. 10:1051 (Sept.) 1959. 6. Roepke, R. R.; Maren, T. H., and Mayer, E.: Ann. New York Acad. Sc. 60:457 (Oct.) 1957.



once-a-day sulfa...

NOTE: Investigators note a tendency of some patients to misinterpret dosage instructions and take KYNEX on the familiar q.i.d. schedule. Since one KYNEX tablet is equivalent to eight to twelve tablets of other sulfas, even moderate overdosage may produce side effects. Thus, the single dose schedule must be stressed to the patient.

KYNEX Tablets, 0.5 Gm., bottles of 24 and 100. Dosage: Adults, 0.5 Gm. (1 tablet) daily, following an initial first day dose of 1 Gm. (2 tablets).

KYNEX Acetyl Pediatric Suspension, cherry-flavored, 250 mg. sulfamethoxypyridazine activity per teaspoonful (5 cc.). Bottles of 4 and 16 fl. oz. Recommended Dosage: Children under 80 lbs.: 1 teaspoonful (250 mg.) for each 20 lb. body weight, the first day, and ½ teaspoonful per 20 lb. per day thereafter. For children 80 lbs. and over: 4 teaspoonfuls (1.0 Gm.) initially and 2 teaspoonfuls daily thereafter. Give immediately after a meal.

KYNEX®

Sulfamethoxypyridazine Lederle

NEW—for acute G.U. infection AZO-KYNEX® Phenylazodiaminopyridine HCl—Sulfamethoxypyridazine Tablets, contains 125 mg. KYNEX in the shell with 150 mg. phenylazodiaminopyridine HCl in the core. Dosage: 2 tablets q.i.d. the first day; 1 tablet q.i.d. thereafter.

LEDERLE LABORATORIES, a Division of AMERICAN CYANAMID COMPANY, Pearl River, New York

Lederle

The Journal

of the INDIANA STATE MEDICAL ASSOCIATION

Devoted to the interests of the medical profession of Indiana

Editor: Frank B. Ramsey, M.D., 1802 North Illinois Street, Indianapolis 2, Indiana

Associate Editors: A. W. Cavins, M.D., 221 South Sixth Street, Terre Haute, Indiana; Lall G. Montgomery, M.D., Ball Memorial Hospital, Muncie, Indiana; David A. Bickel, M.D., 515 Odd Fellows Building, South Bend, Indiana; Stephen L. Johnson, M.D., 521 Sycamore Street, Evansville, Indiana.

Editorial Board: Term Expires

George M. Johnson, M.D., Richmond . . Dec. 31, 1960
Irvin W. Wilkens, M.D., Indianapolis . Dec. 31, 1960
Harold D. Lynch, M.D., Evansville . . Dec. 31, 1961
Jene R. Bennett, South Bend . . . . Dec. 31, 1961
Samuel R. Mercer M.D., Fort Wayne . Dec. 31, 1962
Franklin F. Premuda, M.D., Hammond . Dec. 31, 1962

Necrologist: James B. Maple, M.D., 117 West Washington Street, Sullivan, Indiana.

Assistant Editor: Corki Wilson

Editorial Assistant: Sara M. Snyder

Business Manager: James A. Waggener

1019 Hume Mansur Building, Indianapolis 4, Indiana

'. . . Cooperation Will Add to the Authority . . .'

EVERYONE NOWADAYS enjoys complaining about the high cost of living. Fingers are frequently pointed at the profession or business which has provided the latest reminder of the increasing prices of everything.

Despite the fact that the United States is now spending almost exactly the same proportion of its disposable income on drugs and sundries as it did 20 years ago, a great deal is being said about the high cost of drugs. As a matter of fact, the cost of drugs and medical care has not increased to a much greater degree than has everything else—wages, food, rent, transportation—*everything*.

The cost of medical care may be divided into three large categories—hospitals, doctors and drugs. Like the prices of *everything* else, the prices in each of these categories have risen, although to different degrees.

Whereas the different price factors in the three categories are inter-related and often vary in a reciprocal fashion, some of the personnel of each of the three segments of medical care have been known to cast aspersions at the other two segments and intimate that they, rather than his own, were responsible for most of the high cost.

As a matter of fact it is the total cost that counts. In the old days a patient might spend a relatively small amount for drugs and a relatively large amount for physician services. Today he spends several times as much for highly effective drugs and gets well faster, and consequently spends relatively less money with his doctor. Total cost, in terms of disposable income, has increased only from 4.0 to 5.2% for all medical care. Drugs and drug sundries have contributed only 0.1% of the increase, rising from 0.9 to 1.0%.

Nevertheless, the patient gets a bigger bargain in the fact that he recovers faster, is off work for a shorter time, and does not spend as much time in regaining strength for return to work.

The same principle applies to hospitals. People spend less time in hospitals today—each day costs more than it used to; it costs a little more, even with inflation counted out—but the short hospital stay today produces better results than the long one did 20 or 30 years ago. Result—big bargain.

The Indiana Pharmaceutical Association is concerned with the pharmacist's side of the triangle of high costs of medical care. Individual pharmacists have always considered themselves as friends, associates and aides to the physicians in the production of high quality medical service.

The practicing pharmacists are concerned over the Kefauver hearings even though the retail segment is not (supposedly) included in the committee charges. They point out that there is a real danger, in the present political climate, of passage of a Forand bill, or worse. We need not draw a picture to recognize the dangers in this or other proposals which would not only be wasteful, but would hamper medical progress.

Since Senator Kefauver undoubtedly will continue to manipulate the headlines for his own purposes, much grass-roots effort will be required to prevent an increasingly hostile attitude toward all the medical arts.

The practicing pharmacist feels the public pulse, especially when he presents the prescriptions to our patients. He finds price complaints increasing. Not infrequently, the patient claims the physician has said, "This is too expensive, but it's not my fault." When the patron starts thinking about costs, he soon resents the physician's fee, too.

As a matter of protection to the pharmacist, as well as to the physician, it would be helpful for the latter to say when prescribing an expensive drug, "This is one of the newer drugs, but it's quicker and more effective." Usually, the patient takes this as a signal of higher cost and says nothing.

If the question of price *is* raised, an excellent opportunity is given to point out that it may cost as much as $6,000,000 from conception to marketing of a truly new drug, and that only about 10% of these make a profit. Of course, the pharmacist on the corner would not be unhappy if it were pointed out that even with his high inventory costs he only averages about 33% gross on prescriptions (less than several other types of stores). Also, it may be noted that he has been scrupulous in avoiding comments about our fees, and we sometimes could be more thoughtful regarding the implications for him in our own comments to patients.

As Sir Thomas Percival said, "Amicable intercourse and cooperation will add to the authority of one—and the usefulness of both."

Who Needs Forand Legislation?

THIRTY-FIVE PERCENT of the individuals covered by new contracts obtained from Blue Cross—Blue Shield in their open campaign in 1959 are over 65 years of age.

Fifty-five percent of the same individuals are over 55 years of age. The median age of the entire group is 59.

Here is proof positive that people over 65 and those approaching that age are acquiring medical, surgical and hospital expense protection at a much faster rate than is the remainder of the population.

Indiana, it has ben determined, has not, in recent years, had much of a problem in medical care for its senior citizens. By far the vast majority of people over 65 have some provision for medical expenses. Now it appears that those who have not in the past are now acquiring protection at an accelerated rate.

It has always been acknowledged that, if there was a need for more medical coverage for people over 65, Forand-type legislation would be the most expensive, most socialistic and the most degrading method of supplying it. It is now evident that there is no need for more protection beyond what is already available and in use.

Who needs Forand type medical care? Nobody, it appears, except the politicians!

New State Medical Journal

THE GREAT and growing family of state medical journals welcomed a new and handsome addition to the fold in January, 1960. *The Journal of the Mississippi State Medical Association* made its first appearance early this year, resplendent in a neat green cover and proudly flying its designation as Volume I, Number 1.

The typography, make-up and paper stock of the new journal are excellent. The type face is easily read and the engravings are clean and clear.

Dr. W. H. Anderson is the editor, with Dr. William M. Dabney and Dr. Louis F. Rittelmeyer as associate editors; and the association's executive secretary, Rowland B. Kennedy, is managing editor.

The members of the Mississippi State Medical Association are to be congratulated upon launching a beautiful and very well set up journal.

As L.A. Goes, So Goes the Nation!

AIR POLLUTION in large American cities has now been controlled to the point that the automobile is the only major culprit. Smoke from domestic and industrial chimneys and, in cities where the problem is especially bad, the smoke from incinerators, is now controlled to an adequate degree. There are cities—Los Angeles is the best example—in which further control of smog is necessary for comfort and health reasons. In these areas control of automobile fumes is next on the program.

Some of the larger cities have reduced smoke and soot by more than 50%. Reduction of chimney smoke has served to emphasize how much the remainder of the problem is due to the automobile. The problem has recently acquired a sense of urgency because of the possible connection between lung cancer and auto fumes.

Automobiles emit fumes from two sources, the exhaust and the crankcase. Exhaust gases consist of water and carbon dioxide from completely burned gasoline, carbon monoxide which usually is not considered dangerous out of doors, and either unburned or incompletely oxidized hydrocarbons which are the center of attention in the smog situation.

Recently it was discovered that approximately half of the undesirable effluent from the auto comes from the crankcase. This is vented to the outside without passing through the hot exhaust. In addition to these troublesome hydrocarbons, it has been determined that carbon monoxide accumulates in the atmosphere of Los Angeles to a degree which is alarming.

Automobile manufacturers and kindred inventors and researchers have been at work for several years devising methods of completely burning the exhaust and crankcase gases. Most of these gadgets are in the nature of afterburners. There are numerous burners which vary in price and efficiency. Which one is used depends on the amount of elimination which is required. For about $10 per car half of the hydrocarbons may be removed. For around $300 practically all may be eliminated. A recycling device which moves all crankcase fumes through the carburetor and thus eliminates half of the nuisance may be attached to the engine for between $5 and $10.

Fortune in its January 1960 issue describes the various afterburners, catalytic and non-catalytic, hot and super-hot, with varying prices and costs of servicing. Which one of these devices will be adopted will probably depend upon what standards of performance are set by law.

The Pacific coast in California is geographically and atmospherically situated so as to make their smog and pollution problem the worst. Warm air from the ocean is held in place in the lower atmosphere by the mountains. Los Angeles is the most poorly ventilated city due to mountains on three sides.

The California legislature has ordered the state public-health director to set standards for exhaust purity by Feb. 1, 1960. Other localities are awaiting their experience reports before proceeding with their plans. What works in California will work anywhere, it is said.

Los Angeles has 3,100,000 motor vehicles. Ap-

proximately 2,000 tons of hydrocarbons and 450 tons of nitrogen oxides are emitted each day. When these compounds are held in place by the warm inversion layer, sunlight further transforms them into more toxic and more irritating substances. It is probable that up to 90% of the noxious exhaust fumes must be eliminated from all automobiles to bring the city back to a smog level of 1940.

Since the elimination devices will require upkeep and servicing, some sort of inspection system, which will not be simple, must be set up to police the efficiency of control measures.

Los Angeles, by reason of being in the midst of the most difficult problem, will be the leader and adviser in how to cure it. It is not difficult to understand why the others await the results.

Journal Offers $5 Each for Anecdotes

A new department of *The Journal* is being organized for the publication of accounts of personal experiences of Indiana physicians. The practice of medicine is interwoven and frequently involved with the drama of life. In a lifetime of practice doctors are in contact with many episodes of amusing, thrilling, ridiculous or dramatic import. Members of the association are invited to submit manuscripts for this purpose. Author's names need not be published, initials may be used. The narrations may be short, but should be limited to 1200 words. *The Journal* will pay $5.00 for each one published.

From the Northwest:

To Encourage Giving

IN ANY consideration of income tax it must be recognized at the outset that it is an artificial mechanism and that as now applied it causes serious disturbances in economic balance. Since economic law is a good bit like biologic law, an economic artifact can upset economic balance just as an artifact can upset the balance established by nature. A dam across a river can cause a salmon run to diminish or even disappear. Its deleterious effect can be overcome in part at least by another artifact, the fish ladder.

Just as it often takes years to eventually recognize and understand the biologic dislocations which occur when it is attempted to alter or otherwise interfere with natural phenomena, it also is difficult or often impossible, at first, to sense the implications of artificial obstacles interpolated into our economic system.

Taxation is ageless, has existed in some guise since man began a tribal or communal life and has almost always eventually been so abused by monarchs, councils, socializers, parliaments and our own Congress as to interfere with the welfare of the State. The latter is quite the reverse of the reason given by our tax collectors and tax spenders to justify our currently high, disabling and confiscatory tax structure—namely, it is supposedly for the welfare of the State.

Historically, the excuses given for high taxes and their ultimate effect have always followed a similar pattern, the result being a police state which with us is carried on under the guise of the internal revenue bureau. The next stage inevitably develops into national demoralization as so well illustrated by Gibbon in "The Decline and Fall of the Roman Empire."

The names given to some of the dubious projects which governments utilize to gain more power over their subjects (citizens) by more

Reprinted from Northwest Medicine, Vol. 52, No. 12, Dec. 1959.

taxation and more spending and increasing national debt, varies with the times. By and large the government says it is wiser and better able to spend the people's money for their social welfare than are the people themselves. So we now find our Federal Government involving itself more and more, to mention only two, in the fields of education and biologic research, the latter in no way related to epidemic or communicable disease which is the recognized province of the USPHS. These are disciplines where, as in many others, the Federal politicians have no business, no facility and no competence. But they do offer great opportunities for more spending and, of course, more taxes since each politician has his own bleeding heart project which he must use to insure his reelection.

This fantastically ruinous scheme has occasioned much serious thought among those who clearly see this as a means for the ultimate socialization or communization of this nation. The Committee on Education of the Oregon State Medical Society, evidently, has given this matter serious consideration, which is reflected in a resolution adopted at a meeting of the OSMS at Medford last September.

In brief the resolution recommends that, in order to more adequately support, by private means, charitable and non-profit organizations, such as universities, community funds, colleges, churches, hospitals and other foundations and funds, our tax laws be so revised as to allow for the deduction of an additional sum of money from taxable income over and above the amount given as a gift or contribution by any taxpayer.

It is obvious that this would encourage greater private support of education, for example among other things, by permitting the donating taxpayer to escape taxation of a portion of his income greater than the amount of his contribution. The purpose of this proposal is simple—to encourage giving. There is little doubt that if this recommendation by OSMS is properly implemented, it will produce some remarkable results.

It is certain, also, that tax-raisers and tax-spenders will resist any such suggestion with the excuse that it will disturb fiscal and budgetary processes of government. Of course, our feeling is that, in the absence of war, government spending should be reduced and restricted to government income without resort to increased taxes. There is no other way to restrict the unbridled squandering of taxpayer's wages. In fact, the pertinent elements of the OSMS resolution should come from taxpayers as a clear-cut demand and not as a Casper Milquetoast supplication.

Another source of opposition to the OSMS resolution will probably come from institutions which the implemented resolution would ultimately benefit — namely, those now receiving large Federal grants. This is well and clearly defined by the stand of Coggeshall, last year's president of the Association of American Medical Colleges, who openly espouses socialization of medicine by urging continued and increased Federal support for medical education.

Personal and selfish interests, however, need not hide the fundamental premise that the OSMS resolution would offer an excellent provision to correct some of the hindrances to philanthropy which have resulted from income tax. There should be no reluctance in supporting the suggested revision, since the history of income tax laws is that of constant adjustment. There even is much current interest in outright repeal of the Federal income tax law and such interest seems certain to grow. In the meantime, every effort should be made to ameliorate the damage done by the income tax.

The resolution, introduced as a part of the report of the Committee on Education, was adopted and referred by the Oregon House to its Committee on Public Policy for study. Intent of the resolution, to give written expression to the broad interests of the profession, is clear in its wording.* ◄

* Resolve portion of the resolution was published on page 1584 of the November 1959 issue of Northwest Medicine.

'M. I.'

(Medical Intelligence)

*A. C. OFFUTT, M.D.**

Indianapolis

KNOWING WHERE the enemy lies, his relative strength and character, and the ability to predict his next move—these are vital functions of military strategists and intelligence officers. The accuracy with which the strategists can determine—how many are there, what weapons will they use, where will they strike next—depends largely upon the accuracy of reports submitted by the intelligence officers. Decisions made by the strategists can mean the difference beteen victory and defeat for military forces.

Armed with the same kind of intelligence reports, your health officials are able to aid practicing physicians to wage an effective battle against disease and illness. Without reports submitted by family physicians throughout the state, the health department would be unable to answer such questions as: what disease is it, how many cases are there, what is the most effective means of combating it?

5,000 Front-Line Doctors

Here in Indiana, approximately 5,000 physicians are daily engaged in a front-line battle against disease, illness and disability. Diagnosis of disease and illness, treatment and supervision of the entire medical care program for patients, of course, must rest with the physician. In order for the busy practitioner to meet this obligation, he is frequently called upon to sacrifice his personal interests for the benefit of his patients, and ignore the fact that there are only 24 hours in a day.

By virtue of the fact that the physician is engaged in a full-time occupation, it is often impossible for him to know what each of his colleagues are finding as they visit patients in their own practices. For example, Dr. Brown may find that in his practice, there are two patients who have diphtheria. He is not aware that three other physicians in the county have had the same experience. It is not until he receives the weekly morbidity report from the Indiana State Board of Health, that he learns there are eight cases of diphtheria in his county—a situation which calls for immediate action if an epidemic is to be prevented.

Our imaginary Dr. Brown would not have this information at his disposal if he, or his colleagues, had neglected to report their individual cases of diphtheria to the local health department.

Minimum of Time Required

Since Indiana law requires that reports be made by physicians when certain diseases are involved, the official state health agency, working with local health departments and the Indiana State Medical Association, has developed reporting forms which are designed so that only a minimum amount of time is required for their completion.

Two types of reports are required: one is simply a record of the total number of cases of each disease; the other is used in certain other communicable diseases, and contains the name, address, age and sex of the individual patient, as well as other pertinent data. The latter form is used as a basis for epidemiological studies and investigations, and as a starting point to prevent further spread of certain communicable diseases, including the veneral diseases.

Information Put To Use

It is fallacious to assume that statistics are collected for the purpose of filling a file cabinet.

* State Health Commissioner, Indiana State Board of Health.

On the contrary, if the information gathered is not put to use, then it is ridiculous to continue collecting it.

As the practicing physician sends his reports to the local health department in his community, the health officer compiles the reports from all physicians in the area, and sends them to the Indiana State Board of Health. In general, there are three types of activity initiated by such reports:

1. Immediate Action—A report of a serious disease, capable of spreading rapidly through the population, causes immediate action by state and local public health personnel in order to establish control measures as rapidly as possible. Typhoid fever, amebiasis, diphtheria and diseases that may cause outbreaks in hospital nurseries, are some of the diseases calling for immediate action. An investigation started by one reported case frequently uncovers other cases.
2. Delayed Action—For many communicable diseases, adequate controls have not yet been developed. Information taken from reports of these diseases may one day enable health officials and physicians to develop such controls. Each report adds a bit of information about the disease picture, and when the complete picture is available, concerted action can be taken against the disease.
3. Surveillance—With regard to the diseases of childhood, reports submitted enable the health department to predict the yearly variations in disease prevalence. In addition, knowledge of the diseases that are prevalent in a given locality at a particular time often aids the health department and the physicians make a more rapid diagnosis of the community health situation.

Communicable diseases, while not the major hazard they once were, still constitute a serious threat in a world that is becoming more crowded and more mobile. Authorities point out that new communicable diseases are just now coming to light, and more undoubtedly will appear in years to come. Against this changing background, the practicing physician stands as a key member of a team striving for communicable disease control.

If public health officials are to do their work effectively, they must depend upon the intelligence reports of the communicable diseases, which are provided by the practicing physician. Without such reports, efforts to prevent widespread epidemics or outbreaks can be misdirected or inadequate. ◄

Have You Registered Your Radium or X-ray Unit?

The Radiation Control Act of Indiana requires that all sources of radiation (e.g. x-rays, radium, radioisotopes) be registered with the Indiana State Board of Health by Jan. 21, 1960. If you have not already registered your radiation source, you should do so immediately.

If you have misplaced your registration forms, additional forms may be obtained by writing to the Division of Sanitary Engineering, Indiana State Board of Health, 1330 West Michigan St., Indianapolis 7.

President's Page

Recently I had the privilege of riding to Bloomington, Ind., with one of my senior colleagues for the purpose of testifying in an Industrial Board case. It was a very pleasant trip—the streets were clear of snow or ice and the weather was rather cold but pleasant. As we were leaving Indianapolis the conversation drifted over to the changes that had occurred throughout the years—the changes in downtown Indianapolis which had come about since World War II—going further, the new highway development which now extends past Mooresville, and finally, the highway from Martinsville into Bloomington.



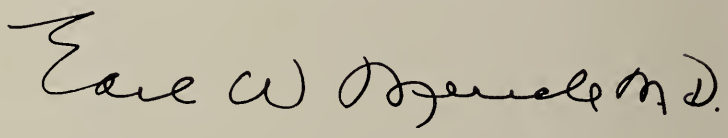
From the discussion of changes in environment that were so evident, we drifted around to talking about the changes that have occurred in medicine, too. It was interesting to note that the drugs used 25 years ago and those used now have very little in similarity and, too, the procedures used 25 years ago and those used now are vastly different. It was interesting to speculate on exactly what did make patients get well—what the doctor's part was in a patient's getting well.

The trend in medicine in the last 25 years has been to an increasing use of hospital facilities by all physicians. Technics and procedures, once considered office procedures, are now largely done in hospitals. Whether this is due to insurance as it is written today or whether it is due to other factors is not conclusive. Certainly no longer do consultants drive about over the state of Indiana as they once did. People are brought into a hospital for study rather than the doctor going to the patient. More and more hospitals are being utilized and with that utilization the dependency of the physician on hospital facilities grows greater. One wonders sometimes if this has been a wise course we have taken. Perhaps more emphasis on directing patients to doctors' offices and establishing facilities in doctors' offices for procedures and practices as they are done today might be a less expensive means of handling many of our patients.

Regardless of what the situation, as indicated in the foregoing, is like in regard to doctor-hospital relationship—it is here. It is something that will require considerable willingness on the part of both to plan together for a future that both can live by. A doctor without a hospital today is handicapped materially and certainly

a hospital without a doctor has no function at all. Already problems are present on the horizon. In fact, they are nearer than that. One major problem is the implementation of the action of the House of Delegates in their last meeting in which the fundamentals of the Hess report were reiterated and were to be implemented. To get this done in the State of Indiana will require much cool thinking—willingness to understand on both sides—and, very likely, considerable time. This is certainly an important consideration for medicine today because in the outcome of this situation, the practice of medicine hangs in the balance.

When Blue Shield and Blue Cross were organized, Blue Shield was to take over the prerogative in regard to pathologists, radiologists and anesthesiologists as soon as it was wisely possible. As the years have gone by this has not been done. There is no reason to feel that physicians in these categories are different from any other doctors and their situation in hospitals is certainly one to be considered in the same manner as any medical practitioner is considered. We are mandated to take action to implement the intent of the Hess report. This we cannot turn away from regardless of situations or personalities. One cannot accept this problem lightly; certainly we cannot put it aside lightly. This, as mentioned previously, is a problem that will require extreme patience, wisdom and willingness on the part of each to see the other side.



The Woman's Auxiliary

REPORTS TO I.S.M.A.

Dear Doctor,

"A task worth doing, and friends worth having, make life worth living."

Your Auxiliary's House of Delegates meets at French Lick April 28-29, 1960. With medicine at such a crucial crossroad, we must *all* work together. Please encourage your wife to send in her reservations now! Mr. Holman of the AMA office will inform us on legislative problems. This we *all* need to know to work together effectively.

See that your wife joins in the entertainment and education at French Lick! Send her a day early for golf, sightseeing or rest.

Sincerely,

Mary Annette Black

President





SOME MEMBERS of the House of Delegates Planning Committee are shown in photos above. At left (lt. to rt.) are: Mesdames Howard Rothring, Kenneth Bobb, Elmer Wallace, Richard Miller, David Silbert, William Tindall, parliamentarian; Joseph Black, president; Harry Baxter, convention chairman; John Ripley, Jackson-Jennings county president; Jack Shields, Marvin McClain, John Spears, P. T. Hodgin, Carl Bogardus and Keith Hammond. At right (standing): Mesdames Guy Martin, John Spears, Jack Shields and Elmer Wallace; (seated) Marvin McClain, John Ripley and David Silbert.

A Journal Special:

Vervain

(verbena officinalis-verbenacea)



by Miki Wilson

". . . and if it fall oute that a snake or any serpent be crepte into the farmer's body, or into the bodies of any of his servants lying asleepe with their mouthes open in the meadowes, there is nothing more soveraign to force the same againe out of such a body than . . . to drink the deconcoction of vervaine made with white wine."

This charming herb, as can be seen, stewed in the wine of the times was a specific against the perils of the medieval countryside. However, the history of the "holy herb" of the Middle ages, began much earlier. The white-robed Druids used it expressly against the plague, and Hippocrates considered it one of the most important herbs used in his simples.

Vervain, however, has not always been considered a 'holy' herb. In its long and delightful history it has been used for black as well as white magic. At one time it was considered, with yarrow, belladonna monkshood and the humble parsly, as beloved by the Devil. He himself, it is said, taught the witches how to use vervain, with other less savory ingredients, in the preparation of unguents and ointments which permitted them to escape from a drab existence and fly to the Sabbath.

Through the ages, it has been a particularly dependable ingredient of love philtres.

The inspiring of this tender emotion, as opposed to the carnal attractions of the Sabbath, should be considered as coming under the heading of White magic. The use of love philtres was winked at by the Medieval Courts of Love, and the knights in armour shed their metal casing, languished by their ladyloves and were frequently touched by the magic potient. In some cases the herb was unmixed, and the juice of the vervain root was rubbed onto the hands of the lovesick. It was only necessary then, to touch the object of one's affections and inspire undying love.

As the herb grew 'holier,' it was used against itself to keep off witches, incubbi and succubi, by being hung over doors and windows and other places of entrance.

And as time went on, vervain became again a strong aid in white magic, if disease and sickness be considered devilish.

The London Pharmacopecia of 1837 states that "necklaces of vervain roots worn with a white satin ribband around the neck is a cure for scropula . . . "

In later times this herb, rich in glucose, and tonic and digestive principles, diminished in use. However, it is still important in the relief of rheumatic pains, menstrual migraines and spasms of the digestive organs. It is being used in the treatment of nervous disorders, and has, in Europe, been suggested as a replacement for quinine.

It is not to be confused with vervaine odorante, of the same family, delicious in teas and jellies. No, it is the vervaine officinale, of black and white repute of which has been said ". . . when four leaves and four roots are steped in wine and sprinkled about the house . . . all therein shall be merry."

(One of a series of articles on herbs in Medical History. Idea, research, copy and art by Miki Wilson, Hawaii.)

A 1960 Goal: Selling the 'Preferred' Programs

This article is one in a series prepared by Blue Cross-Blue Shield.

During 1960 Blue Shield will make a maximum effort to push the Preferred programs, both surgical and medical. This protection is needed in most areas of the state, and many of our problems would be solved if most members had this coverage.

Since 1954 we have sold nearly all new accounts either the Preferred or a Special certificate. In addition, many of the old accounts have been converted to the Preferred schedule, and during the months ahead, we will concentrate on the remaining accounts.

Account members are protected by Preferred, Special or Standard coverage. Approximately 40% have Preferred or Special, with the remaining 60% holding Standard certificates, totaling about 210,000. We want to convert these memberships to a more realistic program that better matches the current cost situation.

The basic problem in persuading accounts to make this change is the difference in fees. We do not dictate what benefits an account must take, but we do try to sell them on the program that is best suited to their needs . . . for the funds they have available.

Doing a Good Job

The Preferred schedule is doing a good job. It is paying about 84% of the surgeon's total charges. Over three-fourths of all claims, distributed about equally by procedure regardless of frequency or cost, are paid in full. This distribution indicates that the Preferred certificate pays in full all cases except highly complicated ones where extra care or extra skill is involved. On an average, members with Preferred coverage paid only $16.00 of each $100.00 of services received.

This proof of performance is one of our major selling points. Another sales point found in the Preferred schedule that is often overlooked is the removal of the Standard schedule limitation which provides a $200 maximum payment for related conditions in any six-month period.

The removal of this limitation assures a member who has Preferred coverage of receiving benefits geared to his real needs. It eliminates most of the problem of claims not paid because benefits have been exhausted.

Here is a specific example illustrating this Preferred schedule advantage:

Paid $1,813!

One of our members was hospitalized in March and April of 1958 with multiple head and body fractures sustained in an automobile accident. For services received under the Preferred certificate, we paid a total of $1,813.00 for 19 separate charges.

If this member had had Standard coverage we would have paid $150.00 for leg fracture, $30.00 for anesthesia, $50.00 for lacerations of face and $13.00 for medical days—a total of $243.00. The unpaid balance would have been $1,570.00.

If the patient had had commercial insurance paying $300.00 per condition the unpaid balance would have totaled $1,513.00.

We use examples such as these in attempting to encourage accounts to convert from Standard to Preferred, and to choose Blue Shield instead of considering a commercial insurance company paying on a per condition basis.

The selling job is ours, but as a doctor, your expressed ideas on the subject of health care have influence on many people, your friends as well as patients. Your active support of Blue Shield will help us achieve our mutual goal—that of providing adequate medical and surgical protection for all the citizens of our state.

W. C. Huddlestone
Public Relations Division ◄

ISMA Sponsors 'Town Meeting'

AMA President Meets Hoosier Leaders, Discusses Problems Facing 'Personal Medicine'

"Town meeting" photographs and the full text of Dr. Orr's speech are carried on the following pages.

A "town meeting" was held in Indianapolis Jan. 11, when Dr. Louis M. Orr, American Medical Association president, met with 235 high ranking leaders of Hoosier business, labor, professions and politics. His hard-hitting address was on the question, "Political Medicine or Personal Medicine?"

Traditionally, a town meeting is a gathering of "town folk" to discuss and solve local problems. From remarks of those attending, from reports in the press, this meeting appears to have been one of the most successful yet sponsored by ISMA in its attempts to explain to the lay public those problems besetting organized medicine today.

Included among the dinner guests at the Columbia Club ballroom Jan. 11 were Indiana Governor Harold W. Handley, Indianapolis Mayor Charles Boswell, Indiana Congressman William Bray (and candidates to those positions), UAW-CIO President Dallas Sells and heads of other major labor organizations.

Professional Associations Represented

There were those representing other professional associations such as the Indiana State Bar Association, the Indiana State Dental Association, etc.

There were Hoosier newsmen, some of whom shot staccato questions at Dr. Orr in a pre-dinner press conference. Their stories the next day seemed to show they were satisfied with his answers—even though before Dr. Orr made his appearance in a special room set aside for the conference, their remarks reflected much of the general dissatisfaction and misunderstanding some individuals and groups hold for physicians and general medicine.

Yes, it was a real town meeting! And Dr. Orr was accorded the recognition of a visiting dignitary representing the medical profession, not only by newsmen attending the conference, but by those who met him at the front door of the Columbia Club at his arrival.

Newsmobiles Meet Orr

Four newsmobiles, representing major Indianapolis radio and TV stations, were waiting to interview the AMA president on-the-spot for broadcasts being aired at the time.

Governor Handley said he attended the dinner because he wanted to pay his respects to AMA's president on behalf of the state of Indiana.

"Your association, of course, has the distinction of being one of the greatest, and the finest, and the most all-American of many of our associations and societies in this country," the governor told Dr. Orr.

"And I further came here because I think that we have one of the outstanding medical associations among the 50 states . . .

"And another reason, and very important, is because I feel that the philosophy of many of us, not only here in Indiana, but throughout the width and breadth of the land, certainly jibes with the philosophy of the American Medical Association."

Later in his address, Governor Handley said, "when we take a look at this federal aid project,

Continued on page 488



PHOTOS by CORKI WILSON
(except where noted)

Dr. Orr Meets the Press, Holds Town Meeting With Hoosier Leaders

"Undoubtedly, experience has taught you—as it has me—that the promised gift can turn out to be a mere election gimmick.

"This year we are going to hear about a good many promises—promises that cannot be delivered. I am convinced that Forand-type legislation is one of those promises."

. . . Louis M. Orr, M.D.

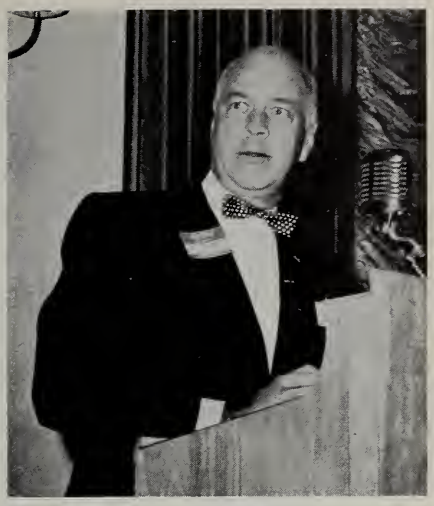




TOWN MEETING LINEUP BASS PHOTO

READING left to right are William G. Bray, Ninth District Congressman; Walter L. Portteus, M.D., and Don E. Wood, M.D., co-chairmen, ISMA Commission on Legislation; Mayor Charles E. Boswell, Indianapolis; Dr. Orr; Indiana Governor Harold W. Handley; Earl W. Mericle, M.D., ISMA president; Guy A. Owsley, M.D., ISMA president-elect.

Business, Politics, Labor, Professions Represented at ISMA Reception and Banquet



. . . YOU'VE DEDICATED YOURSELVES . . .
Indiana's Governor Handley addresses meeting.



"NOW, I BELIEVE . . ."

L. V. Phillips (left), state commissioner of athletics, in a discussion with Okla W. Sicks (center), M.D., ISMA treasurer, and Robert Darrell, pharmacist from Hume Mansur Pharmacy.



IN A HUDDLE

Congressman William Bray talks over 'town meeting' issues wtih ISMA members.

'CHAMBER' REPRESENTED

Jack Retch (right), executive vice president of the Indiana Chamber of Commerce, talks with Dr. Wood.



NOT ALL SERIOUSNESS

ISMA President Earl Mericle chuckles with John Hendricks, M.D., member of ISMA Commission on Legislation.





BASS PHOTO

AMA OFFICIALS

Dr. Orr and Cleon A. Nafe, M.D., Indiana's member of AMA's Board of Trustees, pause in a business discussion to smile for the Bass Photo cameraman.



CIVIC WELCOME

Indianapolis Mayor Boswell gives a few words of welcome to ISMA guests and members preceding Dr. Orr's address.

AMA President

Continued from page 495

this health and federal domination here and there . . . I think we have a lot in common with the medical associations because you learned it the hard way, you've dedicated yourselves, you've given long hours, you want the freedoms and liberties of action which every good American citizen is entitled to."

Many Attend Reception

The banquet was preceded by a reception attended by many of those outstanding Hoosier leaders present later for dinner and Dr. Orr's talk. There, Dr. Orr was able to talk informally with these men and women and answer any questions they might have on current programs and the philosophy of organized medicine. There, ISMA members and officers present were able to mingle with the non-medical people for similar informal discussions.



ISMA WELCOME

Dr. Mericle welcomes Indiana guests on behalf of ISMA, preceding his introduction of Dr. Orr to the assembly.

Because of the attendance of top state leaders from the governor on . . . because of the tremendous interest of local and state press . . . because of the general trend of press coverage . . . because of the many remarks overheard at the time and since . . . because of all this there is real reason to feel this "town meeting" in Indiana was a big step in the direction of acquainting the general public with problems facing free medicine today and in gaining the support of non-medical leaders.

It is felt by many in Indiana that it was a real success and that having leaders in the medical field, such as AMA's president, meet in such a fashion with non-medical citizens can be a strong wedge toward better lay understanding of medicine's fight for survival.

POLITICAL MEDICINE

A plain-speaking doctor appeared at the Columbia Club Monday night and gave voice to sentiments that need to be repeated long and often in this election year.

Dr. Louis M. Orr, head of the American Medical Association, warned his audience that a potion of vote-conscious statism now being brewed in Congress is bad medicine, bad economics and bad politics.

Dr. Orr's fire was directed at the "Forand bill," a scheme to provide federally-subsidized medical benefits to recipients of social security. The bill would supply free hospitalization and nursing care for 180 days out of the year, and push federal taxes upward by billions of dollars ($1 billion to $2 billion the first year; around $7 billion by 1980).

In examining the alleged need for such legislation, Dr. Orr pointed out:

1. That the majority of America's aged are already capable of paying their own way, through savings, pensions, family care.

2. That the Forand bill does not help the indigent minority, because people on public assistance rolls, ineligible for social security, are not covered by it.

3. That by the end of this year, an estimated 60% of those 65 and over who want health insurance coverage will have it—through private programs. The estimate for 10 years hence is 90% coverage.

4. That in England, where socialized medicine of this sort has been on the books for years, the state's medical "progress" has ground to a halt; no major hospital construction in a decade; a surgical waiting list of half a million and a heavy trend to private medical programs.

In sum, the Forand legislation, as even the Department of Health, Education and Welfare has acknowledged, is totally uncalled-for—a raw attempt to buy the votes of America's aged. We join Dr. Orr in urging that it be soundly defeated.

INDIANAPOLIS NEWS
January 14, 1960

Above is reprinted one of the editorials representative of those which appeared throughout Indiana after Dr. Orr's address to over 200 Hoosier civic leaders.

Political Medicine or Personal Medicine?

AMA president gives Hoosiers brief insight on complexities and pitfalls involved in Forand-type legislation for aged health care.

LOUIS M. ORR, M.D., President
American Medical Association

I AM DELIGHTED with this opportunity to be in Indiana again and to talk with you tonight about some vital issues facing you as individual Americans, as a nation and medicine as a profession.

Until last week I had planned to open my remarks with a few minutes about basketball here in Indiana, but after reading about the first three encounters of a certain highly rated local Hoosier quintet, I believe I would be better off on a different subject.

(And when I am in Wisconsin next week, I had better not bring up the subject of football and the Rose Bowl.)

I know that besides basketball the one other single topic which is likely to interest most people and arouse the most comment in Indiana is politics.

Well, this is to be a big year in politics. A new President will be named, a third of the U.S. senators will be chosen, all U.S. representatives must stand for re-election, and many states will elect governors, legislators, judges and other important officials.

This is Tragic!

Most of us anticipate the coming political campaigns. Unfortunately, not all of us will participate in them in any way. This is tragic, I believe, for a free people must *take part* in elections or their free society may well be *taken apart*.

About six weeks ago I admonished all physicians to take a greater interest in politics, to understand the issues, to know the candidates and to work actively for a candidate or to be candidates themselves.

Too many physicians, like a good many businessmen and other professional men, have avoided the political arena too long. They have left this essential and demanding task of politics to others while they busied themselves within their own little vacuum. And I might add that this is too often true not only in politics but also in many civic affairs and projects.

I firmly believe that each of us must be rugged and responsible individuals—ready and eager in our work, competent in our chosen field, and an example and inspiration to others. But I also believe that we must be active, cooperative citizens, ready to do our share of the "fielding" with the rest of the political or civic team. A baseball club of sluggers only, is not good enough. In politics and community life this also holds true. We need those who can get in and pitch, and who can play their positions in harmony with their teammates.

No Prima Donnas Needed

There is no room for the prima donnas—whether they are physicians, business leaders, labor chiefs or any other professional.

All of us obviously cannot be actively engaged in the 1960 political battles. We can, however, know the candidates seeking the offices. We can try to understand the issues involved

Continued

Delivered before more than 200 Hoosier leaders at the Columbia Club, Indianapolis, Jan. 11, 1960.

The first specific aldosterone-blocking agent...

ALDACTONE™

effectively extends the medical control of edema or ascites.
It introduces a new therapeutic principle in the treatment of...

CONGESTIVE HEART FAILURE • HEPATIC CIRRHOSIS
THE NEPHROTIC SYNDROME • IDIOPATHIC EDEMA

ALDACTONE introduces a new class of therapeutic agent, the aldosterone-blocking agent providing:

satisfactory relief of resistant or advanced edema even when all other agents, alone or in combination, are ineffective or are only partially effective.

A New Order of Therapeutic Activity

ALDACTONE acts by blocking the effect of aldosterone, the principal mineralocorticoid governing the reabsorption of sodium and water in the distal segment of the renal tubules.

By so doing Aldactone establishes a fundamentally new and effective approach to the control of edema or ascites, including edema resistant or unresponsive to conventional diuretic agents.

Further, because of its different site and mode of action in the renal tubules, Aldactone has a true, highly valuable synergistic activity when used with a mercurial or thiazide diuretic.

What Physicians May Expect of Aldactone

It is fully expected that Aldactone will change present medical concepts of the therapeutic limitations of managing edema. Many patients living in a greater or lesser state of edematous invalidism can now be edema-free. To others, gravely ill, Aldactone will be life-saving.

When used alone, Aldactone will produce a satisfactory diuresis in about half of those patients whose edema is resistant to conventional diuretic agents.

When Aldactone is used in a comprehensive therapeutic regimen, which includes a mercurial or a thiazide diuretic, a satisfactory diuresis and relief of edema may be expected in approximately 85 per cent of edematous patients *who would not otherwise respond.*

DOSAGE: For most adult patients the optimal dosage of Aldactone, brand of spironolactone, is 100 mg. four times daily. Aldactone should be administered for at least four or five days before appraising the initial response, since the onset of therapeutic effect is gradual when it is used alone. Aldactone manifests accelerated activity with greater response as early as the first and second days when used in combination with a mercurial or thiazide diuretic.

SUPPLIED: Aldactone is supplied as compression-coated yellow tablets of 100 mg.

G. D. SEARLE & CO.
Chicago 80, Illinois
Research in the Service of Medicine

Political Medicine

Continued

between the candidates and between the parties —maybe, even, within the parties.

Knowing the candidates, their careers and their voting records, is fairly simple. Knowing and understanding the issues often is not so easy; indeed it can be quite complex.

Take the issue of the health care of our aging population. There are those who claim that this is a national issue; indeed, they say it is a national emergency.

Accordingly, they have introduced legislation into the 86th Congress called the Forand Bill (the measure takes its title from Rep. Aime Forand of Rhode Island). The bill would provide certain hospital, surgical, nursing home and dental benefits to persons receiving, or eligible for, Social Security retirement and survivor benefits. The benefits, of course, are "free" to the millions of persons paying into the Social Security fund. A further increase in the Social Security tax would pay for these so-called "free" services.

A Community Responsibility

Those who oppose the Forand Bill, including the American Medical Association and many other health and allied groups, contend that the health care of the aged is a family and a community responsibility. Furthermore, we feel that a large majority of those 65 years and over present no special problem and, therefore, no federal emergency solution is needed. Their medical care is either being taken care of by themselves or by their families who are sharing in the financial responsibilities.

For example, Father Dalton, director of Catholic hospitals for the Archdiocese of Boston, testified recently before a Senate group on the problems of the aged. Here is the way he sees the health care problem of the aged:

"It is with regard to the minority that any problem exists. This minority lacks the financial means, the physical or mental health, devoted relatives, the will to make a go of it, or just plain knowledge of how to live with their age.

"Public interest focuses upon this minority all out of proportion. This is no doubt due to the rapidly increasing number of these aged citizens and the fact that such an increase was neither foreseen nor well prepared for. The result is a certain amount of confusion and not a little hysteria in trying to arrive at a sane and sensible solution."

Continued to page 497

"Approved"
PROFESSIONAL LIABILITY INDIVIDUAL INSURANCE
by
'The No. 1 Malpractice Insurer' *
*MEDICAL ECONOMICS, FEB. 3, 1958
Unparalleled Experience ● Specialized Service ● Saving in Cost
THE MEDICAL PROTECTIVE COMPANY
FORT WAYNE, INDIANA
Professional Protection Exclusively since 1899
INDIANAPOLIS OFFICE: Kenneth W. Moeller, Rep.
5950 Indianola Avenue Tel. CLifford 5-6525

Political Medicine

Continued from page 492

Receive No Assistance

We might well ask: "Is this minority the group that the backers of Forand-type legislation hope to help?

I see little, if any, real help for this minority of the aged under the Forand-type legislation. Why? Because most of those on Public Assistance rolls are not eligible for Social Security benefits. Hence, they would receive no assistance under the Forand measure.

These persons currently receive the care they need through private, fraternal and religious organizations, and through local and state programs already established for that purpose.

Other needy individuals who would be eligible for benefits under the Forand Bill already receive care from the Veterans Administration, from other government agencies or from private sources.

The number of aged in these various circumstances may be as much as 20% of the total population over age 65.

In answer to these and scores of other facts exposing the Forand Bill as *unnecessary, unwise* and *costly,* the proponents of the measure have attacked the AMA specifically for—

1. Being opposed to old people and their medical care.

Poppycock!

This is ridiculous poppycock. The AMA for many years has concerned itself specifically with the medical care problems of the aged. It has gone into special diets for senior citizens, recreation needs, and specially-tailored hospital or nursing home accommodations for the sick aged. Today one of the most active scientific and socio-economic groups within the association is the Committee on Aging. All of its members are authorities on the health needs of the aged. And one of its members, a past AMA president, is recognized as a foremost scientist on the medical aspects of aging.

Furthermore, for years the AMA and its presidents have told the American people that the next specialty in medicine would be the geriatrist, a medical doctor specially trained to care for the health and medical needs of the older person.

2. The Forand backers claim we oppose the measure for selfish reasons.

Again, how wrong can you be?

If we were at all selfish in the matter, we would embrace the proposed legislation, for it guarantees the payment of surgical fees for those eligible for Social Security. I do not think it is any secret that many fees now go uncollected because the physician knows that his elderly patient is unable to pay.

No, we strenuously oppose any Forand-type legislation for this basic medical reason:

Political Medicine Bad Medicine

We feel that this measure is political medicine and bad medicine and would result in a deterioration of the nation's health standards.

Medical care is not susceptible to production-line technics. Medical needs of the aged are subject to countless variations, and any workable system of care must be tailored to meet them. Government regulations and controls upon the physician would hamper the physician from prescribing treatment which, in his professional opinion, was indicated. The individual approach to patient care would be lost under the Forand measure.

The medical profession believes and promotes continually the idea that *individual care* of an *individual patient* by an *individual doctor* is the best possible medical arrangement. It is voluntary, private, flexible and effective.

It is not compulsory, open to a third party (namely, government), rigid and complicated by red tape.

3. The proponents say that Forand-type legislation is not socialized medicine. They further say that we are wrong in claiming that it is.

Our Answer!

Our answer is simply that this meausre would be *government* medicine. It would be *political* medicine. It would be *socialized* medicine, although temporarly limited in scope to only those beneficiaries of the OASDI program.

It is government medicine because the federal government in Washington would.

—Administer and run the program through compulsory and earmarked taxes.

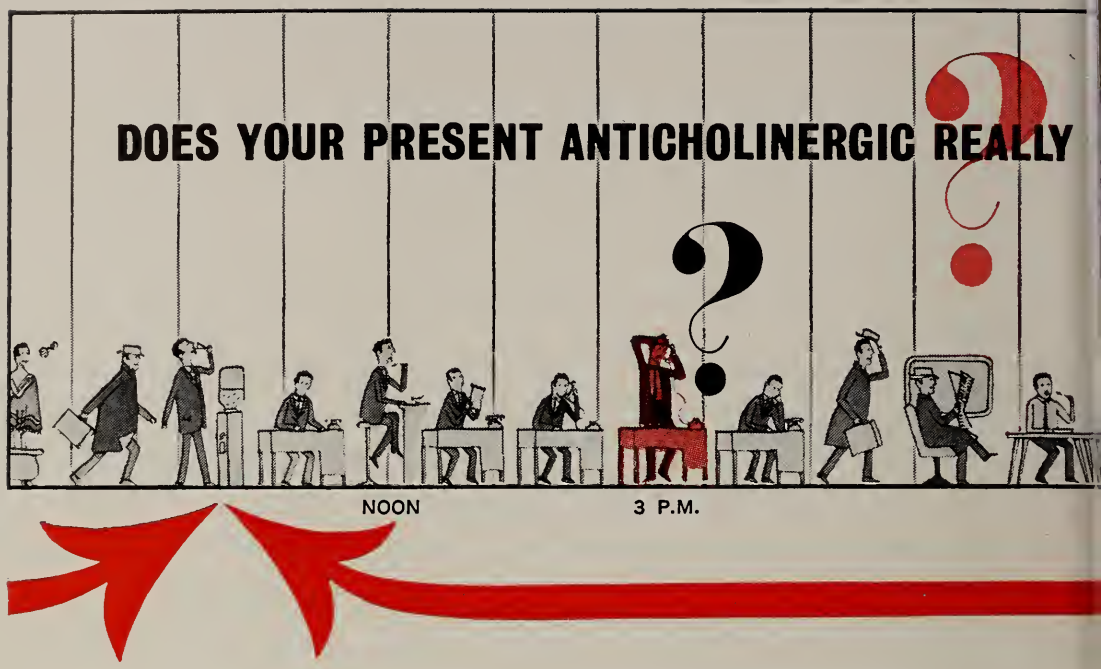
—Control disbursement of funds.

—Determine the benefits to be provided.

—Set the rates of compensation for hospitals, nursing homes, dentists and physicians.

—Audit and control the records of hospitals, nursing homes and patients.

Continued on page 500



The test—you might say the acid test—of an anticholinergic is simple: will it protect your patient from hyperacidity around the clock, **even while he sleeps.** The weakness of t.i.d. or q.i.d. preparations is well recognized; but even some "b.i.d." encapsulations may be unreliable. McHardy, for instance, found a "widely variable duration of action, definitely less than that anticipated" in the "sustained," "delayed," and "gradual release" anticholinergics he studied.[1]

COMPARE THE DATA ON ENARAX . . . the new combination of an **inherently** long-acting anticholinergic (oxyphencyclimine) and Atarax, the non-secretory tranquilizer. Note the effectiveness of oxyphencyclimine:

OBSERVE THE OXYPHENCYCLIMINE REPORTS . . .

McHardy: "[Oxyphencyclimine] has proved to be an excellent sustained-action anticholinergic in our study of this agent over a period of eighteen months."[1]

Kemp: ". . . for the majority of patients, one tablet every 12 hours provided adequate control. This characteristic long action . . . may constitute an advantage of this drug as compared to coated 'long-acting' preparations of other compounds."[3]

Add Atarax to this 12-hour anticholinergic. The resulting combination—ENARAX—now gives relief from emotional stress, in addition to a reduction of spasm and acid. Atarax does not stimulate gastric secretion. No serious adverse clinical reaction has ever been documented with Atarax.

LOOK AT THE RESULTS WITH ENARAX[4,5]:

Does the medication you now prescribe assure you of all these benefits? If not, why not put your next patient with peptic ulcer or G.I. dysfunction on therapy that **does.**

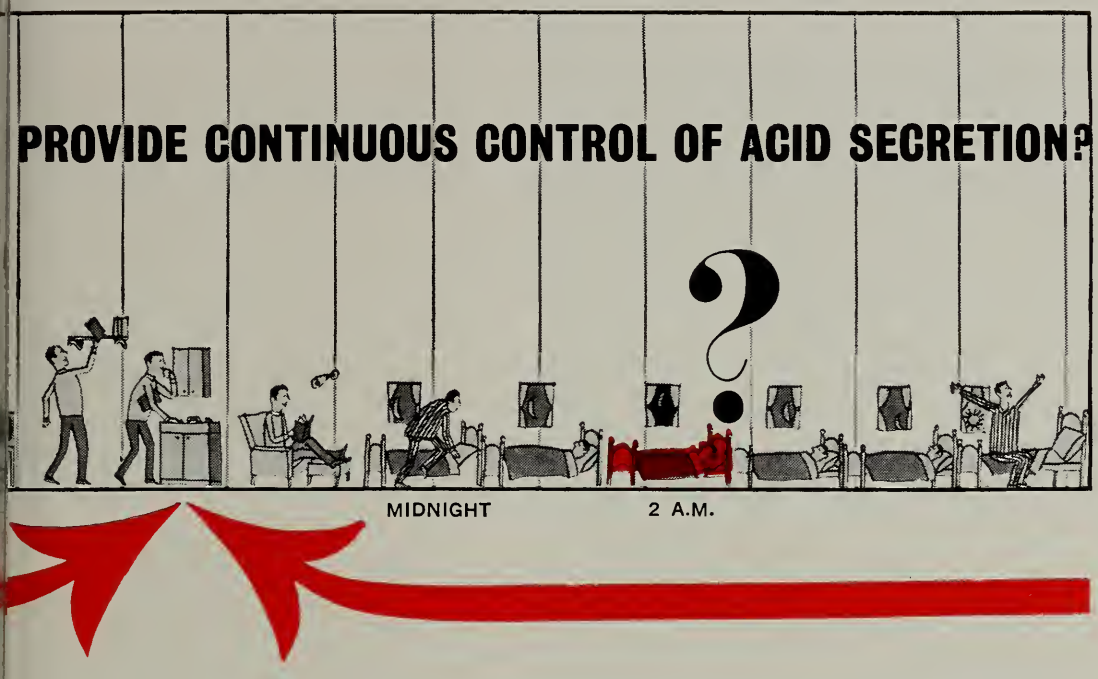
ENARAX®



(oxyphencyclimine plus ATARAX®)

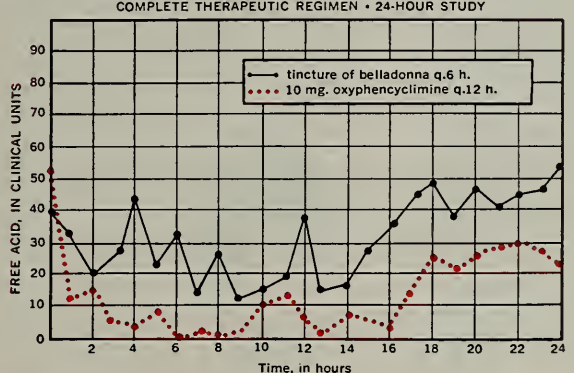
A SENTRY FOR THE G.I. TRACT

PROVIDE CONTINUOUS CONTROL OF ACID SECRETION?



"Prolonged periods of achlorhydria" after 10 mg. oxyphencyclimine q. 12 h.[2]

MEAN GRAPH OF GASTRIC ACIDITY IN 4 PATIENTS RECEIVING COMPLETE THERAPEUTIC REGIMEN • 24-HOUR STUDY



Clinical Diagnosis: Peptic Ulcer—Gastritis—Gastroenteritis—Colitis—Functional Bowel Syndrome—Duodenitis—Hiatus Hernia (symptomatic)—Irritable Bowel Syndrome—Pylorospasm—Cardiospasm—Biliary Tract Dysfunctions—and Dysmenorrhea.

Clinical Results: Effective in over 92% of cases.

As for Safety: "Side reactions were uncommon, usually no more than dryness of the mouth...."[4]

Each ENARAX tablet contains:

Oxyphencyclimine HCl ..... 10 mg.
Hydroxyzine (ATARAX®) ..... 25 mg.

Dosage: One-half to one tablet twice daily—preferably in the morning and before retiring. The maintenance dose should be adjusted according to therapeutic response. Use with caution in patients with prostatic hypertrophy and with ophthalmological supervision only in glaucoma.

Supplied: In bottles of 60 black-and-white scored tablets.

References: 1. McHardy, G., et al.: J. Louisiana M. Soc. 111:290 (Aug.) 1959. 2. Steigmann, F.: Study conducted at Cook County Hospital, Chicago, Illinois, in press. 3. Kemp, J. A.: Antibiotic Med. & Clin. Therapy 6:534 (Sept.) 1959. 4. Leming, B. H., Jr.: Clin. Med. 6:423 (Mar.) 1959. 5. Data in Roerig Medical Department files.

ROERIG Rx

New York 17, N. Y.
Division, Chas. Pfizer & Co., Inc.
Science for the World's Well-Being™

Political Medicine

Continued from page 497

—Promulgate and enforce standards of hospital and medical care.

While limited in scope now, taxpayers know that it is characteristic of federal programs, that once on the books, they expand. They never contract.

Costly from the outset—anywhere from 1 to 2 billion dollars—the Forand-type legislation thus would become more and more costly through the years. Predictions are that by 1980 the legislation would cost between 6 and 7½ billion dollars.

Of course, the proponents of the measure contend that all the benefits of the legislation can be had for only one-fourth of 1% of taxable payroll each for employer and employee, and three-eighths of 1% on the self-employed.

Merely Direct Costs

Remember, that if enacted, the bill would guarantee benefits to some 16 million persons. Can you imagine the cost of 60 days of free hospitalization, the cost of the medical and surgical care, the costs of drugs, and the high administrative costs of the legislation? And these would be merely the direct costs.

We also would have to consider the indirect costs. For example, how many millions of dollars would have to be spent to provide the hospital and nursing home facilities not now in being just to accommodate the aged to whom care is promised in the legislation?

Yes, we can be sure that the cost of Forand-type legislation would mount and mount.

Today Social Security taxes already are scheduled to reach 9% of payroll in the years ahead. The Forand Bill or any similar measure thus would send these taxes even higher, with continued reduction in paychecks.

They Say . . .

Proponents of any Forand-type legislation have said, and undoubtedly will say, that most of the aged over 65 years cannot now meet their health care needs . . . that their economic status is low, even sub-low . . . that they cannot buy, or afford to buy, voluntary health insurance.

For example, here is one slanted statistic we have heard.

"Three-fifths of all people 65 and over had less than $1,000 in money income in 1956 and 1957."

What this statistic fails to take into account is family and non-monetary income, total assets,

. . . MALNUTRITION OR
LEG CRAMPS DURING PREGNANCY?

OUTMODED AS GODEY'S FASHIONS!

℞ NEW

PRENALIN-O®

PRENATAL SUPPLEMENT

1. Oyster Shell Calcium - Phosphorus Free!
2. New Form of Iron!
3. Dry Filled Capsule - Sure, Quick Absorption!
4. Economical Once-A-Day Dosage!
5. Wider Range Nutritional Support!
6. Relieves Troublesome Leg Cramps!

EACH dry filled capsule (lavender and white) provides:

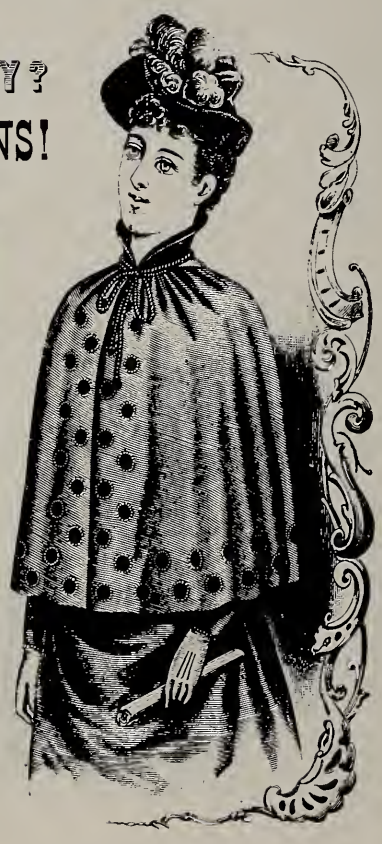
Ferrous Fumarate (Iron)	150 mg.	Vitamin B-12 (Cobalamin conc. NF)	2 mcg.
Oeep sea oyster shell (Calcium)	600 mg.	Folic Acid	0.25 mg.
Vitamin C	50 mg.	Niacinamide	10 mg.
Vitamin A	4000 USP Units	Vitamin K (Menadione)	0.25 mg.
Vitamin O	400 USP Units	Rutin	10 mg.
Vitamin B-1	2 mg.	Sodium Molybdate	3 mg.
Vitamin B-2	2 mg.	Fluorine (Calcium Fluoride)	0.25 mg.
Vitamin B-6	0.8 mg.	Iodine (Potassium Iodide)	0.15 mg.

SAMPLES ON REQUEST

TUTAG

S. J. TUTAG & CO.

DETROIT 34, MICHIGAN



Butazolidin®

brand of phenylbutazone

in arthritis and allied disorders

proved by a decade of experience

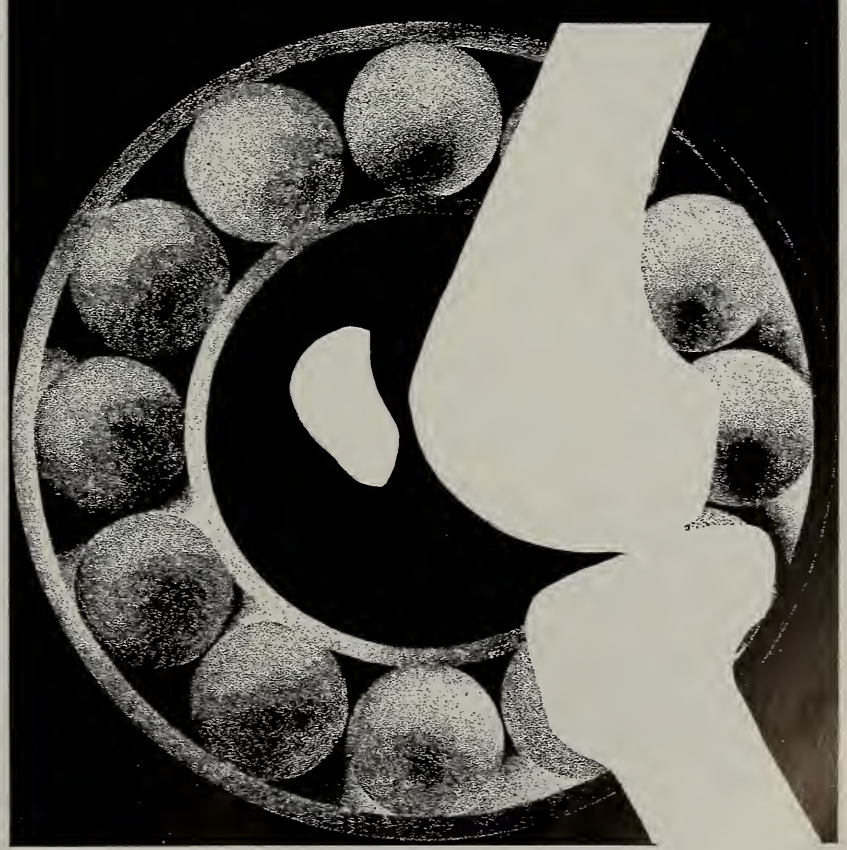
Ten years of experience in countless cases—more than 1700 published reports—have now established the eminence of Butazolidin among the potent non-hormonal antiarthritic agents.

Repeatedly it has been demonstrated that Butazolidin:
Within 24 to 72 hours produces striking relief of pain.
Within 5 to 10 days affords a marked improvement in mobility and a significant subsidence of inflammation with reduction of swelling and absorption of effusion.

Even when administered over months or years Butazolidin does not provoke tolerance nor produce signs of hormonal imbalance.

Butazolidin® brand of phenylbutazone:
Red-coated tablets of 100 mg.
Butazolidin® Alka: Capsules containing Butazolidin® 100 mg.; dried aluminum hydroxide gel 100 mg.; magnesium trisilicate 150 mg.; homatropine methylbromide 1.25 mg.

Geigy, Ardsley, New York



Geigy

BU 7-60

Political Medicine

Continued

other resources, and the reduced financial obligations of the aged person.

I suspect that there are statistics on both sides of the fence to prove, conclusively of course, that there is—or is not—a real problem.

My own feeling is that there is a destitute group within the aged, there is an affluent group, and there is the great middle group—neither rich nor poor.

Most of those in the middle group probably can meet their medical care needs either through income, their health insurance policies or their families.

No Help for the Needy

Obviously then, whatever problem does exist is among the needy and near-needy aged. But costly Forand-type legislation ignores this and proposes to cover everyone—rich, poor or middle bracket—as long as they are eligible Social Security recipients. For a great many of the needy or near-needy aged this would be no help at all, for they are not eligible to receive Social Security benefits in the first place.

To aid these needy persons the American Medical Association and the American Hospital Association recently adopted a resolution dedicating their full resources to accelerate the development of adequately-financed health care programs. Both groups stated that "the indigent or near indigent is primarily a community responsibility."

Already most communities do take care of these persons. And physicians and hospitals assist by providing free service and care.

Let me also emphasize that perhaps one of the most tragic results of passage of Forand-type legislation would be the curbing of the progress and development of voluntary health insurance for the aged.

Voluntary prepayment plans and health insurance have made great advances during recent years. Today more than 43% of those over 65 years are protected by some kind of health insurance. By the end of this year it is estimated that about 60% of those over 65 who wish to purchase such insurance will be covered. Within 10 years the percentage should go to 90%.

In light of this phenomenal growth I ask you: Should we not now give the voluntary health insurance industry the opportunity to continue its gains? I definitely believe we should.

If it is not allowed to do so, then the Forand-type legislation is merely the foot in the door. It will be expanded and expanded until the entire system of medical care in the United States is made compulsory by the federal government.

Not a 'Great Bargain.'

So, you see, the issue of the Forand Bill is quite complex if you do not take the words of the proponents of the measure. And, indeed, it is not quite the "great bargain" that they would have you believe.

Undoubtedly, experience has taught you—as it has me—that the *promised gift* can turn out to be a mere *election gimmick*.

This year we are going to hear about a good many promises—promises that cannot be delivered. I am convinced that Forand-type legislation is one of those promises.

Today in America we as individuals still get our medical care on a personal basis. Let us hope that in a year, 10 years or 50 years we will still have personal medicine, not political medicine. ◄

The Norbury Sanatorium

Established 1901 — Incorporated
Licensed — Jacksonville, Illinois

FRANK GARM NORBURY, A.M., M.D., Medical Director
HENRY A. DOLLEAR, M.D., Superintendent
FRANK B. NORBURY, M.D., Physician

Operating

Maplecrest—

Restful, congenial homelike surroundings are combined with the most modern diagnostic and therapeutic equipment.

Maplewood—

Most comfortable home for individuals requiring rest, scientific diagnosis and treatment. Fireproof construction.

'Governments can legislate and decree, but their words and laws will never duplicate the understanding, love and respect that only friends and relatives can give the older person.'

It's That Time Again

LOUIS M. ORR, M.D., President

American Medical Association

AROUND THIS TIME of year, newspapers inevitably publish the year-end summaries of significant events during the last year, and forecasts for the coming year. Most of the newspapers I have seen so far have concentrated their résumés on such international topics as summit meetings, East-West chilliness and the like. National events most popular with the journalists have been headed by the exchange of visits between our President and the premier of the Soviet Union.

Certainly all of these have been important, particularly from a historical point of view. However, I believe there have been two national developments of immeasurable significance to Americans.

The first has been the oiling and cleaning of machinery for the presidential election next November. The second important development has been the increasing interest and concern about America's elderly population.

Now it might seem to the casual observer that there is little relation between these two. But if you examine them closely, you will see that there is a surprising degree of interdependence between them. And it is quite possible that they might be even closer together by this time next year.

One Important Statistic

What am I talking about? Well, let's start with the growth of our aged population. I am sure most of us share a dislike of dry, unexplained statistics, so I will restrict my remarks to one important statistic, which is this:

Today nearly 16 million Americans are over age 65.

You don't need to be a mathematician to realize that this is quite a sizable percentage of our population, a percentage that is continually growing.

Just during the 20th century, the number of aged Americans has increased so rapidly that we can say a new generation has been added onto man's life.

The reasons for this are many, but I believe some of the most important include wide-sweeping developments in medical science, nutrition, sanitation and the virtual defeat of the old-time childhood killer diseases.

Although few people are surprised that more Americans are living longer than ever before, this new generation of life has brought with it some very special problems and difficulties of its own.

Continued

Delivered before Indianapolis Rotary Club noon luncheon Tuesday, Jan. 12, 1960, Indianapolis.

It's That Time Again

Continued

In the past, old people have been too few to have effected any serious changes on society. Today, however, the needs of the elderly have become of major importance to a sizable portion of our population. To ignore these needs or to exploit them would be cruel indeed. The sensible approach obviously is to study them and then do everything possible to meet them.

Technically Classified "Old"

I am sure those of you with elderly friends and relatives have given much thought to this situation. So have those of us who are not too far away from that day when we will technically be classified as "old."

One of the unfortunate peculiarities of this sudden growth of our aged population is that our society is still regarding the problem by 19th century standards.

Many years ago, humanitarian instincts prompted the idea of retirement for workers who had spent much of their lives earning a living. In order to establish some sort of definition of what was "old age," a man's 65th birthday was decided upon as the time when work should end and retirement begin.

Now this might have been generally acceptable 50 or 100 years ago, but it is not today!

The one aspect of retirement that the philanthropists failed to consider was the individual worker's desires and capabilities. It did not matter whether he wanted to continue as an active, productive worker. He was not asked whether a life of doing nothing would be agreeable to him. No, employers agreed that it was fitting and proper that when a man reached 65, he should be put out to pasture on a pension.

Unfortunately, this antiquated system is still in practice throughout our nation. A man who is likely to live well into his 70s or 80s is often faced with the unpleasant thought of spending 20 or more years of his life with nothing to do.

Regarded as Dependent

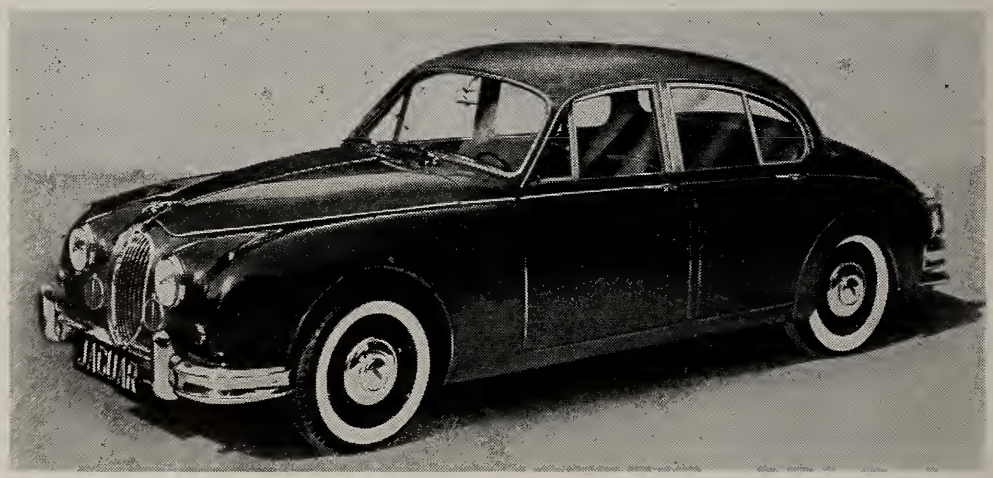
When a man's means of livelihood is taken away from him, certain results are inevitable. One of these is a distinct lowering of his self-esteem and his stature among family and friends. Once a worker has ceased to be the breadwinner, he is regarded as something of a dependent on other members of the family.

Continued

Sports Car Performance

• • • •

Family Car Comfort



Drive the incomparable new Jaguar 3.8 Litre Sports Sedan!

The only 5-passenger sedan in the world that combines competition sports car performance (the famous Jaguar XK engine has won countless trophies round the globe) with unmatched riding luxury. Blazing acceleration. Maximum safety with race-proved disc brakes. Greater visibility with wrap-around windows, thinner pillars. New high-output heating and defrosting system. Optional power steering and automatic transmission. Also be sure to see the luxurious Mark IX sedan and the classic XK 150 convertible, roadster and hard-top coupe. Convenient terms!

JAGUAR

2330 NORTH MERIDIAN STREET

MIDWEST DISTRIBUTORS, Inc.

• INDIANAPOLIS



NIAMID®

the mood brightener

eases mental adjustment to menopause

NIAMID brightens the outlook of depressed menopausal patients — gradually helps them become alert, cheerful, relaxed, and better able to cope with their surroundings.

Start with 75 to 100 mg. of NIAMID daily and adjust according to response. In routine use, up to 200 mg. is given. The gradual response to NIAMID may be noted within several days or weeks.

Infrequent, mild side effects may occur but often are lessened or eliminated by dosage reduction. NIAMID has *not* been reported to cause jaundice, disturbances of color vision, ankle edema, or skin eruptions.

NIAMID (brand of nialamide) is available as 25 mg. (pink) and 100 mg. (orange) scored tablets.

Already prescribed for more than 500,000 patients.

A Professional Information Booklet is available on request from the Medical Department, Pfizer Laboratories, Div., Chas. Pfizer & Co., Inc., Brooklyn 6, N. Y.

Pfizer *Science for the world's well-being™*

It's That Time Again

Continued

You may wonder at this point why a doctor is talking about retirement. You may even say that compulsory retirement has little to do with health.

Well, I will say most decidedly that it has plenty to do with health!

I could recite dozens of examples of men I have known who, after spending a lifetime being useful and productive, suddenly find themselves cut off from all this.

Any doctor will tell you that a sudden, unwanted change in a man's basic way of life is likely to produce grave results, and this is especially true of forced retirement.

Because of all this, we can say that the aged have very essential needs which must be understood and met by their fellow citizens if the elderly are to enjoy any kind of a normal life.

I do not think it is necessary to emphasize that these needs *will* be met, by one method or another.

The next step is to consider *how* these needs will be met, and by *whom*.

Headline-Hungry Lawmakers

Now I do not want to be unfair to the professional politicians, but I think you will agree that many of our headline-hungry lawmakers and would-be statesmen have shown a timely interest in the problems of the aged.

A politician of even sub-average intelligence can see immediately that America's aged might constitute a powerful voting faction, one that could be well-exploited by the clever campaigner.

As you know, Congress invariably blossoms out with benevolence towards those of voting age every time a national election is in sight. Social security benefits have jumped each presidential election year for some time now, and it would not be surprising if Congress amends this oft-amended act one again this year. Indeed, it would be startling if the lawmakers failed to do this.

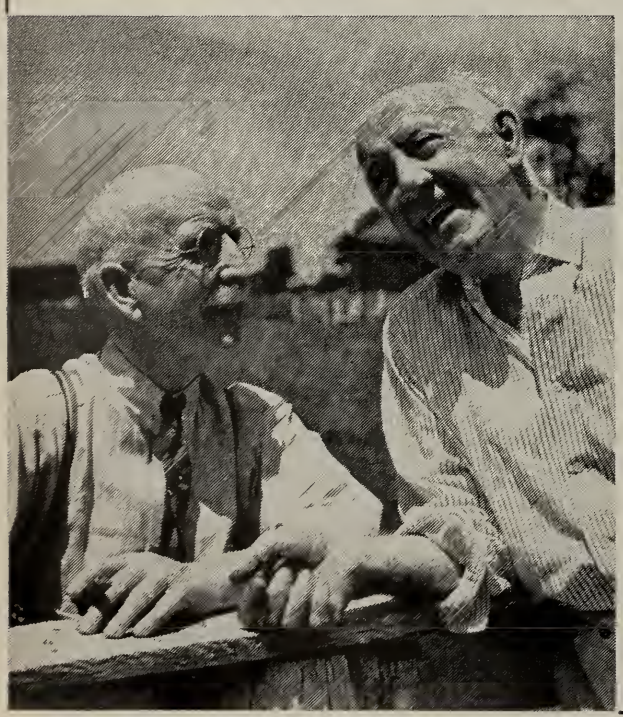
But along with every increase in benefits comes the fringe item that is seldom discussed—a raise in taxes. But this is a subject I am sure you all are only too conscious of!

Within the near future, Congress will be asked to approve a measure which would provide sur-

Continued on page 512

PSYCHIC ENERGIZER

For Your Geriatric Patients



Metalex®

Pentylenetetrazol w/ Nicotinic Acid

METALEX is a vasodilator, a respiratory and central nervous system stimulant. It helps overcome the hypoxia frequently present in athero-arteriosclerosis of old age, its analeptic action increases nerve impulse transmission.

"TONIC" EFFECT—Ameliorates mood, paranoid delusions, loss of memory, confusion, depression, anxiety, apathy, vertigo, insomnia, headache and anorexia due to athero-arteriosclerosis.

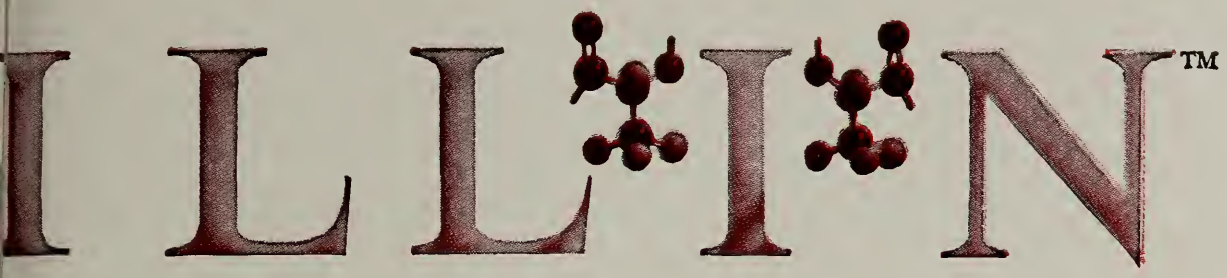
IN TINNITUS—When cerebral function and oxygen supply can be improved, visual and auditory improvement is often noticeable.

SUPPLIED: Tablets—bottles of 100.
Elixir—pint bottles.

Composition: Each tablet and each 5 cc. elixir contains 100 mg. Pentylenetetrazol, and 50 mg. Nicotinic Acid.

Send for samples and literature.

STORCK **Pharmaceuticals,** 2326 Hampton Blvd., St. Louis 10, Mo.



Relation of intermittent high blood levels of SYNCILLIN to antibacterial efficacy

SYNCILLIN, like all clinically available penicillins, is bactericidal. Periodic high blood concentrations may be sufficient to permit complete eradication of sensitive pathogens. According to Eagle,[6] "Soon after penicillin attains effective concentrations, the bacteria cease multiplying; and the bacteriostatic effect persists for a number of hours after penicillin has fallen to concentrations that are wholly ineffective. . . . The therapeutic significance of this postpenicillin recovery period is enhanced by the fact that the recovering bacteria, damaged but not killed by the previous exposure to penicillin, are abnormally susceptible to the host defenses. In consequence, the bactericidal process *in vivo* continues for many hours after the drug itself has fallen to ineffective concentrations."

Reduced rate of inactivation of SYNCILLIN by staph penicillinase

Bacterial resistance to penicillin has been attributed to the action of penicillin-inactivating enzymes produced by the invading organisms. SYNCILLIN is less affected by staphylococcal penicillinase than either of its component isomers. Further, SYNCILLIN is shown to be less inactivated by this enzyme than penicillin V or penicillin G. Penicillinase from *B. cereus* likewise inactivates SYNCILLIN less rapidly than penicillin V or G.

Indications: SYNCILLIN is recommended in the treatment of infections caused by pneumococci, streptococci, gonococci, corynebacteria, and penicillin-sensitive staphylococci. In addition, SYNCILLIN is effective against certain strains of staphylococci resistant to other penicillins. SYNCILLIN, like other oral penicillins, is not recommended at the present time in deep-seated or chronic infections, subacute bacterial endocarditis, meningitis, or syphilis.

Dosage: 125 mg. or 250 mg. three times daily, depending on the severity of infection. Larger doses (e.g., 500 mg. t.i.d.) may be used for more severe infections. SYNCILLIN may be administered without regard to meals. Beta hemolytic streptococcal infections should be treated with SYNCILLIN for at least ten days.

Precautions: At the present time it is not possible to draw definite conclusions regarding the incidence of allergenicity to SYNCILLIN or its cross-allergenicity with natural penicillins. *Therefore, the usual precautions for oral penicillin therapy should always be observed.* Patients with histories of asthma, hay fever, urticaria, or previous reactions to penicillin should be watched with special care. Administration of oral penicillin, in rare instances, may provoke acute anaphylaxis, particularly in penicillin-sensitive individuals.

Diarrhea has been reported occasionally following heavy dosage. If this occurs, lengthen the interval between dosages.

If superinfection occurs during therapy, appropriate measures should be taken. Since some strains of staphylococci are resistant to SYNCILLIN as well as to other penicillins, cultures and sensitivity tests should be performed where indicated by clinical judgment. As is true with all antibiotics, clinical response does not always correlate with laboratory bacterial sensitivity reports.

Supply: 125 and 250 mg. tablets, bottles of 25 and 100. 125 mg. powder for oral solution, 60 ml. vials.

References: 1. Wright, W. W.: Microbiology Report to Bristol Laboratories Inc. 2. Morigi, E. M. E.; Wheatley, W. B., and Albright, H.: Paper presented at the Seventh Antibiotic Symposium, November 4-6, 1959, Washington, D.C. 3. Editorial: New England J. Med. **261**:305 (Aug. 6) 1959. 4. King, A.: Lancet **1**:651 (March 29) 1958. 5. Epstein, E.: J.A.M.A. **169**:1055 (March 7) 1959. 6. Eagle, H. and Musselman, A. D.: J. Bact. **58**:475, 1949.



BRISTOL LABORATORIES, Division of Bristol-Myers Company, SYRACUSE, NEW YORK

It's That Time Again

Continued from page 506

gical, hospital and nursing home care for most social security beneficiaries. This is the Forand Bill, legislation which has been vigorously opposed during the past two years by leaders of the medical and allied health professions.

Now, at first glance, it might seem that the Forand Bill was something that might help our elderly citizens, and that opposition to such governmental philanthropy would be cruel and selfish.

However, once you peek beneath the shiny cover of the Forand Bill, you find that not all the pages are glossy and letter-perfect. To continue the metaphor, many of the pages are crumbling or worm-eaten.

Not Help Aged

Our first and strongest objection to Forand-type legislation is that we feel government medicine would neither help the aged nor those who ultimately would have to foot the bill for this care.

Two prime ingredients in successful health and medical care of any kind are *flexibility* and *voluntary action*. A doctor can only help a patient who wants to get well, a patient who comes to the doctor willingly and freely and who becomes, as it were, a partner with the physician in the task of healing. Also a doctor must be free to tailor his therapy to the individual patient.

Who here would not resent his doctor treating all patients exactly alike, prescribing the identical treatment or drugs for everyone, regardless of complaint?

We feel flexibility and voluntary action are so essential that they must be preserved. Unfortunately, they would both be greatly diminished or even exterminated under any government-supervised or government-financed program. How could physicians possibly render individual care and treatment if everything they did was limited and standardized by official government rules and regulations?

How would you like to fill out forms in quintuplicate every time you caught a cold and had to see your doctor?

Standardize the Human Being!

The federal government may be able to successfully standardize military weapons, machin-

Continued on page 517



It's That Time Again

Continued from page 512

ery, uniforms and the like, but it will have difficulty standardizing the human being!

On this matter, I recall once reading a passage by Bertrand Russell, the British philosopher:

"If individuals are to retain that measure of initiative and flexibility which they ought to have, they must not all be forced into one rigid mold; or to change the metaphor, drilled into one army."

Another serious objection to Forand-type legislation is its probable effect on our already-overcrowded hospitals. To suddenly throw open the doors to all old people, telling them they are *entitled* to so many days of hospital care, would flood the hospitals with thousands of patients.

Physicians believe that patients should be placed in hospitals or nursing homes *only* when necessary. We believe that the length of their stay—as well as the therapy rendered—should be dictated only by their medical condition and not by limitations of legislation or regulations.

Individual the Final Authority

I could continue at length detailling the many serious objections to the Forand Bill. However, one of our strongest reasons for opposition is the belief that the individual is still the final authority in deciding what is best for him.

Monsignor A. C. Dalton, director of Catholic hospitals in Boston, told a recent Senate subcommittee investigating the problems of the aged:

"Above all else, let's not rob the individual of his God-given rights to solve his own problems, to think and act for himself, to be as we all were some time back, rugged and responsible individuals. Let's try to solve our filial responsibilities without dragging into the solution federal agencies."

Let me say that the doctors of America are doing all in their power to help our elderly citizens meet the challenges of old age. But this is an imposing task, one which we cannot accomplish alone. We need your help, you the businessmen, civic leaders, community spokesmen and members of service clubs.

We must show our fellow Americans that the problems and needs of the aged are handled best in the community and in the family. A sound approach to aging is based on the realization that this is a community affair, not a national emergency.

Governments can legislate and decree, but their words and laws will never duplicate the understanding, love and respect that only friends and relatives can give the older person. Helping the aged is a responsibility that can be enforced only by the conscience of every citizen, not by governmental troops.

Let us do all in our power to help the elderly, and by so doing, we will ultimately be helping ourselves, for we too, will be old some day. ◄

A woman waiting at the door ready to go to the store had her arms full of coats, and four little children at her side. Her husband, coming down the stairs, asked why she was standing there. She replied, handing him the coats, "This time you put the children's coats on and I'll go honk the horn."—Campbell *Brevities*.



"Okay, I've got the newspapers spread out . . . bring in that bad nasal drip case."

RADIUM

(including Radium Applicators)

For All Medical Purposes

Est. 1919

Quincy X-Ray & Radium Laboratories

(Owned and Directed by a Physician-Radiologist)

Harold Swanberg, B.S., M.D., Director

W.C.U. Bldg., Quincy, Illinois

A special report to ISMA members on status of the 65 and over age group in Indiana today.

'The Old Folks at Home'

EMMETT LAMB, M.D., Chairman
Commission on Public Health

IT SEEMS there is an ever increasing interest in the problems of the aged and aging in our country. Many factors have contributed to this, and the American Medical Association recognized this interest three or four years ago, and started a positive, constructive approach to it.

Out of preliminary conferences, this subject has been referred to each state medical association with an urgent plea for their careful consideration, evaluation and realistic approach to any problems that might exist. In Indiana, the subject was referred to the Commission on Public Health, and much attention and work is being done along this theme.

We recognize that in this there is an area for careful medical care consideration. The whole subject, however, has been greatly broadened and many lay organizations are taking part in it in various phases. It is not only the medical care of the aged that is now being discussed; as a matter of fact, that phase is being given minor importance. The greater problems of the discussion and effort are along the lines of housing, food, entertainment and the socio-economic phase.

Your Commission on Public Health stands on the conclusion that in general the care of the aged people is the responsibility of the family, the local community, or both, and we want to keep it there. There are problem cases which need more than relatives can provide, and for these we want to secure individual consideration. We are opposed to setting up a minority group, regardless of physical health or economic status, just because they reach the age of 65.

In consideration of this it is thought that perhaps the medical profession of Indiana would like to have some definite information of the status of the older citizens of Indiana.

The 1950 Census of the United States Census Bureau indicated that there were 361,026 citizens in Indiana, age 65 or over.

A further study has been made to bring this up to date by the Indiana State Chamber of Commerce. This was done preparatory for the Wood report to the Congressional Committee. This very careful survey indicates that at the present time there are 442,000 people in Indiana, 65 and over.

112,000 are veterans of military service.

105,000 are protected by Blue Cross and Blue Shield.

128,331 are protected by private insurance carriers.

110,510 are drawing pensions or retirement from private sources.

3,381 are domiciled in mental institutions.

79 are domiciled in T.B. hospitals.

475 are domiciled in Soldiers and Sailors Home.

100 are incarcerated in penal institutions.

2,500 are miners covered by UMW Retirement and Welfare Fund.

Continued



Just one prescription for **Engran** Term-Pak
SQUIBB VITAMIN-MINERAL SUPPLEMENT *(270 tablets)*
calling for just one tablet per day will carry her through term to the six-week postpartum check-up. Thus, you help to assure a nutritionally perfect pregnancy, while providing the convenience and economy of the re-usable Term-Pak. Engran is also available in bottles of 100 tablets.

SQUIBB *Squibb Quality—The Priceless Ingredient*

'ENGRAN'® AND 'TERM-PAK'® ARE SQUIBB TRADEMARKS

Old Folks

Continued

325,583 are drawing monthly social security benefits totaling $17,978,200 per month (as of Dec. 31, 1957).

364,191 are drawing monthly social security benefits totaling $22,554,733 per month (as of Feb. 28, 1959). These are apparently the latest social security figures available, so it is reasonable to assume that this terrific increase has continued.

30,875 is the average number of people receiving medical aid per month from the Indiana State Department of Public Welfare.

300,560 own their own homes.

Of this total, 8,470 persons are in nursing homes. The following breakdown on how nursing home bills are paid may indicate their economic status:

Private, plus organization	4,870
Welfare	2,132
Welfare, plus social security	854
Trustee, plus other sources	614

Every doctor in Indiana is interested in the medical care of the aged, and we have asserted that in hardship cases, regardless of age, we stand on our tradition to supply care consistent with economic status. As a citizen in the community, we are also vitally interested in the socio-economic problems there.

The commission will continue to study this subject and to cooperate and coordinate with efforts in the various areas concerned. ◄



"I warned you, Chin, about kicking the gong around."

THE HARDING SANITARIUM

WORTHINGTON
OHIO

For the Diagnosis and Treatment of Psychiatric Disorders
and with
Limited Facilities for the Aging

GEORGE T. HARDING, M. D.
HARRISON S. EVANS, M. D.
Medical Directors

CHARLES W. HARDING, M.D.
Clinical Director

GEORGE T. HARDING, Jr., M. D.
HERNDON P. HARDING, M. D.
ARNOLD L. NIELSEN, M.D.
ROBERT L. SMITHWOOD, M. D.
W. W. WINSLOW, M.D.

GRACE M. COLLET, Ph.D.
VERNON W. SHAFER, Ph.D.
Clinical Psychologists

MARY JANE McCONAUGHEY, M.S.W.
BENJAMIN E. WHEATLEY, M.S.W.
Psychiatric Social Workers

PAULINE L. TOOILL, R. R. L.
Medical Record Librarian

JAMES L. HAGLE, M. B. A.
Administrator

ESTHER L. SIMPSON, R. N.
Director of Nurses

Phone: Columbus TUXEDO 5-5381



in pneumonia

. . . into a mixed culture of the three organisms commonly involved in pneumonia . . . *K. pneumoniae*, *Diplococcus pneumoniae*, and *Staphylococcus aureus* (in this case a resistant strain) . . . we introduce the five most frequently used antibiotics.

Twenty-four hours later (in this greatly enlarged photograph), note that only *one* of the five leading antibiotics has stopped *all* the organisms, including the resistant staph! This is Panalba.

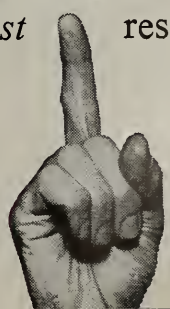
In your next pneumonia patient . . . in *all* your patients with potentially-serious infections . . . provide this extra protection with your prescription :

Dosage—1 or 2 capsules 3 or 4 times a day.
Supplied—Capsules containing Panmycin phosphate equivalent to 250 mg. tetracycline hydrochloride, and 125 mg. Albamycin as novobiocin sodium, in bottles of 16 and 100.
Now available: new Panalba Half-Strength Capsules in bottles of 16 and 100.

Panalba*

(Panmycin* Phosphate plus Albamycin*)

The broad-spectrum antibiotic of *first* resort



Upjohn The Upjohn Company Kalamazoo, Michigan

*TRADEMARK, REG. U. S. PAT. OFF.

Memo Re: Outpatient Blue Shield Benefits

Prepared by Dr. E. T. Edwards, vice-chairman of the Commission on Medical Economics and Insurance, for the information of the Subcommittee on Outpatient Blue Shield Benefits, and published for the information of all members of the Association.

Memo to members, Subcommittee on Outpt. Blue Shield Benefits, Commission on Med. Econ. and Ins.

Intent: To conserve meeting time 8 Nov. 59, the following remarks are submitted for your consideration and comment. A separate mailing with this is also enclosed for your study and questions on Office Accreditation. The latter was presented to the Knox County Medical Society this week (21 Oct.) and has been referred to committee for further study and probable modification.

Medical Economics and Office Practice

Good clinical medical practice makes good medical economics. An accurate diagnosis with appropriate therapy gives the best medical care for the patient and is the least expensive. Preservation of the patient's economic health always has been an important goal of the physician. By improving the patient's physical and emotional problems, an early return to work is possible and, when this is accomplished at the least cost, further savings accrue to the patient.

Medical economics is not only concerned with the cost to the patient of medical care, but with the financial problems facing the physician practicing medicine. While the patient is eager to obtain good results . . . quickly regaining his health with the least expense and inconvenience . . . he does not think about the doctor's "overhead" which is present. As in private enterprise generally, the profit motive helps the physician control waste and overhead, which savings are passed on to the patient. In our economic society, there are many examples of wasteful "nonprofit" operations. Since the office is the only place in which the doctor has complete control over his practice from a business viewpoint, it is obvious that there he can perform most economically for those of his patients who have medical conditions customarily treated in an office situation.

Technology Changes Medical Practice

Technological advances have changed the practice of medicine; the doctor has adapted to these changes. The man "who does everything" is disappearing, for even the relatively isolated general practitioner in a small town utilizes paramedical personnel such as nurses and lab technicians to increase his efficiency. In larger communities (county seats in Indiana) specialists are locating and many G.P.'s are limiting their practice to those aspects of medicine which interest them most and in which they feel most capable.

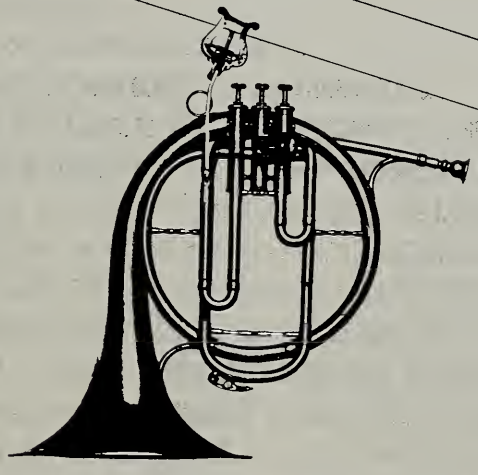
With this system, the American public now enjoys the best medical care man has ever known. Inflation and rising taxes have forced patients to seek other means of paying their medical bills than by the old method of "out of pocket." This is true for most of his other purchases too! Installment credit is acknowledged to have enabled the American to achieve the highest standard of living in the world. In medical financing, he has turned to prepayment, not installment postpayment. This has been accomplished by insurance programs and union medical and welfare funds. While the monies obtained are usually called "fringe benefits," they are neither extra nor free! This money represents so many cents per hour of his work in addition to his wages received in cash.

Benefits Can Be Unrealistic

How these insurance or health and welfare funds are made available to pay for the patient's medical care becomes important. Abuses are to be expected when the program is too limited in its application. Benefits can be unrealistic regard-

Announcing an Old Product

THAT STILL IS THE MOST IMPROVED AGENT FOR BASIC DRUG THERAPY IN HYPERTENSION



Only time and clinical acceptance truly define whether a drug is safe and effective. Of the many Rauwolfia compounds, there is one alkaloidal fraction capable of producing antihypertensive benefits with minimal side effects, purified alseroxylon complex (RAUTENSIN®).[1-6] This compound is less likely to cause such side effects as mental depression, lethargy, listlessness, and drowsiness consistently reported with reserpine.

IN MILD HYPERTENSION

RAUTENSIN®

(Tablets containing 2 mg. purified alseroxylon complex)

IN MODERATE TO SEVERE HYPERTENSION

RAUVERA®

(Tablets containing 1 mg. Rautensin and 3 mg. alkavervir)

Rautensin bibliography: 1. WRIGHT, W. T., JR.; POKORY, C., AND FOSTER, T.: AM. PRACT. & DIGEST. TREAT. 7:1992, 1956. 2. SUCKLE, E.: GERIATRICS 11:509, 1956. 3. FINCH, W. J.: J. OKLAHOMA M.A. 50:259, 1957. 4. TERMAN, L. A.: ILLINOIS M. J. 3:67, 1957. 5. GIFFORD, R. W.: J. ARKANSAS M. SOC. 55:31, 1958. 6. FORD, R. V., AND MOYER, J. H.: POSTGRAD. MED. 23:41, 1958.

SMITH-DORSEY • A DIVISION OF THE WANDER COMPANY • LINCOLN, NEBRASKA

Continued

ing patterns of illness. For example, a strictly surgical benefit for those over 65 years of age is ridiculous when it is known that oldsters will have a reversal in the incidence of surgical to medical illnesses that was present prior to 65.

In addition to diversity of benefit structure, third-party payment programs are on uncertain ground concerning their responsibility for the *quality* of medical services. The insurance companies appear more concerned about unqualified doctors making a "run on the till," whereas union-management funds are more paternalistic concerning their member patient's well-being. The result is that both imply that individual physician integrity is not up to par.

Are we approaching more non-medical controls of medical practice? Both groups accept the standards established by the Joint Commission on Accreditation of Hospitals but do not recognize those same medical staff doctors when they practice in their offices.

Individual Physician Accreditation

If we accept the premise that office practice provides economical medical care of high quality and if third parties, including medical society sponsored Blue Plans, are to broaden their benefits to include financial support for such practice, some form of individual physician acceditation appears necessary to demonstrate convincingly to nonprofessional persons that our services are competent and that we are responsible men.

This could be legally accomplished by the State Medical Licensing Boards giving more specific permits to practice medicine than is now being done. When combined with periodic re-examination, such a process would hardly be palatable to physicians.

What office benefits to offer is limited by the administrative costs of the third party, by the premium increase tolerated or accepted by the patient, and by those office procedures which are too expensive to be paid out of pocket by most patients. Routine examination and screening procedures recurring at regular intervals should not be included, since the cost of administration plus the fee itself would be greater than if it were paid directly by the patient. For example, a yearly $10 chest x-ray plus 60c administration

Continued

OVER 80 YEARS' SPECIALIZED EXPERIENCE IN THE RESTORATIVE TREATMENT OF

"THE PROBLEM DRINKER"

At The Keeley Institute your patients are assured of receiving:

- the most modern, coordinated, comprehensive, rehabilitative regimen
- in addition to medical, nutritional and physiotherapeutic treatment, we also offer psychiatric diagnosis and psychotherapy
- full cooperation throughout with the referring physician
- in addition to the care of the alcoholic we also treat narcotic and drug addiction
- surprisingly low cost—to cover all medical care, medicines, laboratory work, room and excellent cuisine

You can obtain more detailed information by writing us direct.

WE WELCOME YOUR REFERRALS...

THE KEELEY INSTITUTE
DWIGHT, ILLINOIS

Member American Hospital Association, Member Illinois Hospital Association. Licensed by the Department of Public Health, State of Illinois.



WABASH VALLEY SANITARIUM—HOSPITAL

Lafayette, Indiana
Telephone Riverside 3-1679

A hospital for the treatment of neuro-psychiatric disorders.

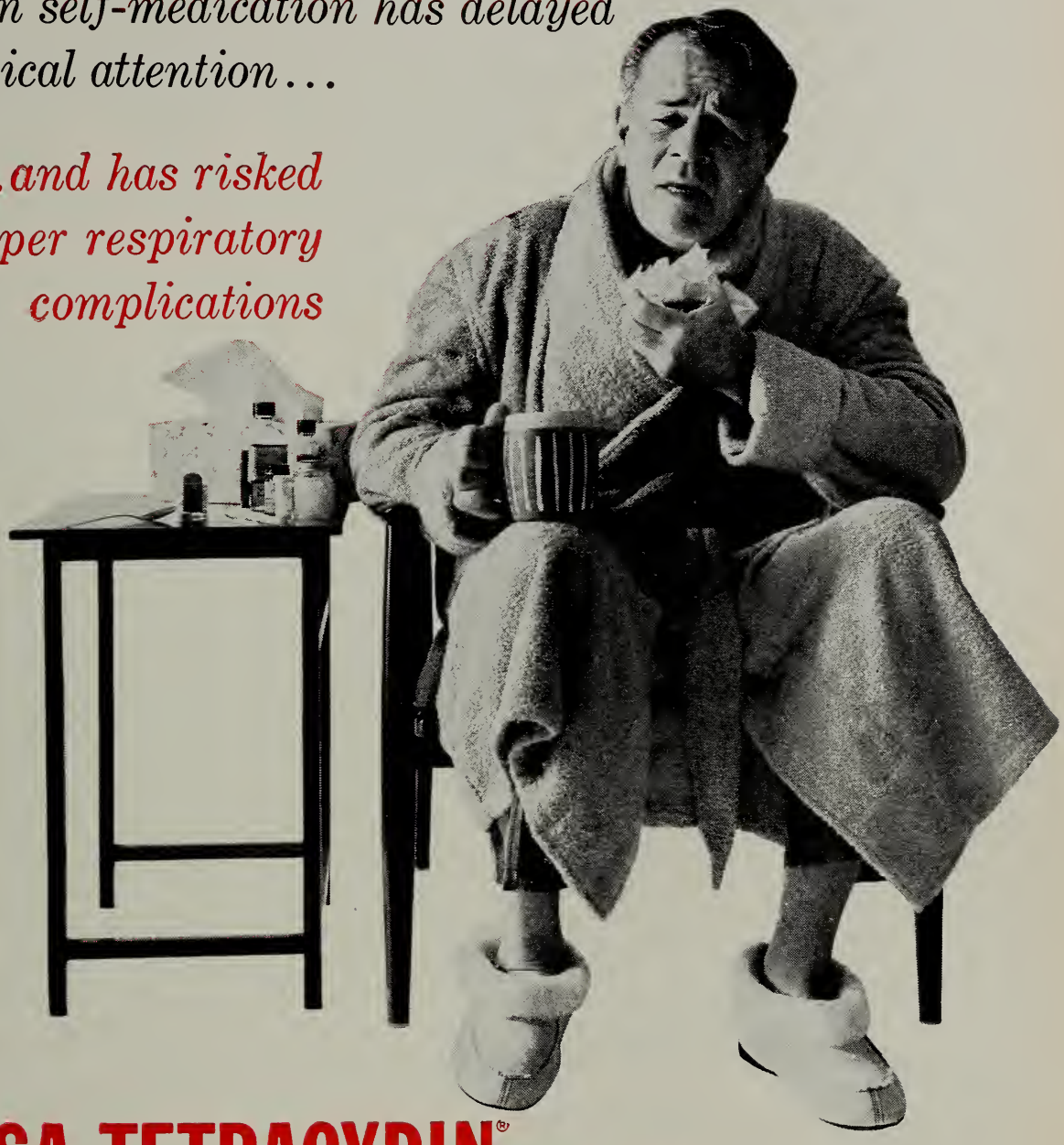
Custodial cases are accepted in limited numbers.

— OPEN STAFF —

DONALD R. KINZER
Manager

in the **"COMMON COLD"**
when self-medication has delayed medical attention...

...and has risked upper respiratory complications



COSA-TETRACYDIN® CAPSULES

Cosa-Tetracyn® — analgesic — antihistamine compound

act quickly to

- *control secondary infection*
- *alleviate cold symptoms*

each capsule contains:

Cosa-Tetracyn	125 mg.
phenacetin	120 mg.
caffeine	30 mg.
salicylamide	150 mg.
buclizine HCl	15 mg.

average adult dose: 2 capsules q. i. d.

Pfizer *Science for the world's well-being*

PFIZER LABORATORIES, *Division, Chas. Pfizer & Co., Inc., Brooklyn 6, N.Y.*

Memo

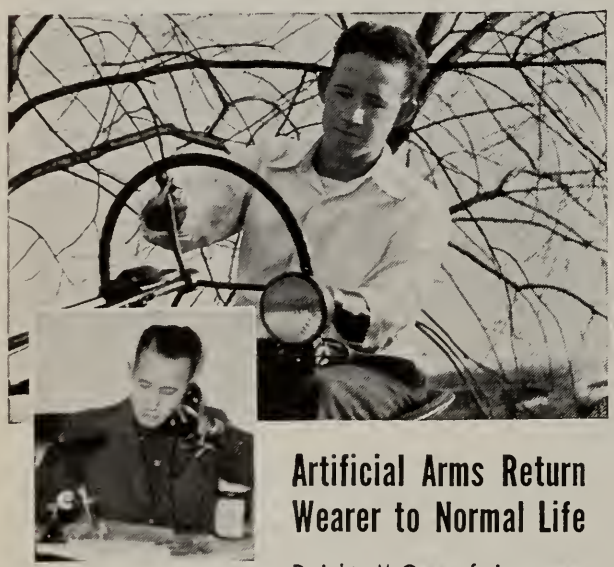
Continued

cost would require a yearly premium of $10.60. At the present time some companies offer outpatient lab and x-ray diagnostic benefits and others routine office and home visit allowances. It is my opinion that only the more expensive consultation procedures (x-rays, complex lab tests) should be included.

Basic Blues Sales Problem

Indiana Blue Shield has a rider which Big Steel and the Budd Company have purchased, but the vast majority of B.S. policies have none or the fracture x-ray benefit only. This demonstrates a basic problem for the Blues as far as policy sales are concerned.

First, approximately half of the total Indiana Blue Shield sales are to large union groups obtained after national union-management negotiation for so many cents per hour to be spent on medical benefits. These same persons (lay people) then decide what types of coverage they want included and what they can afford for the money available.



Artificial Arms Return Wearer to Normal Life

Dwight McGee of Loncoster, Ohio, weoring two Hanger Arms, can write, shave, use a knife and fork, drive an automobile, and says he con do about anything an ordinary person can do. Hanger Arms ore custom-made to fit the weorer's stump and his particular daily needs, ond ore corefully fitted by experienced Hanger fitters. Arms can be furnished with cosmetic or mechanical hand ond hook.

Hanger PROSTHESES

1529-33 N. ILLINOIS ST., INDIANAPOLIS 2, IND.
3108 BURNET AVENUE, CINCINNATI 29, OHIO
FAIRFIELD AT PONTIAC, FORT WAYNE, IND.
418 N. MAIN ST., EVANSVILLE, IND.

The Blues are invited to bid along with commercial insurance companies. Competition is keen, but these large groups of relatively healthy, employed people are the best (financially, in terms of loss potential) kind for an insurance company to have. They have had pre-employment physicals which have eliminated many insurance risks.

Professional insurance men on the Blue Shield staff have frequently expressed a fear that ISMA would "force" Indiana Blue Shield to *only* offer what we physicians think the laborer should have, thereby putting Blue Shield in a poor competitive position endangering their present contracts. These large groups make it possible to offer the aged and individuals of poor health policies which they can afford. Furthermore, the unions insist on omitting deductible and co-insurance features which tend to reduce premiums, but leave the union member, not management, paying the additional expense.

Even More Cost Conscious

The second half of Indiana Blue Shield contracts are sold to small employee groups within the state and to individuals in community drives or from doctors' offices. These policies are sold to persons even more cost conscious than the large groups. Riders become much more difficult to sell. So in considering additional insurance benefits to be offered by Indiana Blue Shield, the above situations must be remembered.

The Blue Cross side of the family has frequently increased premiums being on a service plan offering total payment for most items and faced with increasing hospital costs. It is managed by a majority of hospital administrators.

A hospital has two contracts which enter the picture of outpatient and office benefits. One is the contract it has with its pathologist or radiologist. In the 1959 House of Delegates these physicians recommended a change in this contract.

The more important contract is the one that the hospitals have with the insurance company agreeing to sell these doctors' services for a certain fee. This latter is the contract that Blue Shield says must be changed prior to establishing more benefits for outpatient services from present premium income under existing Blue Shield policies.

Continued





1¼ Grs. Ea.
FLAVORED

Living up to a family tradition

There are probably certain medications which are special favorites of yours, medications in which you have a particular confidence.

Physicians, through ever increasing recommendation, have long demonstrated their confidence in the uniformity, potency and purity of Bayer Aspirin, the world's first aspirin.

And like Bayer Aspirin, Bayer Aspirin for Children is quality controlled. No other maker submits aspirin to such thorough quality controls as does Bayer. This assures uniform excellence in both forms of Bayer Aspirin.

You can depend on Bayer Aspirin for Children for it has been conscientiously formulated to be the best tasting aspirin ever made and to live up to the Bayer family tradition of providing the finest aspirin the world has ever known.

Bayer Aspirin for Children—1¼ grain flavored tablets—Supplied in bottles of 50.

● We welcome your requests for samples on Bayer Aspirin and Flavored Bayer Aspirin for Children.

New GRIP-TIGHT CAP for Children's Greater Protection



THE BAYER COMPANY, DIVISION OF STERLING DRUG INC., 1450 BROADWAY, NEW YORK 18, N. Y.

Memo

Continued

Added Administrative Costs

If there is not premium money diverted from Blue Cross to Blue Shield, they could not pay claims. Blue Shield also states that there will be about 2% greater administrative costs in such a program. The ISMA special committee recommended to the House of Delegates that a transfer similar to that in Iowa be made, but the big question remains—will the hospitals agree to changing their contracts with the insurance companies? Another question is "Will the Indiana M.D.'s support their radiologist and pathologist friends?"

Increasing Blue Plan premiums has met considerable public criticism in the past year. Benefits of the Blue Cross hospital program can hardly be reduced for large group contracts because of union resistance to any but service-type contracts and both Blue Cross and Blue Shield feel that they cannot afford to take the loss of these contracts.

Small group and individual policies might be changed from tradition, as was the recent new "OVER-65" policy to keep the premium costs down. A flat daily room indemnity was offered instead of the "2-bed" room allowance and the Blue Shield benefits were actually increased to provide in-hospital medical and other benefits not present in the old $200 schedule.

A New Status Symbol

Similar action might provide additional funds for an outpatient and office indemnity for x-ray and pathology coverage with service benefits for such services when the patient was in the hospital. The 2-bed principle has presented a new status symbol because many low-income patients, by paying a little more, can now have a private room with resultant "snob values."

A 2-bed room costs more to build and to operate and staff; maybe it is time to reappraise this situation anyway. Huddlestone, writing in the *ISMA Journal,* July 59, page 1094, emphasized this position. He is public relations director for B.C.-B.S.

The July 59 *Bulletin,* American College of Radiology, carried an interesting article on this subject. It described a new Blue Shield medical care insurance contract for groups having both Blue Cross and Cleveland Academy of Medicine Blue Shield Plan. It was on a rider basis covering GM and Ford at a premium of $1.20 per month per family. When the service is rendered in a doctor's office, a special form is used; the same form is used if the service is performed in a hospital where the radiologist does the billing. When the services are done in a hospital department where the hospital bills, the usual Blue Cross form is used; in either case the benefits are identical.

Divided Premiums Planned

"Arrangements between the hospital and radiologist are not disturbed." It is planned to divide the premiums between Blue Cross and Blue Shield on a retroactive basis, each bearing its proportionate amount of the underwriting cost. Something similar might be achieved in this state if the hospitals are willing.

It is believed that greater outpatient and office diagnostic services would reduce questionable hospital admissions that could be diagnosed and treated in the office, resulting in savings to the insurance company. Richard Kilborn of Indiana Blue Shield says that there appears to be such a saving when there is local hospital overcrowding, but not when there are empty hospital beds.

It is recommended that an indemnity schedule for pathology and x-ray be established for outpatient and office with the benefit being limited providing a co-insurance or deductible feature. This is contemplated as being supplementary to the existing Blue Shield riders which are available. It would be designed primarily for inclusion in small group and/or individual policies with possibly the total premium being kept within a salable range by limiting the Blue Cross room allowance, thus reducing total premium cost.

Doctor, what is the value of the title—THE DOCTOR'S PLAN? ◄

A great barrister was constantly ill and was disgusted with his health. Once a friend solicitously advised him to rest for a few months, saying, "Then your constitution might be rebuilt."

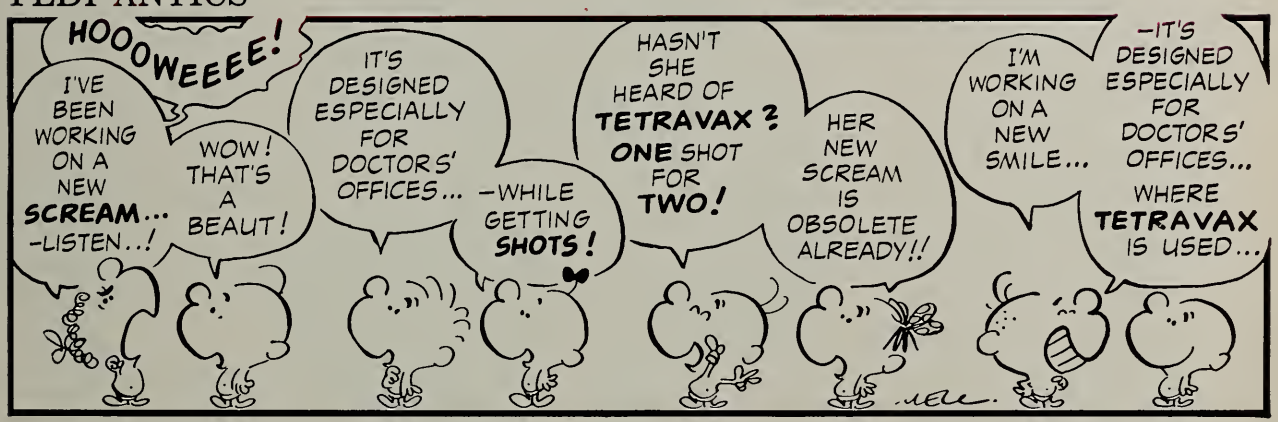
Barked the barrister: "My constitution was destroyed long ago. I am now living under the by-laws."

According to the latest reports from a ritzy Los Angeles suburb, there are so many foreign cars in the neighborhood that it has been over 2 years since anyone was hit above the knees.—*Reformatory Pillar,* St. Cloud, Minn.

FOR SIMULTANEOUS IMMUNIZATION AGAINST 4 DISEASES:

Poliomyelitis-Diphtheria-Pertussis-Tetanus

PEDI-ANTICS



TETRAVAX®

DIPHTHERIA AND TETANUS TOXOIDS WITH PERTUSSIS AND POLIOMYELITIS VACCINES

now you can immunize against more *diseases...with* fewer *injections*

Dose: 1 cc.
Supplied: 9 cc. vials in *clear plastic* cartons. Package circular and material in vial can be examined without damaging carton. Expiration date is on vial for checking even if carton is discarded.



For additional information, write Professional Services, Merck Sharp & Dohme, West Point, Pa.

TETRAVAX IS A TRADEMARK OF MERCK & CO., INC.

MERCK SHARP & DOHME, DIVISION OF MERCK & CO., INC., PHILADELPHIA 1, PA.

Steel Workers Panel Medicine—Sooner or Later!

Prepared for the information of the members of the Commission on Medical Economics and Insurance by Dr. E. T. Edwards when he was chairman of the commission. Published at this time for the information of the membership in general.

John Tomayko, insurance and pensions director of United Steel Workers Union, bluntly told medical society representatives from the 23 counties in the nation having 60% of the steel workers that USW wanted more medical care for its money. This occurred at the June 24, 1959 meeting in Pittsburgh. He was supported by statistics compiled by Isadore Falk, Ph.D., for the steel union.

In September, 1958, the USW resolved to seek FULL PREPAYMENT for COMPREHENSIVE SERVICES OF HIGH QUALITY. Their long range plans are to do this through group practice with controlled hospital admissions and extensive outpatient services by salaried doctors financed by a check-off system in industry. Their short range plans include whatever "improvements" can be obtained in Blue Plans toward the above goal, but Mr. Tomayko insists on early "experimentation" with panel practice adapted from the Kaiser Permanente model. No physician at the meeting doubted that once physical facilities for such experiments were established that they would never be abandoned.

USW Claims Excessive Costs

In a USW informational booklet to its members, the claim is made that excessive hospitalization utilization costs each worker about $2.50-$4.00 per month with a total of $30,000,000 to $50,000,000. These figures are obtained from a comparison of Blue Plan statistics with those of group practice plans (Kaiser) as shown in the following chart:

	Blue Plans	Panel
Average No. hosp. admissions per 1000 persons	135-180	80-90
Average No. days stay per 1000 persons	1050-1350	600-700
Surgical cases per 1000 exclude OB cases	60-70	30-50

Dr. Falk used the above comparisons to raise the question of why the differences in health charges for steel workers in the West under Kaiser Panel and those under the Blue Plans. He found no objective explanations for these cost variations when studying morbidity and mortality statistics related to the areas of high and low charges. His conclusion was that surgery on a fee for service basis was in itself an important factor in surgery and hospital admissions; likewise he stated that when a person has in-hospital medical coverage that medical admissions increase.

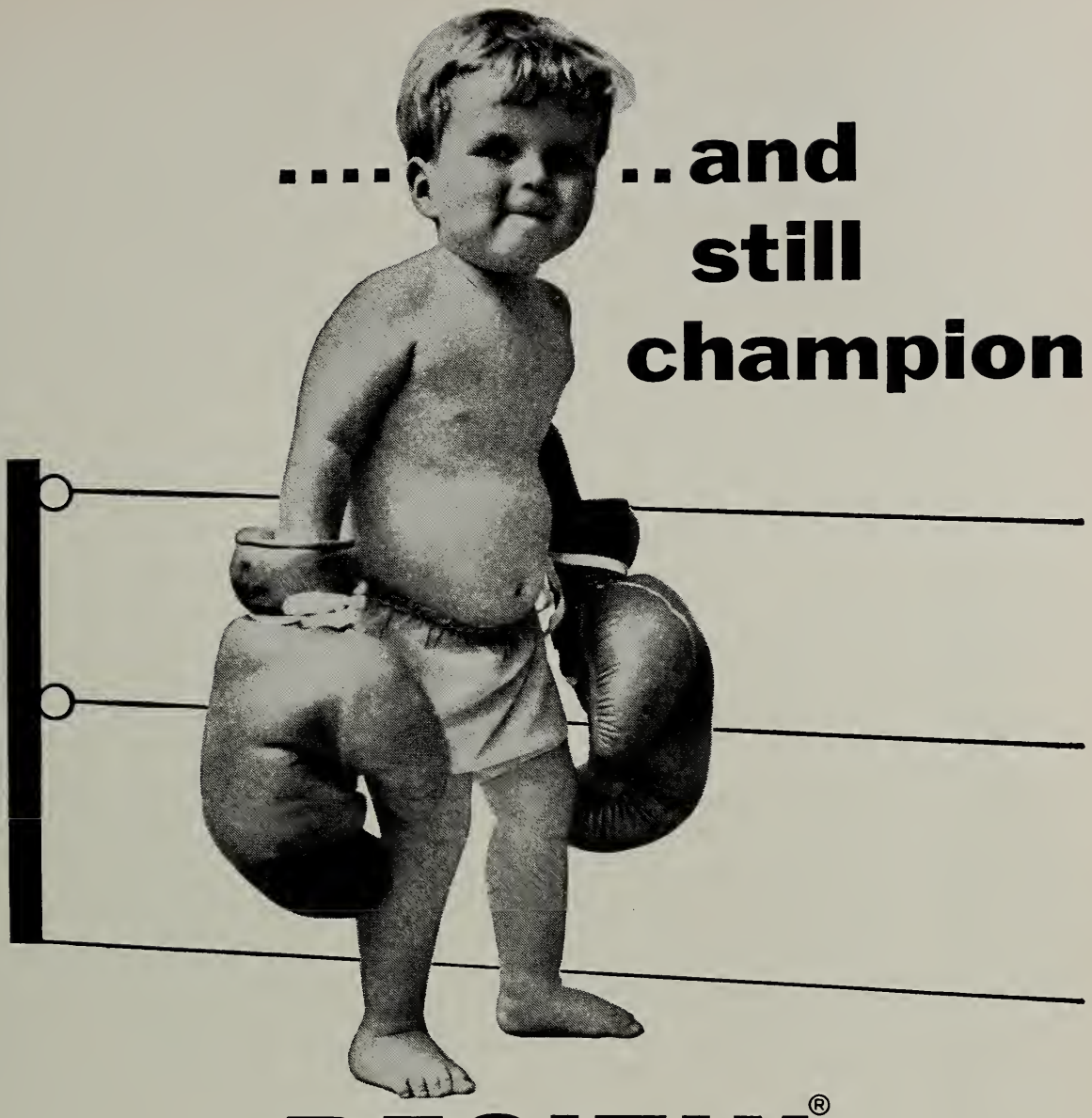
Frowns on Solo Practice

He further claimed that there were excessive increases in fees whenever the benefit schedules were increased. His basic concept of insurance is that it will cover the total expense of medical care. Dr. Falk holds office practice by solo practitioners or partners in low esteem because there is no accrediting program defining the qualifications and abilities of a physician and restricting his office practice to what he is capable of doing.

Group practice is said to exercise control over the quality of work done. Being a medical director of a group may involve sainthood, but it was my understanding that the position was chiefly an administrative or managerial post.

For those doctors who were not familiar with Dr. I. Falk, a brief biographical sketch was given which disclosed that he was a dedicated student of the economics of health care, having been a chief architect and salesman under Oscar Ewing and F.D.R. of federal medical programs. He was described as being in full support of panel plans, desirous of eliminating the financial incentive from surgery, and incensed at insurance companies making money from those seeking health protection.

Continued on page 544



.....and still champion

DESITIN®
OINTMENT

in preventing and healing **diaper rash**



- **blocks** irritation due to urine and excrement
- **fights** ammonia and rash-producing bacteria
- **counters** and clears up chafing, rawness, excoriation

DESITIN OINTMENT the pioneer soothing, protective healing external cod liver oil therapy.

Samples? Please write . . **DESITIN CHEMICAL COMPANY** 812 Branch Ave., Providence 4, R. I.

Panel Medicine

PATIENT CARE REVIEW MECHANISM

Committee	Composition	Purpose	Appeal	Report
10th Councilor District Liaison Committee	Three members appointed by trustee and councilor. Four members appointed by county medical societies.	1. Liaison between the co. medical societies, Hospital Council & third parties re problems and policies. 2. Review & direction of information to proper place & appeals from Claims Review Committee.	None—Advisory only.	Trustee & councilor & county medical societies
10th Councilor District Claims Review Committee	Two members from each participating hospital—with five serving on rotating basis. Chairman will be from Blue Cross or other third party.	*Chairman*—to secure requests & arrange meetings of the committee to act on claims questions by third parties. *Members*—Advise third parties re claims.	Third party appeals to Liaison Committee. Physician appeals to Liaison Committee. Proper cases to appropriate county medical society judicial process.	10th Councilor District Liaison Committee
10th Councilor District Censors Committee	Trustee and councilor and the four county censors with administrative assistant.	To carry out Resolution #36, Pa. House of Delegates. To determine whether participating hospitals have properly functioning audit, tissue & utilization committees.	Through Liaison Committee to appropriate county society judicial process.	10th Councilor District Liaison Committee
10th Councilor District Qualifications Committee	Appointed by trustee and councilor & approved by the county medical societies.	To determine which physicians have special qualifications.	Through Liaison Committee to county medical society judicial process.	10th Councilor District Liaison Committee
County Medical Society Grievance Committees	Elected by county medical societies. Not a councilor district function.	Action on complaints arising from patients. physicians, or from councilor district.	County medical society.	

Panel Medicine

continued from page 532

Patient Care Review Mechanism

To combat criticism of the medical profession, the 10th Councilor District of the Medical Society of the State of Pennsylvania has established a "Patient Care Review Mechanism" with Councilor District Committees (Liaison, Claims Review, Censors, Qualification) in addition to County Medical Society Grievance Committees. (See chart on page 544.) Mr. Greenburg of Tomayko's staff was quoted as saying the union approves this mechanism, but the steel union intends to go ahead with its panel experiment plans. Mr. Tomayko stated that he would like to meet on a local level with county medical societies in steel areas to discuss mutual problems and such mechanisms as in force in the Pittsburgh region.

After the union men had left the meeting there was further discussion by the physicians. Much of this was centered on methods of discipline of physicians for excessive fees. This had been tried in California with open defiance by some doctors who were upheld by a court decision that a medical society could not expel a member for overcharging. It was suggested that the Blue Plans have authority outside the medical society for policing physicians.

The San Joaquin Plan was mentioned as being successful, having been adopted by seven other counties in California. It has published fee schedules and is essentially an open panel system for private insurance companies. The Windsor (Canada) program is another physician-sponsored program; it is a service plan which is underwritten by the doctors accepting reduction in remuneration if bankruptcy threatens.

Challenge to Solo Practice

The physicians present recognized the challenge to solo practice of medicine. They were aware that high, unreasonable fees, overutilization and the quality of medical service were points of attack. The 10th Councilor District Patient Care Review Mechanism was considered a practical start in organized medicine's fight against panel plan's assumed virtues. It was also thought that additional statistical evidence regarding the two concepts of medical practice might be studied by us to determine the validity of panel proponents' claims.

John F. Tomayko had invited representatives of the local societies to meet with industry and steel union representatives to discuss medical care programs. The group of physicians realized that this could *not* be done *prior* to settlement of contract negotiations and the determination by management and union of the amount of money to be spent for medical benefits.

Hoosier Elected

If invited by both parties to discuss relative merits of suggested programs of health care, Drs. Matthew Marshall of Pittsburgh, Pa., and Harry Stimson of Gary, Ind., were elected to be representatives of the Steel Counties Medical Societies. It was felt that this might be an opportunity to combat panel plans. Steel Industries' management has always taken an aloof attitude regarding such meetings, considering that they did not want to intrude on medicine's problems. Tomayko has not been successful in bringing management pressure to bear on organized medicine to achieve his goals. ◄

"I think she's coming back to normal, doctor. She put lipstick on her bandages this morning."

The New

STATE PROFESSIONAL BUILDING

2828 East State Blvd.

Fort Wayne, Indiana

Leasing now, this new medical & dental building with adequate ground floor space, suites designed to your specifications. Presently under construction.

- Air conditioned throughout
- Ample free parking at the door
- Fastest growing area of quality homes
- Four blocks from our newest hospital Parkview Memorial
- New medical supply house being built nearby

INQUIRIES FROM DOCTORS OF MEDICINE INVITED

Write to: State Medical Clinic, Inc.

2220 Kentucky Avenue

Fort Wayne, Indiana

Wanted: Locations Physicians

Following is a list of physicians who have made inquiry at the headquarters office during Dec., 1959, and Jan., 1960, concerning openings in our state for practice.

General Practice

Rodger L. Buck, 37 Essex Street, Medford, Mass.
Frederic A. Helmer, 412 Grandview City, Iowa City, Iowa.
Edward L. Terbush, Twelve Mile, Ind.
John S. Farquhar Jr., 6827 Magoun Avenue, Hammond
Paul Alvarez, 1824 West 5th Avenue, Gary.

Specialists

Ezra J. Beyda, 5014 Spruce St., Philadelphia, Pa., *internal medicine—cardiology.*
Daniel L. Dolan, 805 Forrest Drive, Tullahoma, Tenn., *internal medicine.*
Kong-oo Goh, 68-05A 224 Street, Bayside, N. Y., *internal medicine.*
Robert C. Holcombe, 10608 Lexington Court, Kensington, Md., *internal medicine.*
Jack H. Mostow, 1520 W. 6th Avenue, Apt. 20, Columbus, Ohio, *internal medicine.*
Antonio Cahue, 2901 S. Parkway, Chicago 16, *internal medicine.*
Stuart K. Olson, 106-B Wonju Circle, Oceanside, Calif., *internal medicine.*
J. Eduardo Peres, 216-D DeSales Ave., Mobile, Ala., *ophthalmology.*
John D. Gundzik, 3018 E. 130th Street, Cleveland, Ohio, *ophthalmology.*
Robert Earl Pierce, 1116 Raymond Avenue, Napa, Calif., *pathology.*
Yin Chen Lee, 260-41 74th Avenue, Glens Oaks, Queens, N. Y. C., *pathology.*
Robert J. Miller, 1905 Division Street, Evansville, *proctology.*
Michael Adrian Walsh, 363 Cypress Avenue, Apt. 2A, Bronx 54, N. Y., *urology.*
Harry S. Rowland, Box 14, V. A. Hospital, Richmond, Va., *urology.*
Claude E. Davis, V. A. Hospital, Louisville, Ky., *general surgery.*
Edmond M. Brophy, 1823 Portsmouth, Westchester, Ill., *obstetrics and gynecology.*
Robert R. Fahringer, P. O. Box 148, Danville, Pa., *obstetrics and gynecology.*

Locations

Following are areas where physicians are needed:

DeKalb County—BUTLER—pop. 1,911. Located 12 miles from Auburn where hospital facilities are available. Five room office, plus drug room and dark room available. Five new factories have located in the community within last 5 years. One physician in community. For further information contact Dr. Charles I. Weirich or Mr. C. J. Maxton, Butler, Ind.

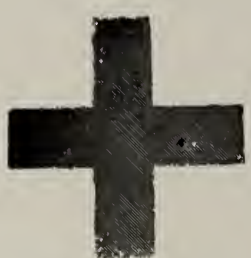
Greene County—WORTHINGTON—pop. 1,700. Nearest hospital located at Linton, 13 miles away. Office of the late Dr. A. H. Fender available. New Gypsum plant being started in the community. For further information contact Mr. G. E. Conway, 2 Washington St., Worthington, Ind.

LaPorte County—MICHIGAN CITY—pop. 28,400. Opening for general practitioner. Office of late Dr. Leonard Piazza available. For further information contact Dr. Francis Fargher, 907 Washington St., or Mr. E. P. Messner, executive secretary, LaPorte County Medical Society, 117 W. 8th St., Michigan City, Ind.

Lawrence County—MITCHELL—pop. 3,300. Located 11 miles from Bedford where hospital facilities are available. Two physicians in community. For details contact Mrs. Claudia Reed, 2632 Applegate St., Indianapolis.

Owen County—FREEDOM—pp. 200. Large surrounding territory without a physician. Contact Mrs. Frank E. Hosseld Sr., Freedom.

Hendricks County — AVON—This is a community which is growing rapidly, located 7 mi. from Danville where new hospital is to be built in near future. Mr. Coy and Mr. Eggers of C & E Drugs, Plainfield, are contemplating building a new office building at Avon, located on U. S. 36, which will house drug store and offices for two physicians and a dentist. Contact Mr. Coy or Mr. Eggers at Plainfield for further details.



IT ALL ADDS UP!

+ Friendly and well trained personnel
+ 33 Modern Laboratories
+ Blue Ribbon Rx Service
+ Finest optical supplies
+ Guaranteed satisfaction

It's easy to do business with White-Haines

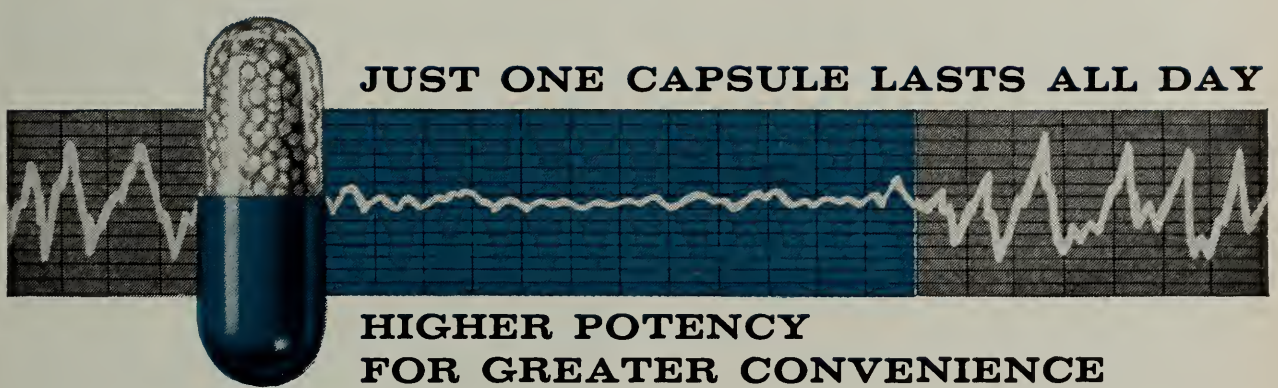
The WHITE-HAINES OPTICAL COMPANY
Blue Ribbon Rx Quality for Over Half a Century
INDIANAPOLIS, SOUTH BEND and TERRE HAUTE
GENERAL OFFICES: COLUMBUS 16, OHIO

NEW AND EXCLUSIVE

FOR SUSTAINED TRANQUILIZATION

MILTOWN® (*meprobamate*) now available in 400 mg. continuous release capsules as

Meprospan®-400



JUST ONE CAPSULE LASTS ALL DAY

HIGHER POTENCY FOR GREATER CONVENIENCE

- relieves *both* mental and muscular tension without causing depression
- does not impair mental efficiency, motor control, or normal behavior

Usual dosage: One capsule at breakfast, one capsule with evening meal

Available: *Meprospan-400*, each blue capsule contains 400 mg. Miltown (meprobamate)
Meprospan-200, each yellow capsule contains 200 mg. Miltown (meprobamate)

Both potencies in bottles of 30.

®WALLACE LABORATORIES, *New Brunswick, N. J.*

CME-8426

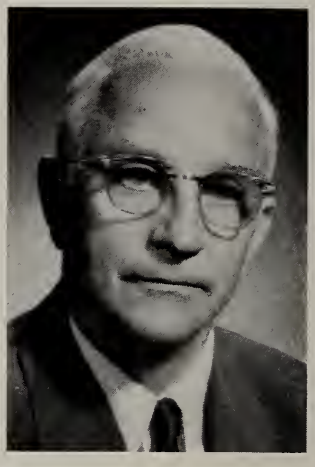
NEWS NOTES—from State and Nation

Indiana University School of Medicine Symposium Features Seven National Cancer Authorities on Program

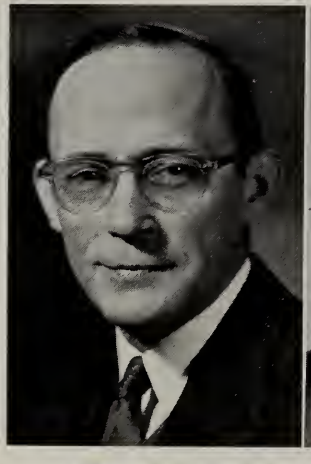
Seven nationally recognized authorities on cancer, including the president of the American Cancer Society and the president of the American College of Surgeons, are on the program for the annual Symposium on Malignancy of the Indiana University School of Medicine, March 29-30.

The Tuesday afternoon and Wednesday sessions are being held in Rice Auditorium of the Indiana State Board of Health Building. The program this year is again being presented with the support and cooperation of the Indiana Division of the American Cancer Society.

Open to all physicians, the symposium will deal with tumors of the colon, one of the most common types of malignancy, the leading cause of cancer deaths and yet the type of cancer which is most amenable to treatment with one of the highest survival rates of the cancer field.



OWEN H. WANGENSTEEN, M.D.
Professor/Director of Surgery
University of Minnesota



WARREN H. COLE, M.D.
Professor/Chairman of Surgery
University of Illinois



JOHN M. WAUGH, M.D.
Chief of Surgery
Mayo Clinic

Subjects under Discussion

Among the subjects to be discussed will be lymphatic and vascular spread; relationship of polyps to cancer; anterior resection of abdominal perineal for low lesions, chemotherapeutic aids, and the "second look" at the patient and his condition. Opportunity will be given at each of the three sessions for questions from the audience and discussion by the panel.

The visiting speakers include: Dr. Waren H. Cole, head of surgery at the University of Illinois and president of the American Cancer Society; Dr. Owen H. Wangensteen, chairman of surgery at the University of Minnesota and president of the American College of Surgeons; Dr. John M. Waugh, surgery chief at the Mayo Clinic; Dr. Edwin R. Fisher, pathologist at the University of Pittsburgh; Dr. John R. Hodgson of the diagnostic roentgenology section at the Mayo Clinic; Dr. R. Kennedy Gilchrist, clinical professor of surgery at the University of Illinois, and Dr. John S. Spratt, Washington University surgeon whose recent paper on polyps of the colon not turning malignant casts doubt on previous concepts of these growths.

Dean John D. VanNuys of the I.U. School of Medicine, Dr. Robert Rohn, cancer coordinator, and Dr. H. B. Shumacker Jr., chairman and professor of surgery, will welcome the physicians at the opening session Tuesday afternoon, March 29.

Continued

WHEN CONSIDERING Contour PATENTED

Check the plus features . . .

✓ **VIVERATION entire body massage**

✓ **Penetrating THERMONIC HEAT**

Enjoy these optional features in any of six locking positions of a "cradle comfort" Contour, the chair lounge totally unlike angular chairs and lounges . . . designed to fit the curves and sized to the needs of the human body . . .

VIVERATION, a Contour innovation, helps relieve mental and physical tensions and increases circulation. At the turn of a knob it massages all over the body in any intensity—from a gentle rhythm to a strong stimulus.

THERMONIC HEAT in any of three intensities adds the time-proven relaxing and tension-relieving benefits of a gentle heat concentrated at nerve centers in back and thighs.

Exclusive with Contour, the THERMONIC HEAT MASSAGE LOUNGE combines the advantages of two regulated "plus" factors—all-over body massage and radiant heat—complete relaxation while you recline in famous head-to-toe Contour Cradle Comfort.

IN YOUR CHOICE OF FINE FABRICS AND VINYLS, SMART HUES



THE ORIGINAL PATENTED Contour® CHAIR LOUNGE

2162 N. Meridian St.
WA 3-1526

10 N. Illinois St.
ME 4-8219

Indianapolis, Indiana

Symposium

Continued



JOHN R. HODGSON, M.D.
Diagnostic Roentgenology
Consultant
Mayo Clinic



JOHN S. SPRATT, M.D.
Instructor of Surgery
Washington University
(St. Louis)

Speakers and subjects for the symposium will be:

Tuesday Afternoon, March 29

Registration—1:00-1:30 p.m. (CDT)

Moderator—Frederic W. Taylor, M.D.

Welcoming Remarks--John D. VanNuys, M.D.
Dean, I.U. School of Medicine

Outline of Program, Presentation of Speakers----------Robert J. Rohn, M.D., Harris B. Shumacker Jr., M.D.

The Significance of Tumor Cells in the Blood Stream ----------Dr. Fisher

The Prophylactic Treatment of Cancer Spread at the Time of Operation----Dr. Cole

Discussion and Questions from the Audience

Development of Surgical Therapy of Cancer of the Colon-------Dr. Wangensteen

Wednesday, March 30

Morning Session—9:00 a.m. (CDT)

Moderator—Harris B. Shumacker Jr., M.D.

The Pathology of Polyps of the Colon ----------Dr. Fisher

The Detection of Polyps by Roentgenology ----------Dr. Hodgson

The Relationship of Polyps to Cancer of the Colon ----------Dr. Spratt

The Surgical Management of Polyps of the Colon and Rectum--------Dr. Waugh

Discussion and questions from audience

Intermission

Cancer Detection Methods in the Recognition of Asymptomatic Cancer of the Colon ----------Dr. Wangensteen

The Diagnosis of Carcinoma of the Colon by Roentgenology ----------Dr. Hodgson

Lunch

Afternoon Session—1:30 p.m. (CDT)

Moderator—J. Stanley Battersby, M.D.

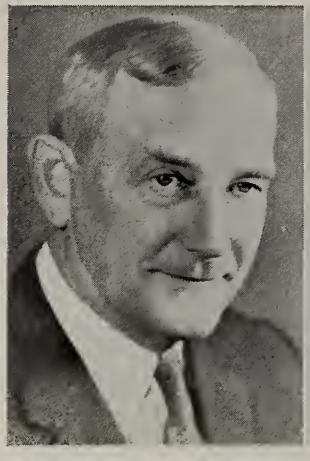
The Lymphatic Spread of Carcinoma of the Colon and Rectum --------Dr. Gilchrist

The Surgical Management and Results for Lesions of the Ascending, Transverse, Descending Colon and Rectum; Including Indications for Anterior Resection ----------Dr. Waugh

The Technique, Indications and Results of Abdominal-Perineal Resection---Dr. Gilchrist

Primary Near or Total Colectomy and the Second-Look Procedure for Cancer of the Colon ----------Dr. Wangensteen

Discussion and questions from audience



R. KENNEDY GILCHRIST, M.D.
Clinical Professor of Surgery
University of Illinois



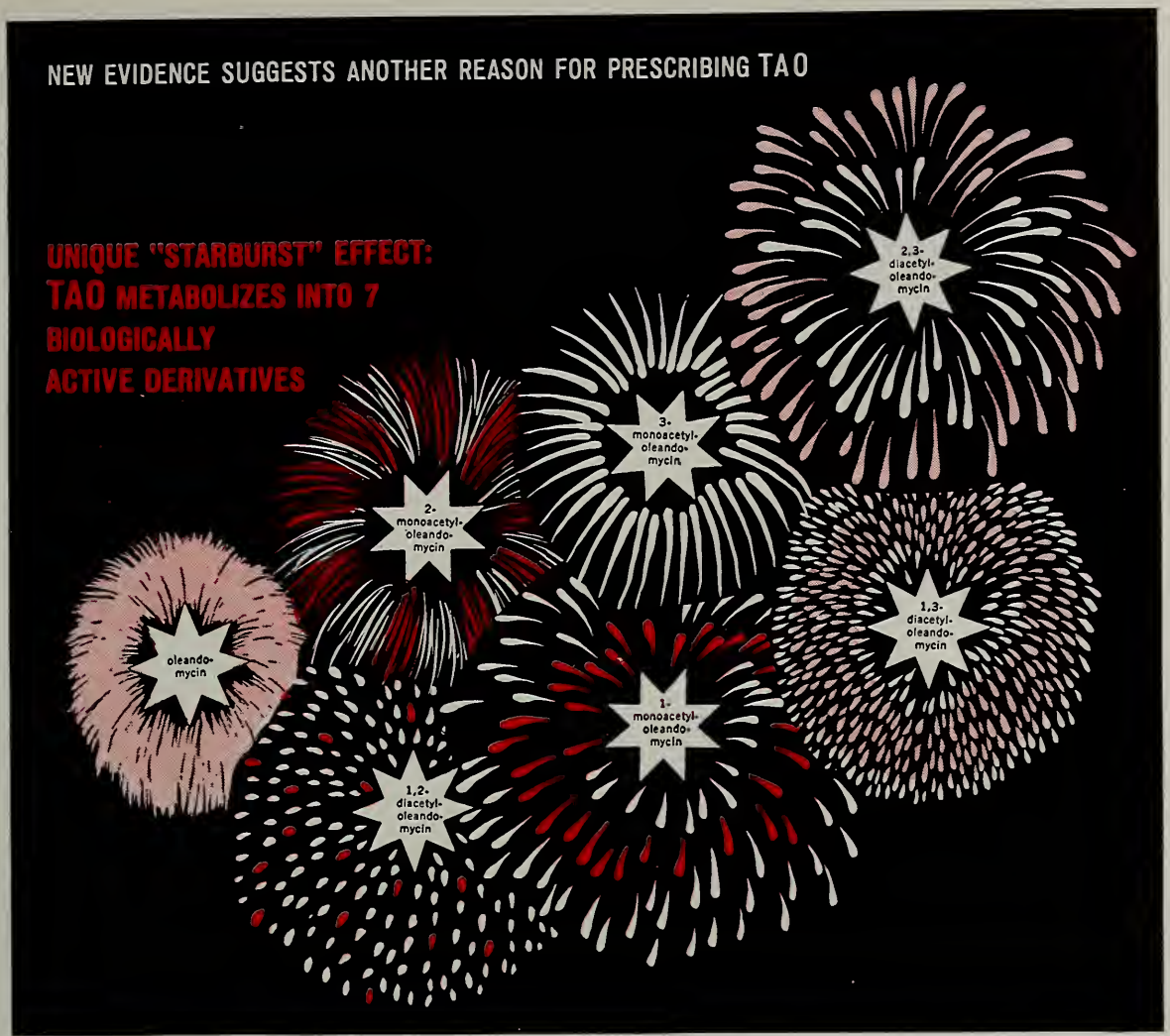
EDWIN R. FISHER, M.D.
Professor of Pathology
University of Pittsburgh

Hospital Housekeeping Course Scheduled

The 12th annual course in hospital housekeeping will be conducted at Michigan State University, East Lansing, Mich. from April 4 to May 26. The only course of its kind, it is sponsored by the American Hospital Association, and is limited to 40 students.

Ten scholarships of $350.00 each are given each year by Huntington Laboratories of Huntington, Ind., to prospective students who are chosen by a committee of three hospital administrators.

NEW EVIDENCE SUGGESTS ANOTHER REASON FOR PRESCRIBING TAO



The impression that TAO is an unusually active antibiotic has steadily gained recognition by impressive clinical performance. Now come reports of **in vivo** and **in vitro** biological and biochemical evaluations that show TAO to be indeed unique.[1,2]

TAO differs from other antibiotics in that it is metabolized to multiple active compounds which **remain** active throughout their presence in the body. These 7 derivatives (in addition to TAO) show activity against common Gram-positive pathogens, including resistant strains of **Staph. aureus.**

In light of these findings, take another look at TAO performance: • 92% success in published cases of Gram-positive respiratory, skin, soft tissue and genitourinary infection • Effective against 78% of 64 "antibiotic-resistant" epidemic staphylococci. (In the same study, chloramphenicol was active against 52%; erythromycin against only 25%)[3] • No side effects in 94%; infrequent reactions mild and easily reversed • Quickly absorbed • Highly palatable.

Sound reasons to: Start with TAO to end 9 out of 10 common Gram-positive infections.

Supplied: TAO Capsules—250 mg., and 125 mg., bottles of 60. **TAO for Oral Suspension**—125 mg. per tsp. (5 cc.) when reconstituted; unusually palatable cherry flavor; 60 cc. bottle. Prescription only.

Other TAO forms available: TAO Pediatric Drops: flavorful, easy to administer. **TAO®-AC:** TAO analgesic, antihistaminic compound. **TAOMID®:** TAO with triple sulfas. **Intramuscular or Intravenous:** in clinical emergencies. Prescription only.

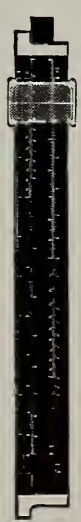
1. English, A. R., and McBride, T. J.: Proc. Soc. Exper. Biol. & Med. 100:880 (Apr.) 1959. 2. Celmer, W. D.: Antibiotics Annual 1958-1959, New York, Medical Encyclopedia, Inc., 1959, p. 277. 3. English, A. R., and Fink, F. C.: Antibiotics & Chemother. 8:420 (Aug.) 1958.

designed for superior control of common Gram-positive infections

Tao®

(triacetyloleandomycin)

Capsules/Oral Suspension



Rx PFIZER

New York 17, N. Y.
Division, Chas. Pfizer & Co., Inc.
Science for the World's Well-Being

Medical Students Can Travel Abroad On Foreign Fellowship Program

Evanston, Illinois—A program to further international relations for the United States by making it possible for medical students to serve as unofficial ambassadors has been announced by the Association of American Medical Colleges and Smith Kline & French Pharmaceutical Company.

Established by a $180,000 grant from Smith Kline & French, the new program will provide foreign fellowships through which students of United States medical colleges may travel abroad for a limited period of time to work in remote areas of the world.

These fellowships will provide selected medical students with broad clinical experience, an understanding of preventive medicine as practiced abroad, an opportunity to study diseases not common to the United States and a definite awareness of the acute need for American physicians and their medical knowledge abroad. In addition, this opportunity will afford the selected Fellow the chance to play the role of individual ambassador or missionary. He will be representative of the method of medical education in the United States today while communicating the most recent information available on medical science to distant areas of the world.

Any student who has completed his third year of medical school is eligible to apply for a fellowship. If accepted he may spend 12 weeks or more at a foreign mission or other remote private medical facility, or a public health unit, clinic or hospital.

The award of a fellowship will be determined on the basis of the applicant's ability, potential and his objectives in wanting to study abroad. Emphasis will be placed on the applicant's plan for study and experiences which would not be afforded to the applicant at a medical school here in the United States and through which the student will bring back significant knowledge to the United States.

Cash awards will be made on an individual basis. A contribution to the expenses of the wife or husband accompanying the Fellow will be made when this seems desirable in terms of the objectives of the program and of the fellowship. No awards will be made for the expense of children.

At the termination of time spent abroad, a Fellow is expected to write a report summarizing his clinical experiences abroad, including his personal evaluation of the effectiveness of the trip as a part of his medical education.

Medical students who wish to apply for a fellowship must submit their application to the dean of their medical school. If the application is acceptable, the dean will then endorse it and forward it to the selection committee at the Association of American Medical Colleges.

A great many of our troubles are man-maid.—*Arc Sparkle*, Weld Tooling Corp., Pittsburgh.

All of us can give friendship to those who need it; loyalty to those who depend upon us; courtesy to all those with whom we come in contact; kindness to those whose paths may cross ours; understanding to those whose views may not be in accord with our own.—Carl E. Holmes.



PROTECTION AGAINST LOSS OF INCOME FROM ACCIDENT & SICKNESS AS WELL AS HOSPITAL EXPENSE BENEFITS FOR YOU AND ALL YOUR ELIGIBLE DEPENDENTS

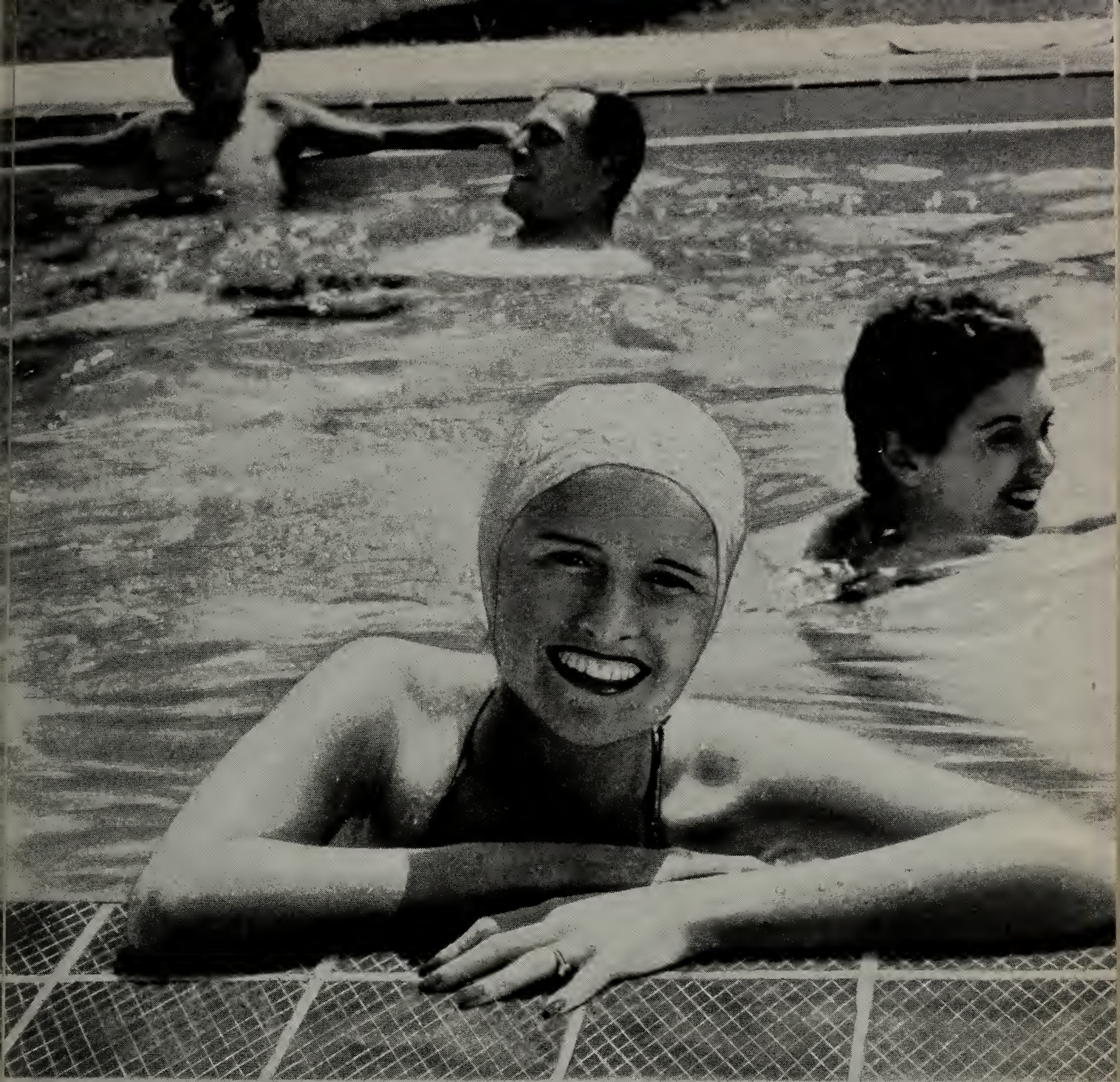
ALL PREMIUMS COME FROM — PHYSICIANS SURGEONS DENTISTS — ALL BENEFITS GO TO

PHYSICIANS CASUALTY & HEALTH ASSOCIATIONS

OMAHA 31, NEBRASKA

Since 1902

Handsome Professional Appointment Book Sent to you FREE upon request.



Of course, women like "Premarin"®

THERAPY for the menopause syndrome should relieve not only the psychic instability attendant the condition, but the vasomotor instability of estrogen decline as well. Though they would have a hard time explaining it in such medical terms, this is the reason women like "Premarin."

The patient isn't alone in her devotion to this natural estrogen. Doctors, husbands, and family all like what it does for the patient, the wife, and the homemaker.

When, because of the menopause, the psyche needs nursing—"Premarin" nurses. When hot flushes need suppressing, "Premarin" suppresses. In short, when you want to treat the whole menopause, (and how else is it to be treated?), let your choice be "Premarin," a complete natural estrogen complex.

"Premarin," conjugated estrogens (equine), is available as tablets and liquid, and also in combination with meprobamate or methyltestosterone.

Ayerst Laboratories • New York 16, N. Y. • Montreal, Canada

5854

Added Unsaturated Fats and Oils Will Not Reduce Blood Cholesterol

Addition of unsaturated fats and oils to the otherwise unchanged ordinary diet will not reduce blood cholesterol and prevent heart attacks and strokes, the Food and Drug Administration disclosed recently. Representations to the public that salad oils, shortenings, oleomargarine and similar products have value for these purposes are false and misleading and will cause such products to be misbranded, FDA declared in a statement of law-enforcement policy published in the Federal Register.

George P. Larrick, commissioner of Food and Drugs, said there is widespread interest in the possible relationship between blood cholesterol levels and heart and artery diseases. As a result, he explained, reference to the term "cholesterol" in the labeling of common foods now being offered to the public may have the effect of a claim of special value for preventing or treating these diseases.

Commissioner Larrick added: "Scientific investigations of fatty substances as a possible factor in lowering blood cholesterol and preventing heart disease should be continued, and this policy statement does not interfere in any way with legitimate research and clinical evaluation of unsaturated fats in the diet.

"It is our responsibility, however, to point out that the public has been misled into relying prematurely on data which are still experimental, incomplete and contradictory, and to head off false and misleading promotions based on such data."

Cholesterol, FDA explained, is a substance that is manufactured in the body and has an important function in many of the body tissues. It is also present in animal fats and oils such as butter, lard, bacon and meat fat. The blood level of cholesterol is controlled largely by synthesis in the body and is affected very little by the amount present in our foods.

FDA further pointed out the view of nutrition scientists that it is impracticable for a person to add enough unsaturated fats to an otherwise unchanged diet to bring about any significant change in blood cholesterol. Increased weight they add, is the only result that is likely to be achieved by increasing the intake of fats.

The FDA policy statement, based on an extensive survey of leading medical authorities, follows:

§ 3.41 Status of articles offered to the general public for the control or reduction of blood cholesterol levels and for the prevention and treatment of heart and artery disease under the Federal Food, Drug, and Cosmetic Act.

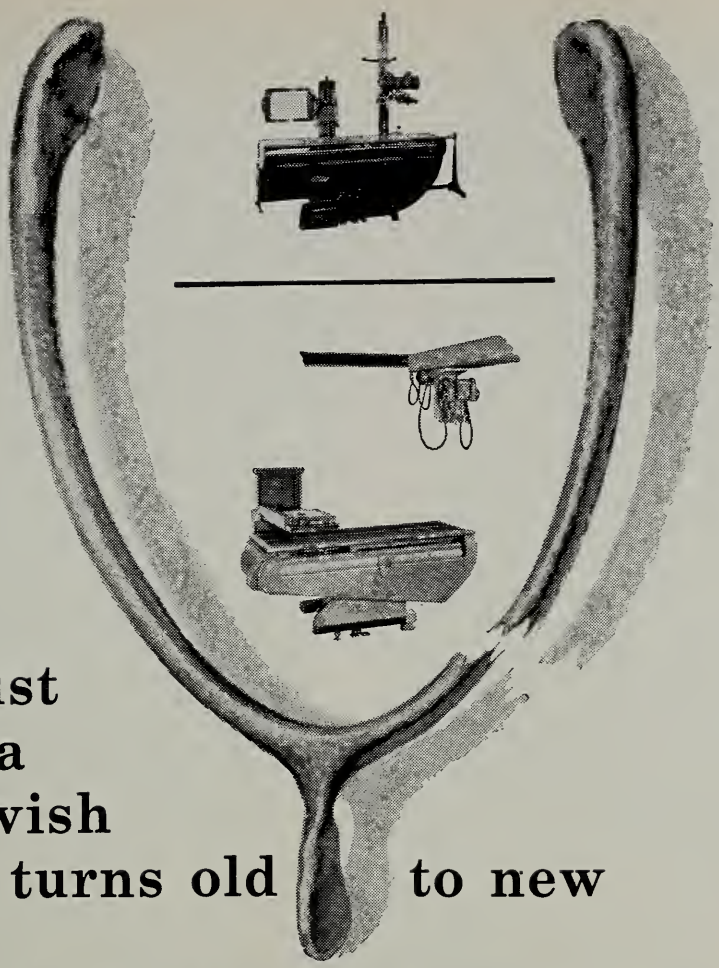
(a) There is much public interest and speculation about the effect of various fatty foods on blood cholesterol and the relationship between blood cholesterol levels and diseases of the heart and arteries. The general public has come to associate the term "cholesterol" with these diseases. A number of common food fats and some other forms of fatty substances are being offered to the general public as being of value in the control of reduction of blood cholesterol levels and for the prevention or treatment of diseases of the heart or arteries.

(b) The role of cholesterol in heart and artery diseases has not been established. A causal relationship between blood cholesterol levels and these diseases has not been proved. The advisability of making extensive changes in the nature of the dietary fat intake of the people of this country has not been demonstrated.

(c) It is therefore the opinion of the Food and Drug Administration that any claim, direct or implied, in the labeling of fats and oils or other fatty substances offered to the general public that they will prevent, mitigate, or cure diseases of the heart or arteries is false or misleading, and constitutes misbranding within the meaning of the Federal Food, Drug, and Cosmetic Act.

———

The famous wine-taster, touring Europe in quest of outstanding wines, had become a foreign car addict even before they were imported in to the U. S. in such quantities. Induced to try one of the new American compact jobs, he returned from his spin with the verdict, "Domestic, but good."—*Wall Street Journal.*



Just a wish turns old to new

Modernize without capital outlay on the G-E Maxiservice® x-ray rental plan

Think of renting x-ray equipment as conveniently as you subscribe for telephone service! Exclusive Maxiservice rental plan offers all new-model G-E x-ray units . . . takes no capital from your savings. Makes it worry-free to "go modern" in x-ray and always stay that way. For complete details, contact your G-E x-ray representative, listed below.

All this for one monthly fee —

- Modern x-ray equipment, free of obsolescence worries
- Comprehensive coverage: periodic inspection, maintenance, tubes, parts, emergency repairs
- Freedom to add or replace equipment as improvements appear
- Full property insurance on equipment — in case of accidental damage or loss, G.E. repairs or replaces equipment
- Local property taxes paid in full

Progress Is Our Most Important Product

GENERAL ELECTRIC

DIRECT FACTORY BRANCHES

CHICAGO
1061 W. Jackson Blvd. • SEeley 3-0700

CINCINNATI
3056 W. McMicken Ave. • MUlberry 1-7230—31

INDIANAPOLIS
1845 W. 18th St. • MElrose 5-4576

LOUISVILLE
501 W. Oak St. • JUniper 3-9562

RESIDENT REPRESENTATIVES

FORT WAYNE
H. J. Wallace • 918 Oakdale • Kenmore 9749

ISMA Members Invited to Attend Annual Pediatric Postgraduate Course

The annual Pediatric Postgraduate Course of the University of Louisville will be held each Tuesday, 9:30 a. m. to 12:30 p. m. from April 12 through May 31, in the amphitheatre of the Children's Hospital, Louisville. Members of the ISMA are invited to attend. The program will be as follows:

April 12	Natural History of Left-to-Right Shunts Preventive Role of the Physician in Well Baby Care	Joseph A. Little
April 19	Childhood Tuberculosis Value of Growth Studies	Mary Cruise William C. Adams
April 26	The "Virus" Problem of Everyday Infection Physiological Basis of Fluid Therapy	Frank Falkner
May 3	Optimum Time for Elective Surgery Office Orthopedics Office Urology	Alex J. Steigman
May 10	Diagnosis of Rheumatic Fever The Ubiquitous Staphylococcus	Katharine Dodd Hugh B. Lynn S. P. Auerbach R. Lich, Jr.
May 17	The Newborn Meningitis	Margaret Vermillion
May 24	Pediatric Diagnostrix Iron Deficiency Anemia	Joseph A. Little Mary Cruise Alex J. Steigman
May 31	Salicylism	Joseph A. Little William C. Adams Katharine Dodd

AEC Grants Go to Notre Dame, Valparaiso

The Atomic Energy Commission has announced grants to two Indiana schools. The University of Notre Dame will receive $36,900 and Valparaiso University $27,540, a part of $1,800,000 to 56 universities and colleges for the purchase of laboratory equipment to expand nuclear educational programs at the graduate level.

This year is the sixth of a series of grants which have totaled $12,741,917 and have aided 125 educational institutions in their nuclear engineering programs since 1952.

Army Announces Publication of Volume II on Neurosurgery

The U. S. Army announces the publication of the second volume of the history of neurosurgery in World War II. Entitled "Neurosurgery, Volume II," this book deals with injuries of the spinal cord, including lesions of the intervertebral disc, and peripheral nerve injuries.

There are 705 pages, 295 illustrations and color plates and 15 tables. The volume may be obtained for $7 per copy from the Superintendent of Documents, Washington 25, D. C.


in every arthritic state
long-term therapy
with maximum relief of pain
without steroids
Buffered
Pabirin®
Tablets
improved salicylate therapy
SMITH-DORSEY • a division of The Wonder Company • Lincoln, Nebraska

Dear Doctor:

Auxiliary Organization Chairman Heads Campaign Seeking 100% Participation in Distaff Programs

(Note: The following letter was sent to 12 county society secretaries by the auxiliary organization chairman. It is hoped that through publishing this letter, those county societies still not having organized auxiliaries will be prompted to help gain 100% participation in auxiliary work.)

January 5th, 1960

Dr. —
—, Indiana
Dear Doctor — and members of the — County Medical Society:

The Woman's Auxiliary to the Indiana State Medical Association is *still* striving for 100% membership.

Out of 92 counties comprising the state of Indiana, the Woman's Auxiliary has formed or is forming auxiliaries in 80 of them. This gives us an 87% statewide county coverage of which we are justly proud—but not content. Prior to my Oct. 1 correspondence to you, 19 counties were still unorganized. I'm sure you will be pleased to hear that since then, seven of them have consented to form their own auxiliary. This leaves 12 counties unaccounted for.

It is regrettable that — County is one of these 12. We would like to rectify this as we feel that the Woman's Auxiliary can be of benefit to you, to your wife, to the community and to the medical profession.

I would like to emphasize, doctor's, that the Woman's Auxiliary *is not* a social organization. Our purpose is to support the medical profession in its program for the advancement of medicine and public health. However, to do this effectively we need a hundred percent membership and support.

Again, doctor's, we request permission from you as members of the — County Medical Society to organize, if possible, an auxiliary within — County. To restate a portion of my Oct. 1 correspondence to you—we would also appreciate the name of the wife of a member capable and willing to act as temporary chairman. Her only responsibility will be to call a meeting of the wives of your members so that we may visit with them and discuss the organization of an auxiliary.

Awaiting your reply.

Sincerely,
Mrs. Edward L. Rigley
President-Elect & Organization Chairman
1704 Ridgedale Road
South Bend, Ind.

Arteriosclerosis Booklet Available For Distribution to Patients

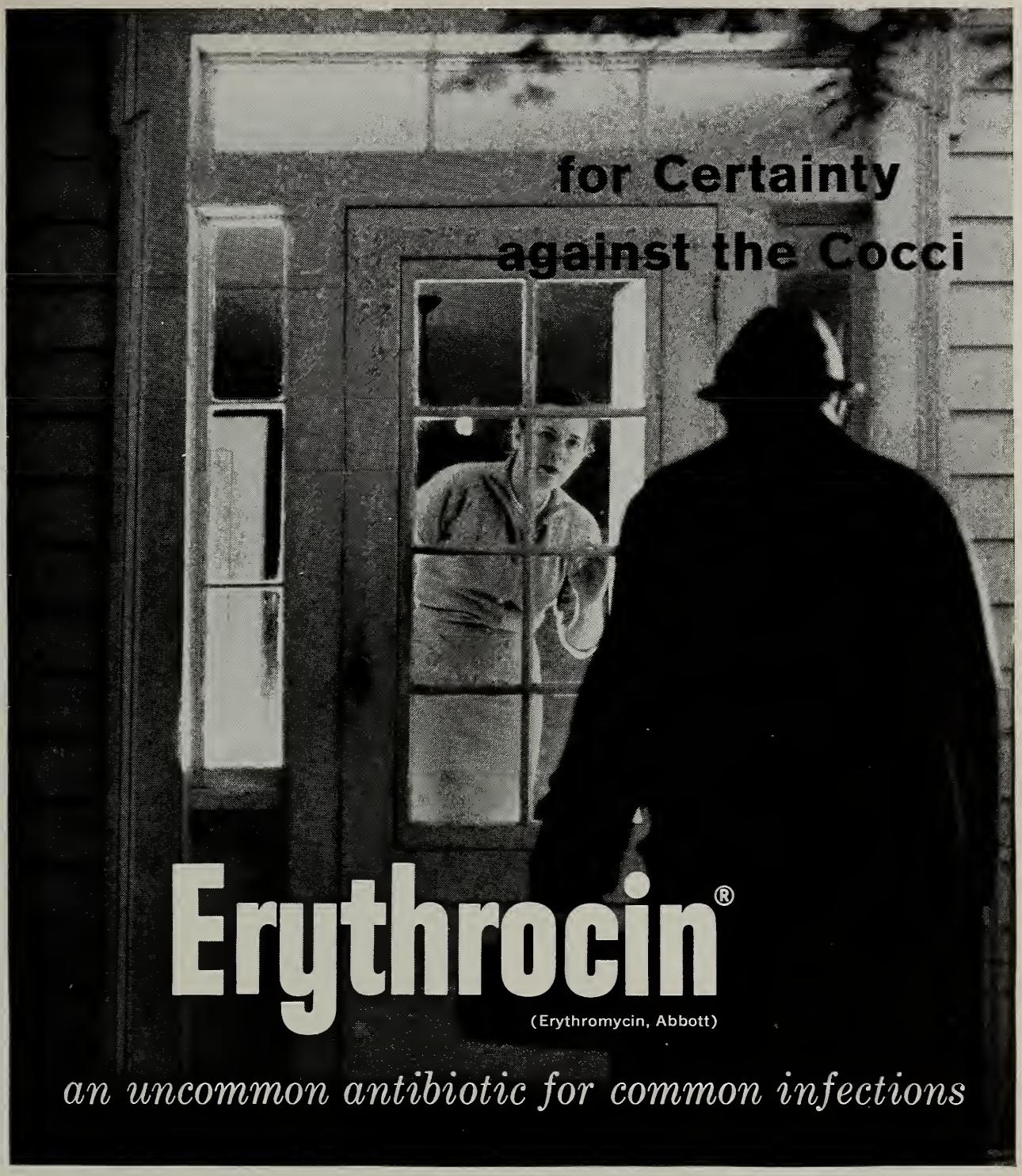
A "Statement on Arteriosclerosis" has been published in the form of a 20-page booklet for the information and education of the public. Illustrated and concisely written, the booklet outlines the actors which predispose to arteriosclerosis and discusses control measures.

Drs. Louis N. Katz, Samuel A. Levine, Irvine H. Page, Howard B. Sprague, Jeremiah Stamler, Frederick J. Stare, Paul Dudley White and Irving S. Wright are authors of the statement. It is published by the National Health Education Committee.

Limited quantities of free copies are available to physicians, for distribution to patients. Address the Committee at 135 E. 42nd St., New York City, 17.

Gill Spring Congress is April 4-9

The Gill Memorial Eye, Ear and Throat Hospital of Roanoke, Virginia, 33rd Annual Spring Congress will be held April 4-9. Otolaryngology will be covered in three full-day programs April 4-6. Ophthalmology will be the subject for April 7-9. Full information as to fees and registration may be obtained by writing Dr. E. G. Gill, Box 1789, Roanoke.



Provides fast, high blood and tissue concentrations—plus an unparalleled safety record. Erythrocin is available in easy-to-swallow Filmtabs® (100 and 250 mg.); in tasty, citrus-flavored Oral Suspension (200 mg. per 5-cc. teaspoonful); and for intravenous and intramuscular use.

ABBOTT

®FILMTABS—FILM-SEALED TABLETS. ABBOTT. U.S. PAT. NO. 2,881,085

909132

Medical Assistants News:

Two-day Medical Assistants Convention at Richmond Includes Talk by World Traveler—Reporter—College President

by Marie Theobald Wilhite

"We've been planning for a year
To make this the best convention
Of your career-
So, come from far and come from near,
But please plan to be here."

Members of the Wayne-Union Medical Assistants Association are busily making preparations for the Fourth Convention of the Indiana State Association of Medical Assistants. Convention Headquarters will be the Leland Hotel, Richmond, Ind., and the dates—Saturday and Sunday, April 30 and May 1, 1960.

Tentative outline for the two-day convention is as follows: *Saturday, April 30:* 10 a.m.-1 p.m. Registration; 2-4 p.m., Workshops; 6-7 p.m., Social Hour—"Oasis" (guests of Finances System of Richmond); 7 p.m., Banquet; 10 p.m.—Fun for all.

Sunday, May 1: 8:30-9:30 a.m., Breakfast "Too much Coffee"; 10 a.m.-12:30 p.m., business meeting and election of officers; 1:15 p.m., Luncheon—speaker will be Mr. Charles Mathews, and 2:45-3:45 p.m., Installation of Officers.

Registration

Registration fee—$8.00, which will include banquet, breakfast and luncheon. All medical assistants interested in attending the convention should send registration fee to Mrs. Dorothy Soblitt, registration chairman, 11 Sunset Drive, Richmond, Ind., and check should be made payable to the: Wayne-Union Medical Assistants Convention Fund. Deadline for registration is April 15, 1960, and any registration cancelled by April 25, 1960 will be refunded.

Speaker at the banquet on Saturday evening will be Landrum R. Bolling, president of Earlham College, and his subject "World Turmoil Ahead — The 1960's." Since graduation from college Mr. Bolling has devoted much of his time to journalism and the teaching of political science. He has served on the faculties of Brown University, Providence, R. I.; Beloit College, Beloit, Wis., and Earlham. Journalistic experience has ranged from the editing of a small-town weekly to serving as a foreign correspondent.

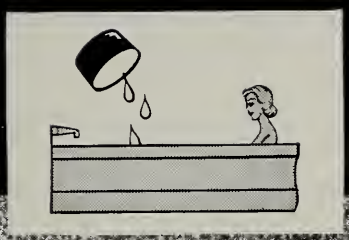


Dr. Bolling

Mr. Bolling was a war correspondent attached to Allied Forces, Hqs. in the Mediterranean during World War II. The winter of 1944-45 he spent in Yugoslavia with Tito's forces and covered the Allied advance into Austria. At the end of the war Mr. Bolling became chief of the Overseas News Agency bureau for Central Europe with headquarters in Berlin. He has lectured extensively under the auspices of Rotary International and other organizations, particular-

proven successful[1] in almost every case of

skin itch and dryness



Used in the bath SARDO releases millions of microfine water-dispersible globules* to provide a soothing, softening suspension which enhances your other therapy. SARDO baths . . .

1 **rehydrate the dry, itchy, scaly skin**

2 **add comfort to the therapeutic care**

3 **act to measurably increase natural emollient skin oil**

4 **minimize loss of natural oil and excessive moisture with a fine non-occlusive film**

Patients will appreciate pleasant, convenient, easy to use, pine-scented SARDO. Non-sensitizing. Most economical. Bottles of 4, 8 and 16 oz.

1. Spoor, H. J.: N. Y. State J. Med. Oct. 15, 1958

Sardo®
in the bath

for atopic dermatitis
eczematoid dermatitis
senile pruritus
contact dermatitis
soap dermatitis



Samples and literature yours for the asking.

Sardeau, Inc. 75 East 55th Street New York 22, N. Y.

© 1959 *Patent Pending, T.M.

Medical Assistants

continued

ly on the goals and tactics of international communism.

Mr. Bolling joined the Earlham faculty as professor of political science in 1948, and he served as general secretary of the College from 1955-58, and assumed the presidency of Earlham in 1958.

TV Commentator

In 1957 and 1958 Mr. Bolling made a reporting tour abroad, and his columns on international affairs have been carried by a number of midwestern newspapers and radio stations have programmed his tape recorded interviews and commentaries on foreign affairs. He is a frequent guest commentator on television programs devoted to international affairs or problems of higher education.

The convention program and speakers sound interesting and exciting. Let us each make arrangements to be in Richmond, on April 30-May 1, to enjoy the Wayne-Union medical assistants hospitality and to make this another grand and worthwhile convention! See you in Richmond!

Yes Doctor

I am happy, thankful and glad you sent me and my family to Heid's for correct shoes—this eliminates one of our handicaps.



HEID'S 50th Year

Shoes for Men, Women, Children

411 N. Illinois, Indianapolis

Phone MElrose 5-4247 Drive-In Parking

Yale School of Medicine Announces Sesquicentennial Celebration Plans

Yale School of Medicine, celebrating a century and a half of existence on Oct. 28 and 29 of this year, will mark the occasion by meetings, exhibitions and addresses. Among a notable group of guest speakers will be Sir Howard Florey of Oxford, England.

It was in October, 1810 that the Connecticut General Assembly granted a charter to Yale College for the establishment of the Medical Institution of Yale College, and the fifth medical school in the United States came into being.

The first medical faculty at Yale was a notable one. Among its members were Eneas Munson, foremost authority on Materia medica, Nathan Smith and Benjamin Silliman, still counted among Yale's greatest, and Eli Ives and Jonathan Knight, leaders in medicine and both presidents of the American Medical Association. The Connecticut Medical Society has always aided in the enterprise, and worked in close cooperation especially during the first half century of the school's existence.

Other events associated with the sesquicentennial celebration will take place during the academic year 1960-61. These include an exhibition of medical art at the Yale Art Museum and a scientific meeting to be held in conjunction with the dedication of a new medical school auditorium. Program details will be announced later.

Pan-Pacific Surgical Association Schedules Fall Congress in Hawaii

The Eighth Congress of the Pan-Pacific Surgical Association will be held in Honolulu, Hawaii, Sept. 27 through Oct. 5, 1960.

All members of the profession are eligible to register and are urged to make arangements as soon as possible if they wish to be assured of adequate facilities because of limited space.

An outstanding scientific program by leading surgeons promises to be of interest to all doctors. Ten surgical specialty sections are held simultaneously.

Further information and brochures may be obtained by writing to Dr. F. J. Pinkerton, Director General of the Pan-Pacific Surgical Association, Suite 230, Alexander Young Building, Honolulu 13, Hawaii.

Squibb Announces Chemipen

Squibb Alpha-Phenoxyethyl Penicillin Potassium

new chemically improved penicillin which provides the highest blood levels that are obtainable with oral penicillin therapy



As a pioneer and leader in penicillin therapy for more than a decade, Squibb is pleased to make Chemipen, a new chemically improved oral penicillin, available for clinical use.

With Chemipen it becomes possible as well as convenient for the physician to achieve and maintain higher blood levels—with greater speed—than those produced with comparable therapeutic doses of potassium penicillin V. In fact, Chemipen is shown to have a 2:1 superiority in producing peak blood levels over potassium penicillin V.*

Extreme solubility may contribute to the higher blood levels that are so notable with Chemipen.* Equally notable is the remarkable resistance to acid decomposition (Chemipen is stable at 37°C. at pH 2 to pH 3), which in turn makes possible the convenience of oral treatment.

And the economy for your patients will be of particular interest—Chemipen costs no more than comparable penicillin V preparations.

Dosage: Doses of 125 mg. (200,000 u.) or 250 mg. (400,000 u.), t.i.d., depending on the severity of the infection. The usual precautions must be carefully observed with Chemipen, as with all penicillins. Detailed information is available on request from the Professional Service Department.

Supply: Chemipen Tablets of 125 mg. (200,000 u.) and 250 mg. (400,000 u.), bottles of 24 tablets. Chemipen Syrup (cherry-mint flavored, nonalcoholic), 125 mg. per 5 cc., 60 cc. bottles.

*Knudsen, E. T., and Rolinson, G. N.: Lancet 2:1105 (Dec. 19) 1959.

'CHEMIPEN' IS A SQUIBB TRADEMARK.

SQUIBB

Squibb Quality—the Priceless Ingredient

Current GP, Surgical Problems Included in Mayo Program

Staff members of the Mayo Clinic and the Mayo Foundation for Medical Education and Research will present again this year a three-day program of lectures and discussions on problems of current interest in general medicine and surgery.

The American Academy of General Practice and the College of General Practice of Canada have advised the Committee on Clinical Reviews that up to 21 hours of Category I credit may be obtained by members of the American Academy of General Practice or the College of General Practice of Canada attending.

There are no fees for this program.

The number of physicians who can be accommodated is necessarily limited. Those wishing to attend should communicate with the Clinical Reviews Committee, Mayo Clinic, Rochester, Minn.

Mrs. Gastineau Establishes AMEF Traveling Trophy

For her untiring efforts on behalf of AMEF and as the first national AMEF-Woman's Auxiliary chairman, Indiana's own Ethel Gastineau, president of the Woman's Auxiliary to the AMA, has received special recognition.

When presented with a AMEF cup honoring her services, Mrs. Gastineau established the award as a traveling trophy. To be known as the Ethel Gastineau award, it will be won by the state whose efforts have been the greatest on behalf of AMEF.

AMA Supervises New Series Over Nationwide Radio

Common illnesses that strike American families and their treatment by family physicians is the subject of a new public service radio series which started in December over the nationwide network of the American Broadcasting Company.

The series, under the supervision of the American Medical Association, is called "Highroad to Health." It is being presented in cooperation with Lederle Laboratories, a Division of American Cyanamid Company.

Weekly programs of 15 minutes each deal with a wide range of health problems from the careless household accident to the burdens created by chronic illness. Subjects covered include hypertension, acute childhood infections, cancer, household accidents, toxemia of pregnancy, chronic illness, geriatrics, mental health, rheumatic fever, tetanus, surgery, nutrition and medical emergencies.

Each program opens with a nine-minute dramatization of a health problem. This will be followed by a five-minute discussion of the problem by a guest physician who will also answer questions posed by the program host.

Dr. Gerald Dorman, eastern co-chairman of the Physicians' Advisory Committee on Radio and Television of the AMA, has said of the series, "We feel that 'Highroad to Health' will be a useful link between the public and the medical profession. It will cover a wide range of health problems in a factual, informative answer and will contribute to a better understanding of how the family physician wants to guard family health."

"Highroad to Health" is available to ABC stations each Wednesday at 2:15 p.m. and also each Saturday at 10:30 a.m. Local newspaper program listings or ABC stations should be consulted for exact broadcast schedules.

Indiana ABC stations include WTTS, Bloomington; WJPS, Evansville; WGL, Fort Wayne; WFBM, Indianapolis; WKBV, Richmond, and WNDU, South Bend.

Two Hoosier Projects Approved Under Hill-Burton Grants

The Department of Health, Education and Welfare reports that for the month of November, two projects were approved under Indiana's share of the Hill-Burton grants.

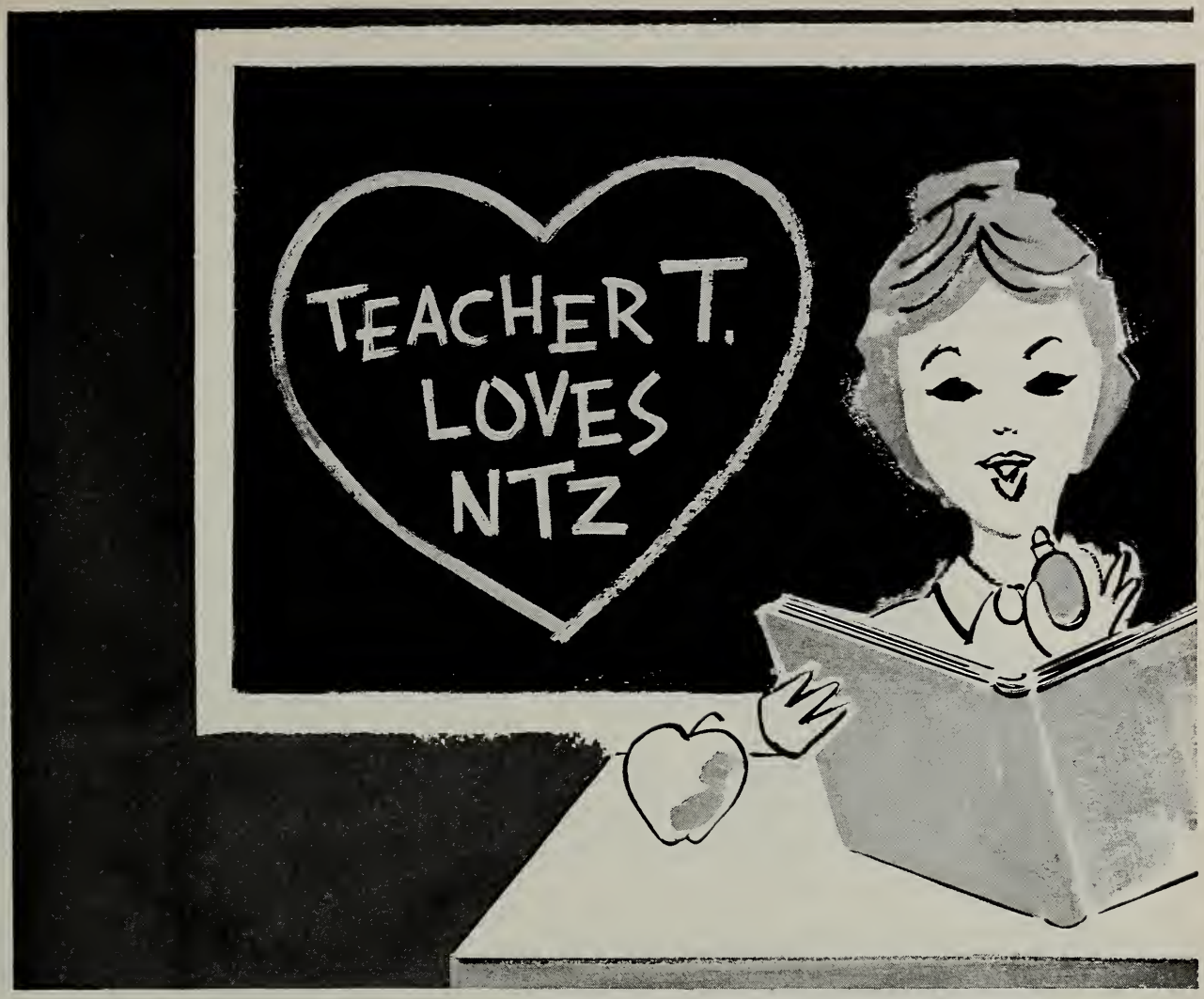
A project at Hendricks County Hospital, Danville, will cost an estimated $2,155,450, $717,333 of which is the approved federal share.

St. Margaret Hospital, Hammond, will receive a $12,000 Federal share on a project estimated at $115,000.

As of November 30, 1959, 65 projects at a total cost of $69,387,391, including a federal contribution of $22,805,302 and supplying 3,048 additional beds were completed and in operation.

Twenty-two projects at a total cost of $23,-039,838, including a $3,910,371 federal contribution and designed to supply 3,048 additional beds were under construction at that time.

Those projects approved but not under construction total three, at a cost of $4,444,075, including a $1,446,208 Federal share, and supplying 145 additional beds.



**In her book,
the lasting relief from colds
puts NTZ Nasal Spray
in a class by itself.**

NTZ® NASAL SPRAY

*20 cc. spray bottles;
also 1 oz. bottles with dropper*

Neo-Synephrine® HCl, 0.5%
—unexcelled decongestant—

Thenfadil® HCl, 0.1%
—topical antihistaminic—

Zephiran® Cl, 1:5000
—antibacterial spreading agent—

Winthrop LABORATORIES
New York 18, N. Y.

NTZ, Neo-Synephrine (brand of phenylephrine), Thenfadil (brand of thenyldiamine) and Zephiran (brand of benzalkonium, as chloride, refined), trademarks reg. U.S. Pat. Off.

Potentiated Relief for Colds...Sinusitis...Hay Fever

Official Says Insurers Demonstrate Capacity for Coverage of Aged

Health insurance companies are demonstrating effectively their capacity for providing medical, surgical and hospital care coverage for older people, Robert R. Neal, general manager of the Health Insurance Association of America, said recently.

Mr. Neal, speaking in Washington, D.C., during the annual meeting of the American Association of University Teachers of Insurance, emphasized that the insurance carriers are making rapid strides in developing and offering health insurance programs specifically designed for people age 65 and over. Among the plans offered to older persons who want assistance in meeting their health care expenses, he named the following:

"1. Continuation of insurance on older active workers under group insurance plans.

"2. Continuation of group insurance on retired workers and their dependents, generally with part or all of the premium paid by the employer.

"3. Continuation on an individual-policy basis of coverage originally provided by group insurance.

"4. New issuance of group insurance at advanced ages.

"5. Continuation into the later years of individual insurance bought in the productive years.

"6. New issuance of individually-purchased policies at advanced ages.

"7. Issuance of insurance that becomes paid-up at age 65."

Many health insurance companies have been writing policies in line with or similar to these plans for some time, Mr. Neal brought out. The companies, he said, are gearing their efforts to the need for providing more and better coverages at a cost which the public can pay. Looking to the future, Mr. Neal added:

"It is reasonable to assume that within a few years most private health insurance carriers will have acted to eliminate the older policyholder's anxiety that his coverage will not be renewed when he reaches age 65. Moreover, it can be expected that coverage of persons over age 65 will increase more rapidly in the future."

New Management Program Possible Through Grant to College of Surgeons

The John A. Hartford Foundation has made a grant of $146,275 to the American College of Surgeons to inaugurate a program for the improvement of medical management of surgical and injured patients.

The College has had a functioning committee on trauma since 1922, and now has 241 state and local trauma committees in the United States and Canada. Through the grant, these committees and cooperating organizations will be able to work more effectively in determining patterns of care and devising improvements in care.

Safe transportation of the injured, first-aid, self-aid, organization and staffing of hospitals involved in emergency medical care, disaster medical care and professional education will be some of the elements of the over-all problem to receive special attention. ◄



"I hope you don't mind . . . I haven't had my coffee break this morning!"

———

Life is getting very complex these days. Mack McGinnis passes along a tale about a telephone repairman who had finished some installation work in one of those modern buildings with no windows. In fact it was so fancy and utilitarian that he couldn't even find the way out and the pangs of claustrophobia began to grip him. Finally he reached an office where a secretary was typing like 60.

"How," he asked in desperation, "do I get outside?"

Without looking up from her typewriter she said, "Dial 9"—Ollie M. James, *Cincinnati Enquirer*.



BAD DIGESTION INCLINES ONE TO SKEPTICISM, INCREDULITY, BREEDS BLACK FANCIES AND THOUGHTS OF DEATH

JOSEPH CONRAD

When bad digestion is the consequence of digestive enzyme deficiency, Entozyme may dispel dreary symptoms such as pyrosis, flatulence, belching, and nausea, for it is a natural supplement to digestive enzymes. It provides components with digestive enzyme activity: **Pepsin,** N. F., 250 mg., **Pancreatin,** N. F., 300 mg., and **Bile Salts,** 150 mg. Because Entozyme is actually a tablet-within-a-tablet, these components are freed in the physiological areas where they occur naturaliy. Entozyme has proved useful in relieving many symptoms associated with cholecystitis, post-cholecystectomy syndrome, sub-total gastrectomy, pancreatitis, infectious hepatitis, and a variety of metabolic diseases.

A. H. ROBINS CO., INC. • RICHMOND 20, VA.

ENTOZYME®

Add 1

Artist from Hawaii has 'Funny' Escapades During Search for Journal Feature Material

by corki

With forgiveness from *Esquire,* I'd like to tell a few tales from behind the scenes of some *Journal* features — namely on Miki Wilson, artist, who came up with the new series on herbs in medical history which we began in February.

But to clear the air in case it sounds strange to you having artists from San Francisco and Hawaii doing special work for the *Journal* in Indiana . . .

While living in San Francisco I worked with Miki Wilson (no relation!) and Rosebud Lane quite extensively—or rather, they sweetly supplied artwork for the publication I edited for the government there.

To make a long story short, Miki moved to Hawaii, I moved to Indiana and Rosebud stayed in San Francisco. However, they both retained their interest in my work, and I my interest in their talents as artists. It may seem a hard task to work with artists by mail and normally would be—except those years of hashing out illustrations in San Francisco left us all understanding each other so that all I need are a few words of an idea to either and, bingo, back comes an art sketch showing what I had intended to say in words!

So, one day a letter arrived from Hawaii asking if what I had in mind by asking for something unusual, medically speaking, might not be herbs in medical history. Let's face it, I hadn't thought of just that subject but it hit the nail pretty square and the powers that be agreed it seemed a good idea. Thus was born a new idea for the *Journal.*

Then comes another letter with this intriguing paragraph:

"I'm thinking of doing a thing like the herb articles on Hawaiian herbs. There is a tremendous lore here as well as practicing herbalists . . . (Hawaiian). . . . My housekeeper had her husband cure diabetes that way. Yes, really. Other doctors checked. Then there are interesting things like papaya leaves, only thing for coral cuts. And Guava for diarrhea."

This all sounded intriguing. We know that some herbs are used in medical treatment today; why not see what could be found in the lore of Hawaii in use of herbs. And now the fun has begun.

An excerpt from another letter reads:

"Am thinking (means beginning) on the Hawaiian herbs and talking to people about the local cures. Have some dillies! Funny, these islands are very haunted. Everyone who understands that sort of thing knows that. There are still 'kahumas,' although I doubt if I'll ever meet one.

"Have been talking with people and hearing so many stories that last night I awoke scared to death. Lumpi (her delightful dachshund that 'speaks' three languages) was sleeping on the bed and I felt her. She slept and her fur was smooth, so I finally went back to sleep. Dogs, and cats, always know if there is a 'presence.' This place can become rather weird under the sunny surface. I don't really want to know, except where it touches my interest!"

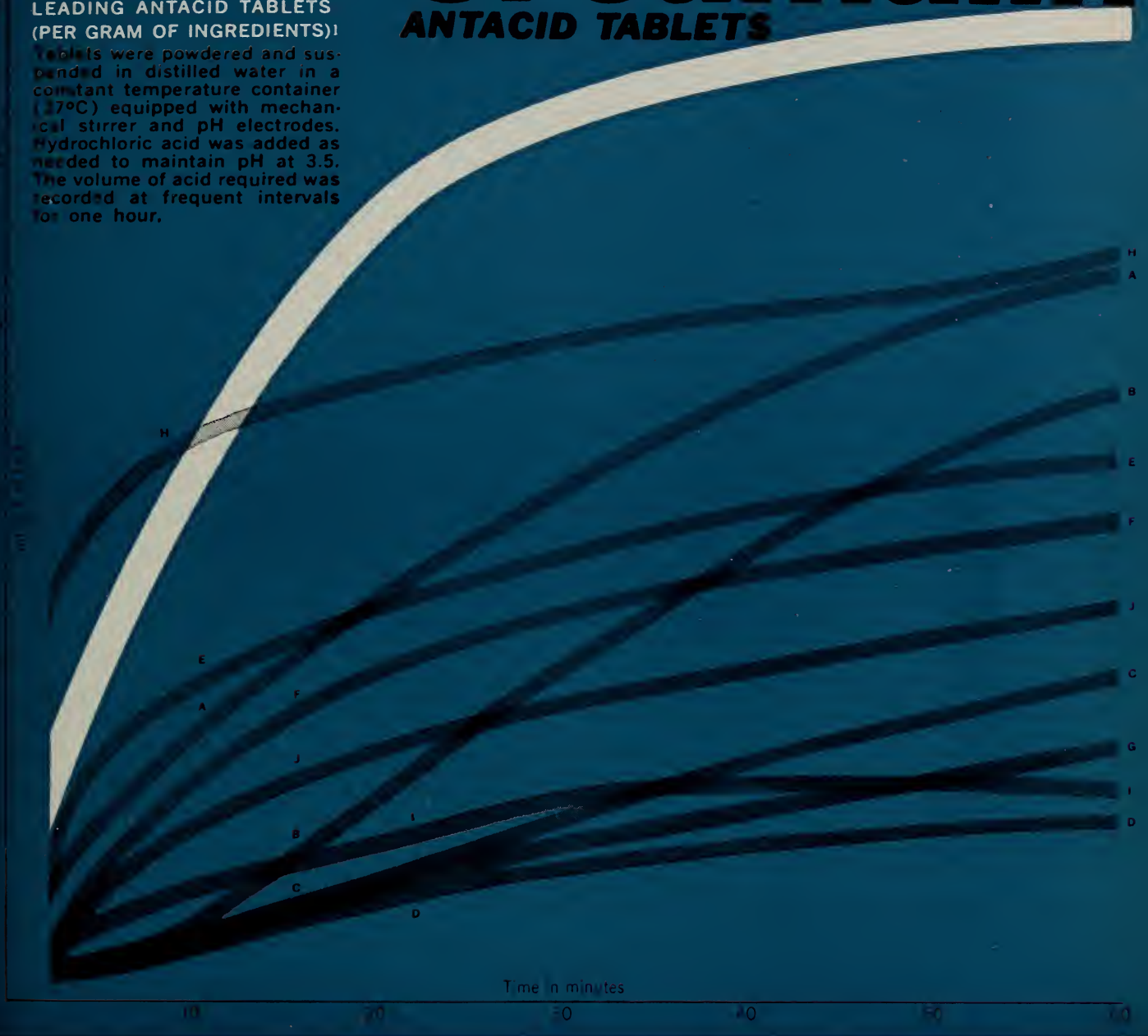
Thus far our artist seems to have avoided any serious clashes with Hawaiian haunts or kahu-

More gastric acid neutralized faster...with new Creamalin®

ANTACID TABLETS

ACID NEUTRALIZATION WITH LEADING ANTACID TABLETS (PER GRAM OF INGREDIENTS)[1]

Tablets were powdered and suspended in distilled water in a constant temperature container (37°C) equipped with mechanical stirrer and pH electrodes. Hydrochloric acid was added as needed to maintain pH at 3.5. The volume of acid required was recorded at frequent intervals for one hour.



GREATLY HEIGHTENED REACTIVITY to acid characterizes the action of New Creamalin Antacid Tablets.[1,2] They act faster and longer than other leading tablets and neutralize considerably more acid.[1] These tablets provide virtually the same effects as a liquid[2] with the convenience of a tablet. New Creamalin tablets give faster, greater and more prolonged relief.

NOT CONSTIPATING, New Creamalin Antacid Tablets will not produce "acid rebound" or alkalosis. They have a pleasant taste.

Creamalin, trademark reg. U. S. Pat. Off.

EACH NEW CREAMALIN ANTACID TABLET contains 320 mg. of specially processed, highly reactive, short polymer dried aluminum hydroxide gel (stabilized with hexitol), with 75 mg. of magnesium hydroxide.

Adult dosage: Gastric hyperacidity—2 to 4 tablets as necessary. Peptic ulcer or gastritis—2 to 4 tablets every two to four hours. Tablets may be chewed, swallowed whole with water or milk, or allowed to dissolve in the mouth.

How Supplied: Bottles of 50, 100, 200 and 1000.

1. Hinkel, E. T., Jr.; Fisher, M. P., and Tainter, M. L.: *J. Am. Pharm. A. (Scient. Ed.)* 48:380, July, 1959. 2. Hinkel, E. T., Jr.; Fisher, M. P., and Tainter, M. L.: *J. Am. Pharm. A. (Scient. Ed.)* 48:384, July, 1959.

Winthrop LABORATORIES New York 18, N. Y.

FOR PEPTIC ULCER • GASTRITIS • GASTRIC HYPERACIDITY

Add 1

continued

mas. (I keep forgetting to ask what a "kahuma" is—and am not sure I really want to know, either, except where it touches MY particular interests!)

However, she didn't avoid a monkey! Her latest escapade goes like this:

"Am writing this to tell you about an unusual day I had today . . . it's connected with the Hawaiian herbs business. I have a wonderful housekeeper, every once in a while. She is part Hawaiian and really more of a friend than help, so to speak.

"She is fascinated with the herb stuff I've been doing, and, as one thing leads to another, has started discussing the local flora and its medicinal usage with me. Her father 'cured' everything from his garden.

"So . . . today we went out herb hunting. I'm pressing samples, since I can't find all the Latin names. (Some I have found, but not all.) However, the usage is current and she has used them all . . . her husband, too, and some other people I've talked to.

"She is so enthusiastic that it's marvelous . . . anyway, we went into an estate (she knows the gardener) and found a lot of things. While we were walking through what seemed to be a natural forest (it is!) with vines, trees and plants (overlooking the road), a monkey came trotting down. I almost had a heart attack, convinced that the wilds were upon us!

"Hazel, the housekeeper, said, 'Hello, Dede,' and it was the beginning of a beautiful friendship. Dede and I fell in love. She followed us all over in our herb hunt, clung to my legs looking pleadingly at me as if to say, 'never leave me,' and then took a flying leap and landed, tail firmly established, on my arm.

"We had an extraordinary time. I never expected to be accompanied by a monkey . . . and so friendly.

"Thought you might be amused by the situation, since you got me into it."

She added that Lumpi (the dog) smelled her from head to foot, when she returned from her escapade, with a judicious mixture of consternation and disgust.

These are the latest from our artist in Hawaii in quest of herb "specials" for the *Journal*. I'm beginning to look forward to her notes on what happens to her in the quest for herb specimens as much as to the finished *Journal* articles and art.

Note Not to Be Noted

Shades of San Francisco color! The city that you don't call "Frisco" is proud of its characters and local color. But Indianapolis gave it a run for its name the other day with a pink, yes pink! wagon making like something out of the past, pulled by a horse decorated with pink flowers, and driven by a couple in clothing of a year long gone by.

Advertising a new restaurant south of the city (with all the annexing by the city, I'm not sure if it's in or out of the city limits). Anyhow, it reminded me of the Seals baseball team (coast league team before the Giants took over) trying to drum up fans by riding horseback through San Francisco's "Wall Street" district.

Man Bites Dog?

And from a past issue. Last September we ran the papers from an Indiana rabies symposium—and are still getting orders for reprints and requests for copies.

All of which brings to mind the story of Veterinarian White of White's Pet Hospital. Seems he's had five series of rabies shots and when he had a check made on the situation, to see if he was still safe from rabies, his titers were so high the physician suggested he bite the dog!

Lookout, Fido. ◄



"The doctor wasn't too encouraging, dear. He told me not to buy any long-playing records!"

Deaths . . .

Charles Eldridge Barnett, M.D.

A former Fort Wayne surgeon and researcher, Dr. Charles E. Barnett, died in January at his home in St. Petersburg, Fla. He was 93.

Dr. Barnett, a former president of the Mississippi Valley Medical Association and the Allen County Medical Society, practiced in Fort Wayne for 27 years, leaving there in 1932.

A graduate of the Indiana University School of Medicine in 1890, Dr. Barnett also attended the former Fort Wayne College of Medicine and later was professor of surgery-anatomy there.

He was a member of the American College of Surgeons and the American Urological Association, and a veteran of the Spanish American and First World wars.

Donnell R. Ivey, M.D.

Dr. Donnell R. Ivey, 82, retired Royal Centre physician, passed away Jan. 18. He had received his ISMA 50-year pin in 1954, having practiced for 40 years of that time in Royal Centre.

A graduate of Central College of Physicians and Surgeons in 1904, Dr. Ivey had been president of the Community State Bank at Royal Centre since 1933. He was a member of Masonic and Elks lodges and the Methodist church.

Hiram H. Jones, M.D.

Dr. Hiram H. Jones, who began his practice in Salamonia, Ind., in 1915, died Jan. 1, after an extended illness. He was 74.

A graduate of the Indiana University School of Medicine, Dr. Jones was a life resident of Jay County. He was a former teacher there, and was county coroner four years.

Dr. Jones served overseas with the Medical Corps in World War I and was a member of the Odd Fellows Lodge.

Harold A. Luckey, M.D.

Dr. Harold A. Luckey, 63, who was affiliated with the Wolf Lake Luckey Hospital for many years, died Jan. 19 at Whitley County Hospital.

A native and life-long resident of the Wolf Lake community, Dr. Luckey was a 1932 graduate of the Indiana University School of Medicine. He was a member of the Masonic Lodge, American Legion, Scottish Rite and Shrine.

Ivan J. Markel, M.D.

Dr. Ivan J. Markel, an Elkhart physician for more than 40 years, died Jan. 7 after suffering a heart attack at his office.

A graduate of Indiana University, where he played football in the early 1900's, Dr. Markel received his medical degree at Rush Medical School, Chicago.

Dr. Markel was instrumental in the establishment of the Elkhart county health unit and served as commissioner in its early days. He was a member of Tryian lodge, the Presbyterian church and a veteran of World War I.

Lindsey Morrison, M.D.

An 89-year-old retired Hammond physician, Dr. Lindsey Morrison, died Dec. 18 in his home.

Valedictorian of the medical class of 1900 at the University of Louisville, Dr. Morrison practiced in Louisville until moving to Hammond in 1922. He was a 50-year Club ISMA member.

Dr. Morrison, a proctology specialist, was president of the American College of Proctology in 1934, and former head of the staff at St. Margaret Hospital. He had retired in 1957.

District and County News

Allen

At a joint meeting with the Allen County Bar Association Feb. 2, members of the Allen County Medical Society heard Dr. Milton Helpern, chief medical examiner for New York City, discuss "Investigation of Sudden, Suspicious, Violent Deaths." Over 150 were present.

Carroll

Dr. Eldon Baker, Delphi, is the new president of the Carroll County Medical Society. Dr. George Wagoner was elected vice president for 1960, and Dr. Robert Seese is the new secretary-treasurer.

Clark

Twenty-five members of the Clark County Medical Society met at Jeffersonville Jan. 19, to hear a report on the Forand Bill and for a general business meeting.

County News

continued



NINTH DISTRICT physicians and their wives who gathered at Lafayette County Club Feb. 3 for a legislative meeting included (left to right): Dr. and Mrs. Peter Petrich and Dr. and Mrs. Lee J. Maris, all of Attica; Dr. K. O. Neumann, ninth district councilor, Lafayette; Dr. and Mrs. C. G. Kern, Lebanon; Dr. and Mrs. Hugh McAdams, Lafayette; Dr. and Mrs. Forrest Babb, Stockwell; Dr. Ramon DuBois, Lafayette; and Mrs. Robert W. Kohne, Lafayette. Not Pictured were Dr. Kohne and Dr. and Mrs. Robert W. Vermilya, Lafayette.

Decatur

Dr. Robert A. Porter, Westport, is the new president of the Decatur County Medical Society. Assisting him in 1960 will be Drs. D. D. Dickson, vice-president, Richard A. Dietz, secretary-treasurer, and William Shaffer, delegate.

Jackson-Jennings

Eighteen members of the Jackson-Jennings Medical Society met Jan. 23, for a general business meeting and a report on Federal legislation.

Jay

Members of the Jay County Medical Society have elected Dr. Elizabeth Tate the 1960 president. Other new officers include Drs. A. C. Badders, vice-president, R. M. Steffy, secretary-treasurer, William H. Cripe, delegate and F. E. Keeling, alternate delegate.

Jefferson-Switzerland

Dr. Francis W. Hare will serve as president of the Jefferson-Switzerland Medical Society in 1960. Assisting him will be Drs. George A. May, vice-president, and Marcella S. Modisett, secretary-treasurer.

Dr. Robert O. Zink is the delegate and Dr. Francis Prenatt the alternate delegate from Jefferson County. Representing Switzerland County will be Dr. Antha Ann Hamilton, delegate, and Dr. Noel Graves, alternate delegate.

Lake

Dr. F. F. Boys has been installed as president of the Lake County Medical Society. Assisting him are Drs. R. N. Bills, president-elect, and Dr. Leon Armalavage, secretary.

Branch presidents include Drs. D. T. Ramker, George Lewis and Lee Hickman. Those who will serve four-year terms on the council are Drs. F. R. LaFollette, A. F. Gregoline and Lowell Steen.

Owen-Monroe

Nineteen members of the Owen-Monroe Medical Society met Jan. 28 to hear Dr. Jerry Miller speak on properties of a new anesthetic agent, Fluothane, and psychological aspects of anesthesia.

Posey

Dr. L. John Vogel is the new president of the Posey County Medical Society. Serving as secretary-treasurer in 1960 will be Dr. Herman Hirsch. Drs. Frank W. Oliphant and John Christ will serve as delegate and alternate delegate, respectively.

continued



ATTENDING THE EIGHTH DISTRICT legislative meeting at Muncie on Feb. 4 were (left to right): Mrs. H. E. White, Farmland; Mrs. L. W. Painter, Winchester; Mrs. Charles Alvey, Muncie; Dr. B. B. Dulin, Dr. A. T. Jones, and Dr. P. T. Lamey, all of Anderson; and Dr. I. S. Hostettler, Dr. and Mrs. T. E. Stout, Dr. T. M. Brown and Dr. Leland Brown, all of Muncie. Dr. C. R. Chambers, Union City, Dr. J. L. Doenges, Anderson, and Dr. Dean Jackson, Hartford City, also attended the meeting.



ATTENDING THE SEVENTH DISTRICT legislative meeting at Indianapolis on Jan. 27 were (left to right): Dr. Jacob E. Gillespie, Indianapolis; Dr. Robert W. VanBokkelen, Mooresville; and Dr. Floyd A. Boyer, Dr. Ralph V. Everly, seventh district councilor, Mrs. James C. Katterjohn, Marion County Auxiliary legislative chairman, and Mrs. Donald J. White, Marion County Auxiliary president, all of Indianapolis.



SERENE SURROUNDINGS

ACCREDITED PSYCHIATRIC HOSPITAL FOR PRIVATE DIAGNOSIS AND TREATMENT

Approved by the Joint Commission on Accreditation of Hospitals.

Equipped to provide latest acceptable methods of treatment, including Out-Patient Pavilion.

Ample classification facilities with qualified psychiatric nursing.

Full occupational therapy and recreational activities.

Forty acre estate to assure privacy in a restful setting.

write to the address below for new illustrated brochure

WILLIAM E. HILLARD, M.D.
Medical Director

CHARLES W. MOCKBEE, M.D.
Associate Medical Director

ISABELLE DAULTON, R.N.
Director of Nursing

GRACE SPINDLER, R.N.
Associate Director of Nursing

ELLIOTT OTTE
Business Administrator

CHARLES M. CLIFFE
Associate Business Administrator



THE EMERSON A. NORTH HOSPITAL, Inc.
(Founded 1873)

5642 HAMILTON AVENUE, CINCINNATI 24, OHIO
Telephones: KIrby 1-0135 KIrby 1-0136

continued



ALSO ATTENDING THE SEVENTH DISTRICT MEETING were Robert Amick, from ISMA headquarters, Dr. John W. Hendricks, Indianapolis; Dr. and Mrs. Robert Foster, Franklin; Mrs. Harold Onyette, Greenwood; Mrs. Robert C. Bullers, Franklin; and Art Loftin, Marion County Medical Society executive secretary.

Putnam

Twelve members of the Putnam County Medical Society met at the Greencastle IBM plant in December for a tour and an explanation of the company's medical program.

New officers for 1960 are Dr. James B. Johnson, president and Dr. Frederick C. Reigle, secretary-treasurer.

Randolph

Dr. Wayne Harmon is the new president of the Randolph County Medical Society. Assisting him in 1960 will be Drs. Morris McClure, vice-president, and R. C. Chambers, secretary-treasurer.

Wabash

Dr. Richard M. LaSalle has been elected president of the Wabash County Medical Society. Other new officers include Drs. Robert M. LaSalle Jr., vice-president and Lloyd H. Smith, secretary-treasurer.

White

White County Medical Society members have elected Dr. Frank S. Baynes president for 1960. Other new officers are Drs. C. H. Mayfield, vice-president, and W. Martin Dickerson, secretary-treasurer.

Whitley

Dr. Donald Reid is the new president of the Whitley County Medical Society. Assisting him in 1960 will be Drs. Robert Roth, vice-president, J. B. Mishler, secretary-treasurer, C. J. Heritier, delegate, and John Langohr, alternate delegate. ◄

Indiana State Board of Health

DIVISION OF COMMUNICABLE DISEASE CONTROL

MONTHLY REPORT - January, 1960

Disease	Jan. 1960	Dec. 1959	Nov. 1959	Jan. 1959	Jan. 1958
Animal Bites	225	246	239	331	98
Chickenpox	879	592	180	622	602
Conjunctivitis	82	68	24	71	17
Diphtheria	1	1	0	0	0
Dysentery, Unspecified	67	40	23	31	102
Impetigo	88	97	72	38	25
Infectious Hepatitis	57	38	39	32	37
Infectious Mononucleosis	16	20	10	22	3
Influenza	2177	1114	583	730	665
Measles (Rubeola-Rubella)	578	280	95	643	654
Meningitis, Meningococcal	1	4	2	2	1
Meningitis, Other	9	49	17	6	8
Mumps	256	178	89	246	415
Pertussis	39	95	29	186	27
Pneumonia	272	259	98	275	167
Poliomyelitis	0	4	13	0	0
Streptococcal Infections	668	492	229	547	355
Tinea Capitis	12	16	5	13	32

Commission Meetings

Medical Education and Licensure

Sunday, Nov. 15, 1959
(Student Union Building)

The meeting of the Commission on Medical Education and Licensure was called to order at 2 p.m., Sunday, Nov. 15, 1959.

The following members were present:

Francis L. Land, M.D., chairman; Kenneth G. Kohlstaedt, M.D., secretary; Robert W. Harris, M.D., Harry Klepinger, M.D., Dallas Fickas, M.D., Elton R. Clarke M.D., Kemper N. Venis, M.D., Jack E. Shields, M.D., William N. Wishard Jr., M.D., and Ralph C. Eades, M.D.

Doctor Kohlstaedt read the minutes of the last meeting. The minutes were accepted as read.

Doctor Land then discussed the resolution known as Resolution (A) concerning intern training introduced by the Council at the 1959 Convention of the Indiana State Medical Association.

It was understood that this resolution would be introduced at the AMA meeting in December.

Doctor Land discussed the I. U. Medical Center announcement of a Two-Year Family Practice Program. It seems that this program is the only one of this type in a medical school in the United States.

Doctor Kohlstaedt mentioned that the Marion County General Hospital has been working in cooperation with the medical school on this program.

Suggestions Discussed

The suggestions made by last year's commission were discussed:

1. The establishment of a mid-winter scientific (only) meeting at French Lick.

The commission members considered such a meeting impracticable.

2. Further study of the problems pertaining to osteopathy in our state.

It was suggested that the committee on licensure continue a study on this subject.

3. Closer liaison with teaching profession with view to examining medical and scientific teachings prior to adoption as a prophylactic measure.

It was decided that Dr. Clarke continue his work on this subject. He was made chairman of this committee.

Suggested School Health Policies for Indiana. Dr. Jack Shields, chairman, Dr. Dallas Fickas and Dr. Robert W. Harris to work as committee to have a report on this for the Executive Committee in December.

4. A thorough study of internships in Indiana.
   a. How long should they be?
   b. What should be included, excluded in their programs?

The Council on Medical Education states what this should be.

Dr. Klepinger was appointed to make arrangements with the heads of the medical school to coordinate a meeting on Hospital Intern Day.

   c. We should support the Land Resolution presented to the AMA House of Delegates.

It was moved and seconded that the commission would support this resolution.

Teaching in Medical Schools

   d. We should interest our profession more with regard to teaching in the medical schools and their curricula.

It was decided that the commission is interested in this and would like to know what is being done to modernize the curricula. It was agreed to have a special meeting and invite the Liaison Committee of the State Medical Association and representatives from the medical school who are informed on the curricula.

This meeting would be under the direction of the sub-committee on education and Dr. Eades is to handle this meeting.

5. Consideration of types and content of residency training in our hospitals.
   a. All post-graduate work should be evaluated.

Regulations are well defined in the Essentials.

6. Study the varieties of nursing school teachings offered in our hospitals.
   a. How badly, if at all, is an outpatient department needed?

Dr. Land suggested that the commission have a sub-committee to study nursing recommendations and actions we could take to have a more practical educationl program. Dr. Kohlstaedt and Dr. Harris were appointed to this committee.

State Registration Board

7. What should be the relationship of our Indiana State Board of Registration to national boards?

This was put on the agenda for a later meeting.

8. What should we do about temporary training permits, especially for foreign doctors?

It was suggested that the sub-committee on licensure make recommendations for the commission to act upon at the next meeting.

9. Methods of publicizing medical ethics.

The commission decided that this had to do definitely with the sub-committee on education.

Dr. Kohlstaedt suggested that the commission ask Dr. Wood to attend a commission meeting.

It is recommended to the Council of the Indiana

State Medical Association that a special commission be established to explore all avenues and anything that can be done to improve and stimulate interest in medical ethics, especially re-education among the medical profession.

10. The art of medicine should be present both within and without the profession.

(The commission does not understand this recommendation.)

11. Scientific medicine, *per se,* should be evaluated.

(The commission does not understand this recommendation.)

12. Better liaison with University Chapter, Student AMA.

This was not discussed at length, but it was the belief of the commission that there is a good liaison with the Student AMA.

13. Interest the doctors in getting practice of medical principles over to their patients.

It was agreed that No. 13 would fall under No. 9, as per above.

14. Invite M.D.'s to attend various committee meetings.

Meetings Open to Doctors

It was the consensus that most commission meetings were open to attendance by the doctors.

15. We should "re-think" our position and assert ourselves in a more positive way, concertedly.

(The commission does not understand this recommendation.)

16. The district meetings need to be studied, evaluated and given a thorough overhauling.

a. Stimulate attendance.

b. Better programs.

c. Better, more efficient organization.

(The commission agrees this should be done but does not consider it a problem of the commission)

The Sub-Committee on Licensure. It seems that narcotic addiction is becoming a problem. It was agreed that the California plan for addicts is an interesting one and should be looked into.

It seems that another problem is that of nurses practicing medicine, making house calls, diagnosing cases, etc. It is felt that something should be done about this.

Future Meetings

National Medical Education and Licensure meeting in Chicago, Feb. 7-9. Dr. Land suggested having the next commission meeting in Chicago on the closing day of this meeting; however, no date was set for the next meeting. It was suggested that Mr. Waggener contact the AMA for the program of this meeting and have one sent to each member of this commission.

The meeting was adjourned. ◄

Association News

EXECUTIVE COMMITTEE

Jan. 9, 1960.

Roll call showed the following present: Don E. Wood, M.D., chairman; Wendell E. Covalt, M.D.; Earl W. Mericle, M.D.; Guy A. Owsley, M.D.; Maurice E. Glock, M.D.; Okla W. Sicks, M.D.

Frank B Ramsey, M.D., editor of *The Journal;* Robert Hollowell and Ralph Hamill, attorneys, and James A. Waggener, executive secretary.

The annual audit for 1959 was explained by the treasurer in the form of a report. Both the audit and the treasurer's report were approved on motion of Drs. Mericle and Covalt.

Membership Report

Number of members as of December 31, 1958	4,201
1959 members as of December 31, 1959:	
Full dues paying (including 12 *new* members at $30)	3,563
Interns	39
Residents	174
Council remitted	40
Senior	396
Military	43
Honorary	1
Total 1959 members as of December 31, 1959	4,256
Gain over last year	55
Number of members December 31, 1958	4,201
Delinquent members as of December 31, 1959	3
Number of AMA members as of December 31, 1958	4,046
1959 AMA members: Dues paying	3,385
Exempt, but active	733
Total 1959 AMA members as of December 31, 1959	4,118
Gain over last year	72
Number of AMA members as of December 31, 1958 (including 6 members who paid AMA dues in 1959)	4,052
Delinquent AMA members as of November 30, 1959	13
(The above paid 1958 AMA dues but not 1959)	
Number who have paid state dues but not AMA dues in 1959	124
	137

Headquarters Office

The secretary reported on the activities of the field staff in working with county societies, hospital staffs, on various matters.

(Advertisement)

Tetracycline Phosphate Complex (TETREX®)
U.S. PAT. NO. 2,791,609

in the Therapy of

ACUTE PHARYNGITIS, ESPECIALLY WITH LYMPHADENITIS

Ideally, selection of the proper antibiotic for treatment of acute pharyngitis should await the laboratory reports on the susceptibility of the infecting bacteria. But the busy practitioner who sees many patients a day during the upper respiratory infection season may sometimes find it difficult to avoid the empirical choice of an antibiotic. Unfortunately, this practice may sometimes result in therapeutic failure.

No matter what the pressure of the immediate situation, it is worthwhile to consider taking a bacterial specimen from the infected pharynx for culture and sensitivity studies before starting treatment. Thus, a rational basis will be provided for changing the antibiotic should the first choice prove ineffective.

Which Antibiotic?

All other things being equal, the drug of choice is the one to which the pathogen is most susceptible. But if the exigencies of the situation force the physician to a prompt use of antibiotic, a broad-spectrum preparation that produces immediate high blood levels (e.g., tetracycline phosphate complex, TETREX) probably has the best chance of controlling the pathogen.

Later, the laboratory report frequently may indicate that any one of several antibiotic agents would be equally effective against the particular microorganism in question. In such a case other factors such as frequency and severity of side effects, sensitizing potential and toxicity should be considered.

If the acute pharyngitis in question should be due to gram-negative Klebsiella[1], penicillin will be of no value, nor will erythromycin be effective. However, this organism is susceptible to tetracycline. If the pathogen should turn out to be gram-positive Streptococcus or Staphylococcus, then penicillin, erythromycin, and tetracycline may all be effective against it.

Penicillin, however, in addition to having a limited spectrum, also causes many minor and some serious sensitivity reactions. In a recent survey[2] it was found that penicillin produced severe skin reactions. But most important was the observation that anaphylactic shock, with a fatality rate of about 9 per cent, was the most frequent serious reaction. Such severe reactions are almost always associated with parenteral administration.

The tetracyclines (e.g., TETREX) have the advantages of a broad range of antimicrobial activity and low toxicity. And in addition, the physician does not have to trouble himself or his patients with repeated blood studies when he prescribes TETREX. Minor reactions such as gastric upsets or mild skin rashes occur occasionally. The most serious side effects are staphylococcal and monilial overgrowth, but these are rare and can be adequately controlled.

Some Microorganisms Susceptible[a] *to Tetracycline* (TETREX)[b]

Streptococcus; Staphylococcus; Pneumococcus; Gonococcus; Meningococcus; *C. diphtheriae; B. anthracis; E. coli;* Proteus; *A. aerogenes; K. pneumoniae;* Shigella; Brucella; *P. tularensis; H. influenzae; T. pallidum;* Rickettsiae; Viruses of psittacosis and ornithosis, lymphogranuloma inguinale, primary atypical pneumonia; *E. histolytica; D. granulomatosis.*

[a] Some strains are not susceptible.

[b] Table adapted from Goodman, L. S., and Gilman, A.: The Pharmaceutical Basis of Therapeutics, 2nd edition, New York, The Macmillan Co., 1956, pp. 1322-1323.

High blood, body fluid, and tissue levels of active drug are quickly attained when the new phosphate preparation of tetracycline (TETREX) is used.

The semisynthetic tetracyclines have been in constant use since they were introduced in 1952. They have been proved clinically and have established themselves as safe, effective, and valuable antibiotic agents. But the final decision, the choice of agent, and the control of therapy must remain where it has always been, in the hands of the individual physician.

References: 1. Zinsser, H.: A Textbook of Bacteriology. 11th edition, New York, Appleton-Century-Crofts, 1957, p. 409. 2. Welch, H.: Lewis, C. H.; Weinstein, H. I., and Boeckman, B. B.: Severe reactions to antibiotics. A nationwide survey. Antibiotic Med. & Clin. Ther. 4:800 (December) 1957.

BRISTOL LABORATORIES
Division of Bristol-Myers Company
SYRACUSE, NEW YORK

The secretary presented a letter from Barton, Curle & McLaren giving quotation on insurance covering office furniture and equipment and materials carried by the field staff. Mr. Hollowell reported on his examination of the proposed policy, and by consent it was agreed to purchase $20,000.00 worth of insurance covering the headquarters office.

The secretary reported on the condition of the addressograph and the offer which had been made for exchanging it for a new machine, and this was approved on motion of Drs. Mericle and Owsley.

Legislation

National. Dr. Wood reported on the arrangement for the dinner meeting on Monday night, January 11, at which time Dr. Louis Orr would address representatives of other organizations, and the secretary was instructed to prepare host badges for physicians who would be in attendance.

1960 Annual Convention Oct. 2-5, 1960, French Lick

A discussion was held regarding the results of the meeting held Dec. 16 with the presidents of the various specialty groups, and upon motion of Drs. Owsley and Mericle the president was instructed to write a letter to the presidents of these various specialty groups following their 1960 annual meeting to find what decision was made by the respective groups toward combining their 1961 meetings with that of the Indiana State Medical Association.

It was taken by consent that a wire should be directed to these groups at the time of their annual meeting over the signature of the president and president-elect urging them to take favorable action on the proposal to combine their 1961 meetings with that of the Association.

Organization Matters

Permanent membership cards for senior members. The secretary presented the idea of issuing a permanent membership card for senior members and a quotation on a gold card. Upon motion of Drs. Glock and Mericle the policy of issuing a permanent membership card for senior members was approved and the secretary was instructed to obtain samples of other type of cards and prices thereon.

Letter from Dr. A. C. Offutt concerning the appointment of three representatives of the Indiana State Medical Association to the Advisory Hospital and Health Center Planning Council was read and by consent the secretary was instructed to notify Dr. Offutt to reappoint David L. Adler, M.D., Kenneth L. Olson, M.D., and James W. Crain, M.D.

Medicare. Medicare contract modifications were presented to the committee. Upon motion of Drs. Glock and Mericle these were to be referred to the attorney for review and if approved the president was authorized to sign.

The request of the Hoosier State Press Association for the Association to take space in its annual convention issue of *The Indiana Publisher* was approved on motion of Drs. Owsley and Glock.

On motion of Dr. Owsley, taken by consent, the secretary was instructed to make plans for the members who will go to Washington in May for the annual meeting with the Indiana delegation in Congress and their staffs, and to stay over as delegates to the annual meeting of the United States Chamber of Commerce.

A letter asking the association to make a contribution to the American Economic Foundation was referred by consent to the Commission on Medical Economics and Insurance.

A letter of thanks from Mr. Hollowell for the sympathy expressed to him in the death of his wife was read.

The secretary presented his correspondence with the Joint Commission on Accreditation of Hospitals concerning the holding of staff meetings outside of a hospital and in conjunction with the county medical society meetings. Upon motion of Drs. Glock and Covalt the secretary was instructed to send copies of this correspondence to the officers of all county medical societies.

New Business

Headquarters building.

The attorneys discussed the question which had been raised regarding the apparent conflict which existed between the action of the House of Delegates and the Constitution and Bylaws of the state medical association on the placement of authority for the building program, and presented the following memorandum:

House of Delegates resolution:

"We move that the Council of the Indiana State Medical Association be empowered by the House of Delegates to proceed with the business of the construction of a headquarters office building at a total cost not to exceed $250,000."

* * * * * * * * *

"We move that the chairman of the Council shall appoint, with the concurrence of the Council, a board of five members from the Indiana State Medical Association, who will be known as the 'Building Committee,' with authority to obtain real estate for, and to construct an office building for the Indiana State Medical Association, this committee subject to the help and direction of the Executive Committee. This committee to have a duration of appointment coinciding with the time necessary for the completion of this project."

* * * * * * * *

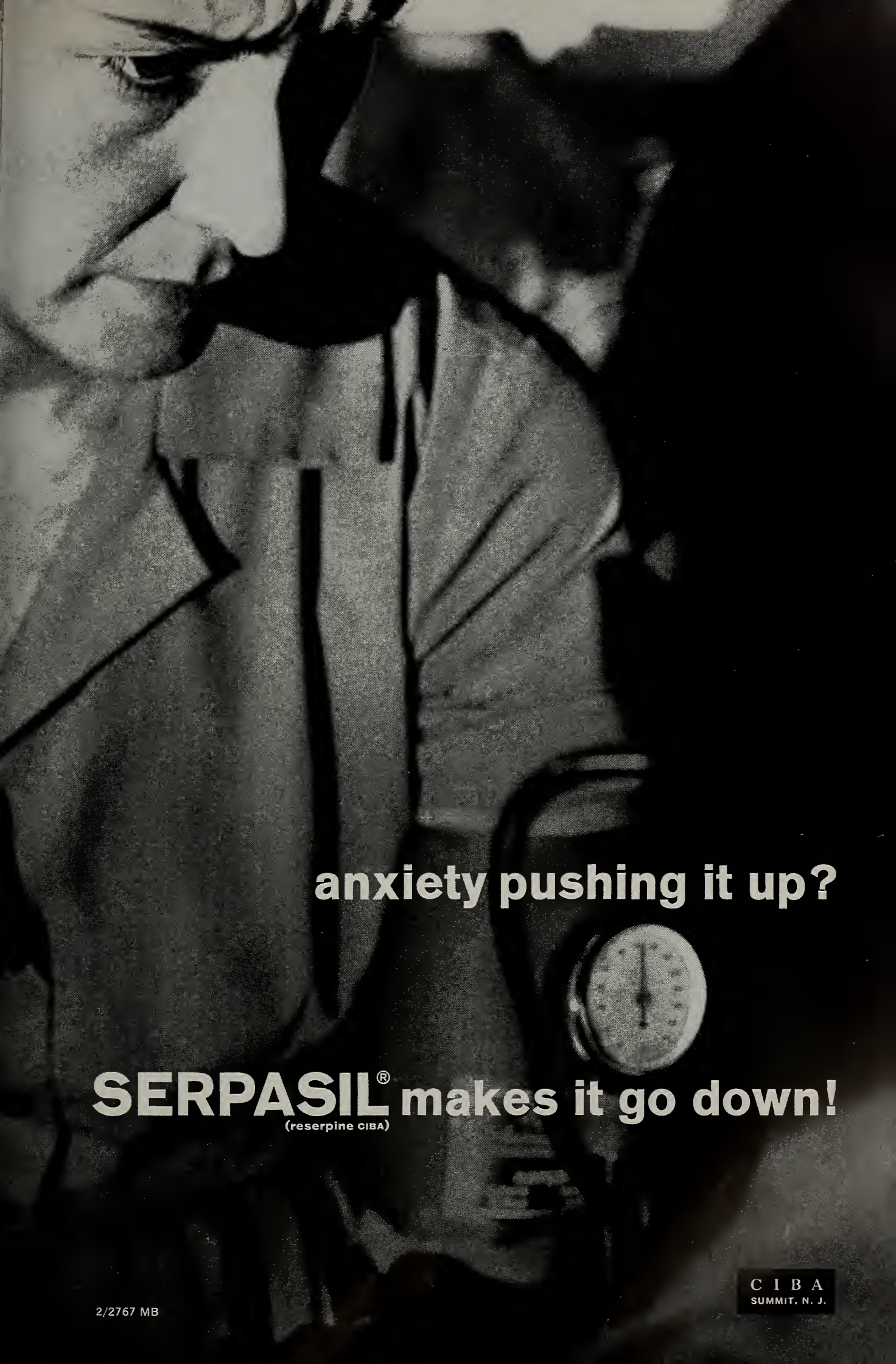
"We move that the Council be advised by the House of Delegates to implement the financial procedure necessary for the construction of this building."

Constitution

Article VI—Council "* * * it shall constitute the Board of Trustees of this organization, having full charge and control of all the property of the Association."

Bylaws

Chapter XXIX—Investment of Surplus Funds. "Section 1. The investment of all surplus funds of this Association shall be under the direct control and


anxiety pushing it up?
SERPASIL® makes it go down!
(reserpine CIBA)
2/2767 MB
CIBA
SUMMIT, N. J.

management of the Executive Committee, subject to instructions in regard thereto which may be given by the Council at its option. The Executive Committee shall have the right and is encouraged to obtain the advice and counsel of the investment departments of any bank or trust company of Indianapolis in regard to the discharge of the duties covered by this chapter of the Bylaws."

In addition, under Article VI, the Council has the power of the House between sessions, except legislative functions. Under Chapter IX of the Bylaws—Executive Commitee, it is provided:

"* * * It shall make decisions for the Association, including matters pertaining to the *Journal*, during the intervals between the meetings of the Council, and shall report its actions to the Council."

Upon motion of Drs. Mericle and Glock, the following resolution was adopted by the Executive Committee:

"WHEREAS by Section 1 of Chapter XXIX of the Bylaws, the investment of all surplus funds of this Association is under the direct control and management of the Executive Committee, subject to instructions in regard thereto which may be given by the Council at its option; and

"WHEREAS a resolution of the House of Delegates at the last annual convention provided for a 'Building Committee with authority to obtain real estate for, and to construct an office building for the Indiana State Medical Association; this committee subject to the help and direction of the Executive Committee.

"BE IT THEREFORE NOW RESOLVED that the Building Committee be directed and authorized to select and purchase real estate for a site for the construction of a building."

Upon motion of Drs. Mericle and Owsley the attorneys were called upon to prepare necessary resolutions for submission to the Council.

Stump Memorial Lecture. Dr. Wood announced that the first Albert Stump Memorial Lecture would be given at noon on Jan. 27, 1960, and extended an invitation to the members of the Committee to attend.

Mr. Hollowell reported that in reviewing the proposed site under consideration by the Association for a building he had found it necessary to obtain information concerning the insurability of title, etc., and that the transcript had cost him some $56.00. This amount was allowed upon motion of Drs. Mericle and Covalt.

The Journal. The editor gave a brief report on the *Journal* and told of the necessity of changing deadlines in order to meet publication schedules.

By consent it was agreed that the Committee would meet again at 3:00 p. m., on Wednesday, Feb. 17, 1960.

There being no further business the meeting was adjourned.

THE COUNCIL

January 10, 1960.

The Council of the Indiana State Medical Association convened for its midwinter meeting at 10:00 a.m. (EST), Sunday, Jan. 10, 1960, in Room M-124, Indiana University Student Union Building, Indianapolis, with Dr. Maurice E. Glock, chairman, presiding.

Roll call showed the following present:

COUNCILORS

First District—William B. Challman, Mount Vernon
Second District—J. H. Crowder, Sullivan; Philip T. Holland, Bloomington, alternate
Third District—John M. Paris, New Albany (also AMA alternate delegate)
Fourth District—Joe M. Black, Seymour
Fifth District—Robert K. Webster, Brazil; V. Earle Wiseman, Greencastle, alternate
Sixth District—Harry P. Ross, Richmond
Seventh District—Ralph V. Everly, Indianapolis; Charles A. Jones, Franklin, alternate
Eighth District—Guy A. Owsley, Hartford City (also president-elect); Gordon B. Wilder, Anderson, alternate (also AMA delegate)
Ninth District—Kenneth O. Neumann, Lafayette; A. E. Stouder, Kempton, alternate
Tenth District—James P. Vye, Gary
Eleventh District—Max R. Adams, Flora; Earl W. Bailey, Logansport, alternate
Twelfth District—Maurice E. Glock, Fort Wayne
Thirteenth District—Burton E. Kintner, Elkhart; Raymond E. Nelson, South Bend, alternate

OFFICERS

Earl W. Mericle, Indianapolis, president
Okla W. Sicks, Indianapolis, treasurer
Harry Pandolfo, Indianapolis, assistant treasurer
Frank B. Ramsey, Indianapolis, editor, THE JOURNAL
A. W. Cavins, Terre Haute, associate editor, THE JOURNAL

EXECUTIVE COMMITTEE

Don E. Wood, Indianapolis, chairman
Wendell E. Covalt, Muncie, member

GUESTS

Harold C. Ochsner, Indianapolis, AMA delegate
Francis L. Land, Fort Wayne, AMA delegate
Robert M. Brown, Marion, AMA alternate delegate
Cleon A. Nafe, Indianapolis, member of AMA Board of Trustees
Philip B. Reed, Indianapolis, chairman, Grievance Committee
Edward T. Edwards, Vincennes, vice-chairman, Commission on Medical Economics and Insurance
A. C. Offutt, Indianapolis, State Health commissioner
Jack E. Shields, Brownstown
R. Case Hammond, Evansville
Frederic W. Brown, Fort Wayne
Mr. John B. Twyman, Gary, excutive secretary, Lake County Medical Society

STAFF

Robert Hollowell, Indianapolis, attorney
Ralph Hamill, Indianapolis, attorney
Howard Grindstaff, field secretary
J. A. Waggener, executive secretary

The chairman introduced Judge Ralph Hamill, Indianapolis, new associate legal counsel for the association.

On motion of Drs. Neumann and Paris, minutes of the Council meetings held at Indianapolis on October 5 and 9, 1959, were approved as printed in the December, 1959, issue of *The Journal.*

Reports of Councilors

The councilors announced, or confirmed, the following district meeting dates for 1960:

First District—Mount Vernon, May 19, 1960
Second District—Vincennes, May 26, 1960


the clock strikes 2
and your ulcer patient
sleeps undisturbed
daricon®
oxyphencyclimine HCl, 10 mg. tablets
2 tablets daily—'round-the-clock relief
from ulcer and other GI disorders.
Additional information is available on request from the Medical Department,
Pfizer Laboratories, Division, Chas. Pfizer & Co., Inc., Brooklyn 6, New York.
Pfizer Science for the world's well-being™

Third District—French Lick, May 18, 1960
Fourth District—Columbus, May 11, 1960
Fifth District—Greencastle, May 25, 1960
Sixth District—Shelbyville, May 11, 1960
Seventh District—Indianapolis, May 18, 1960 (tentative)
Eighth District—Anderson, June 8, 1960
Ninth District—Lafayette, May 18, 1960
Tenth District—Whiting, May 11, 1960 (tentative)
Eleventh District—Wabash, May 18, 1960
Twelfth District—Fort Wayne, May 3, 1960
Thirteenth District—Elkhart, September 28, 1960

(On motion of Drs. Neumann and Everly, the Council authorized a letter sent to each of the retiring councilors expressing the appreciation of the Council for the service they had given to the Association and the Council during their terms as councilors.)

Reports of Officers

DR. EARL W. MERICLE, president:

Since the last Council meeting it has been my privilege to go to the district meeting at South Bend and an installation of officers meeting at Gary. I can report to you that the county and district societies are very healthy. There is plenty going on in Gary and it is being well handled.

I have one other matter to bring up; that is in regard to the Pharmaceutical Association. Yesterday Dr. Karl L. Kaufman, dean of Pharmacy at Butler University, brought a request to me in which he is asking some consideration from us in this present situation in which the drug manufacturers are being criticized for the prices that are being charged for drugs. Dr. Kaufman doesn't ask anything special except he would like something like the following to be published in our *Journal* if we see fit. Here is his request and I would like to read it, with your permission.

"A representative of the Indiana Pharmaceutical Association has approached me to discuss some serious problems facing this group. Because of the possible ramifications I believe these problems merit attention and thought by every physician. I might point out that our friends in Pharmacy do many favors for us. They have helped us in past and current battles in Congress, and in our public relations efforts. The practicing pharmacists are concerned over the Kefauver hearings, even though the retail segment is not supposedly included in the committee charges. They point out that there is real danger in the present political climate of passage of the Forand Bill, or worse. We need not draw a picture to recognize the dangers in this or other proposals which would not only be wasteful but would hamper medical progress.

"Since Kefauver will undoubtedly continue to manipulate the headlines for his own purposes, much grass roots efforts will be required to prevent an increasingly hostile attitude toward all the medical arts.

"The practicing pharmacist feels the public pulse, especially when he presents the prescriptions to our patients. He finds price complaints increasing. Not infrequently, I am told, patients claim the physician has said, 'This is too expensive, but it's not my fault.' When the patient starts thinking about costs he soon resents the physician's fee, too. As a matter of protection to the pharmacist, as well as to the physician, it would be helpful for the latter to say, 'I'm prescribing an expensive drug. This is one of the newer drugs, but it is quicker and more effective.' Usually the patient takes this as a signal of higher cost and says nothing.

"If the question of price is raised, an excellent opportunity is given to point out that it may cost as much as six million dollars from conception to marketing of a truly new drug and that about only 10% of these make profit. Of course the pharmacist on the corner would not be unhappy if it were pointed out that even with his high inventory he averages only about 33% gross on prescriptions, which is less than several other types of stores. Also, it may be noted that he has been scrupulous in avoiding comments about our fees, and we sometimes could be more thoughtful regarding the implications for him in our own comments to patients. As Sir Thomas Perceval said, 'Amicable intercourse and cooperation will lead to the authority of one and the usefulness of both.'"

This is the request of Dr. Karl Kaufman—that this or something similar to this be published in our *Journal* which will indicate to our members and to people at large that we are back of the pharmacists as they have been back of us.

(On motion of Drs. Challman and Everly, the Council approved of publication in *The Journal* of a condensation of Dr. Mericle's remarks, the article to be written by the editor of *The Journal,* and to be submitted to Dr. Kaufman prior to publication.)

Dr. Neumann commented that he appreciated receiving the news notes that Dr. Mericle had been sending out during the last few months and he hoped this feature would be continued.

DR. OKLA W. SICKS, treasurer, in presenting the audit compiled by Wolf and Company, certified public accountants, explained that inasmuch as the fiscal year of the association is now Oct. 1 to Sept. 30 (by House of Delegates action), the audit for 1959 is for the nine months ended Sept. 30, 1959. He also called attention to the fact that the accounts of the association are now being kept on an accrual basis, rather than a cash basis as was the case prior to 1959.

Dr. Sicks reported that the following transactions in securities had been completed since the last meeting of the Council:

General Fund: The $5,000 U. S. Savings Bond, G, No. V-940-006-G, due December 1960, was transferred to new U. S. Treasury Note at 4¼% (was 2.5%) to mature in May 1964.

The U. S. Savings Bonds, G, Nos. V-765-543-G and V-805-738-G, for $5,000 each, which matured in 1959, were cashed and the funds placed in 91-day U. S. Treasury Bills at 4½% (was 2.5%), to be held for use in leasing building grounds, etc.

The $30,000 in Treasury Bills, held in escrow for payment of the $10.00 per member to the American Medical Education Foundation, was deposited to the General Fund checking account upon maturity.

The $10,000 in Treasury Bills, matured Dec. 23, 1959, was deposited in the General Fund checking account.

Medical Defense: The $3,000 in U. S. Treasury Bills, due Dec. 10, 1959, was reinvested in U. S. Treasury Bills at 4.5% (was 3.94%).

The $2,000 in Treasury Bills, matured Dec. 31, 1959, was deposited in the Medical Defense checking account to pay attorney fees in defense cases.

(On motion of Drs. Paris and Webster, Dr. Sicks' report was approved.)

The report of Wolf and Company follows:

The Council
Indiana State Medical Association
Indianapolis, Indiana

Gentlemen:

We have examined the financial records of Indiana State Medical Association for the period January 1 to September 30, 1959. Our examination was made in accordance with generally accepted auditing standards, and accordingly included such tests of the accounting records and such other auditing procedures as we considered necessary in the circumstances.

The accounts of the association, previously maintained on a cash receipts and disbursements basis, were converted to the accrual basis on January 1, 1959, a change which we approve. The adjustments to net assets arising from the change are detailed in Exhibit B, Statement of Net Assets.

In our opinion, the accompanying financial statements present fairly the position of Indiana State Medical Association at September 30, 1959, and the results of its operations for the nine months then ended, in accordance with generally accepted accounting principles.

Respectfully submitted,
WOLF AND COMPANY
Certified Public Accountants

Indianapolis, Indiana
October 28, 1959

Indiana State Medical Association
Indianapolis, Indiana

Exhibit A

STATEMENT OF FUNDS

September 30, 1959

ASSETS

General fund:			
Cash			$ 25,480.66
Note receivable	$ 1,857.62		
Loan receivable	1,000.00		2,857.62
Deposits:			
Postmaster	284.14		
Insurance	56.80		340.94
Expense advances			238.33
Accrued interest receivable			1,862.29
Due from medical defense fund	1,947.80		
Due from student loan fund	5,101.29		7,049.09
Reimbursement due for Medicare expenses			1,670.87
Investments, at cost, less amortization:			
U. S. Treasury bonds	145,544.39		
U. S. Treasury bills	49,665.10		
U. S. Savings bonds	96,000.00		
	291,209.49		
Less accumulated amortization	336.08		290,873.41
Office furniture and equipment:			
General office	15,692.30		
Medicare office	4,437.52		
	20,129.82		
Less accumulated depreciation	4,882.68	15,247.14	$345,620.35
The Journal:			
Cash		5,311.95	
Accounts receivable:			
Advertising	14,871.34		
Other	225.06	15,096.40	
Due from general fund		19,913.48	
Postal deposits		303.09	40,624.92
Medical defense fund:			
Cash		3,293.51	
Accrued interest receivable		121.96	
Investments, at cost, less amortization:			
U. S. Treasury bonds	14,235.94		
U. S. Treasury bills	4,950.30		
U. S. Savings bonds	9,000.00		
	28,186.24		
Less accumulated amortization	189.49	27,996.75	31,412.22
Student loan fund:			
Cash		1,470.06	
Notes receivable		18,964.40	20,434.46
			$438,091.95

LIABILITIES

General fund:			
Liabilities:			
Accounts payable		$ 4,858.98	
Accrued payroll taxes		102.66	
Due American medical education fund		34,370.00	
Due The Journal		19,913.48	
Unrealized convention income		17,073.89	
Dues collected in advance		32,249.25	
Deposits on tape recordings		377.00	
		108,945.26	
Net assets (Exhibit B)		236,675.09	
			$345,620.35
The Journal:			
Accounts payable		8,162.00	
Net assets (Exhibit B)		32,462.92	
			40,624.92
Medical defense fund:			
Due to general fund		1,947.80	
Net assets (Exhibit B)		29,464.42	
			31,412.22
Student loan fund:			
Due to general fund		5,101.29	
Net assets (Exhibit B)		15,333.17	20,434.46
			$438,091.95

Exhibit B

STATEMENT OF NET ASSETS

For the Nine Months Ended September 30, 1959

General fund:		
Balance, December 31, 1958		$217,642.83
Adjustment arising from change in accounting method, January 1, 1959 (Note):		
Add:		
Note receivable	$ 2,372.79	

Prior year billing—			
Medicare		2,425.42	
Refund prior year expenses		120.57	
Premium on bond purchases (net)		206.45	
Furniture and equipment (net)		12,774.72	
Postal deposit		199.47	
		18,099.42	
Deduct:			
Accounts payable—trade	$ 3,049.53		
Accrued expenses	4,369.36		
Employe payroll deductions	258.75		
Deposits on tape recordings	638.01		
Current year dues received in prior year	5,507.00	13,822.65	4,276.77
Adjusted balance, January 1, 1959			221,919.60
Net revenues (Exhibit C)			14,755.49
Balance, September 30, 1959			236,675.09
The Journal:			
Balance December 31, 1958			4,152.96
Adjustment arising from change in accounting method, January 1, 1959 (Note)—accounts receivable (net)			21,779.82
Adjusted balance, January 1, 1959			25,932.78
Net revenues (Exhibit D)			6,530.14
Balance, September 30, 1959			32,462.92
Medical defense fund:			
Balance, December 31, 1958			26,639.90
Net revenues (Exhibit E)			2,824.52
Balance, September 30, 1959			29,464.42
Student loan fund:			
Balance, December 31, 1958			15,293.29
Adjustment of student notes receivable related to prior year transaction			2.83
Net revenues			37.05
Balance, September 30, 1959			$ 15,333.17

Note:

The accounts of the association, previously maintained on the cash basis, were converted to the accrual basis at January 1, 1959.

Exhibit C

STATEMENT OF REVENUES AND EXPENDITURES

For the Nine Months Ended September 30, 1959

GENERAL FUND

Revenues:	Amount	Estimated (Annual)	Unrealized
Dues	$147,796.75	$179,966.00	$ 32,169.25
Less dues allocated:			
The Journal	11,934.00	11,922.00	12.00*
Medical defense fund	4,745.00	4,742.50	2.50*
American Medical Education fund	34,370.00	34,360.00	10.00*
	51,049.00	51,024.50	24.50*
Dues available for operations	96,747.75	128,941.50	32,193.75
Interest on investments	7,291.72	7,000.00	291.72*
Received from A.M.A.	734.38		734.38*
Other income	735.62	1,000.00	264.38
Total revenues	105,509.47	136,941.50	31,432.03

Expenditures:	Amount	Budgeted (Annual)	Unexpended
Committees and commissions (Schedule C-1)	16,038.95	23,100.00	7,061.05
Officers and council (Schedule C-2)	6,912.14	13,095.00	6,182.86
Headquarters office (Schedule C-3)	57,750.66	75,255.00	17,504.34
Women's auxiliary	1,005.25	1,005.25	
Employes retirement fund	4,682.66	5,475.00	792.34
Management service	4,364.32	4,364.32	
Total expenditures	90,753.98	122,294.57	31,540.59
Net revenues	14,755.49	14,646.93	

* Indicates revenue in excess of estimate.

Indiana State Medical Association
Indianapolis, Indiana

STATEMENT OF OPERATING EXPENDITURES

For the Nine Months Ended September 30, 1959

Schedule C-1

COMMITTEES AND COMMISSIONS

Standing committees:	Amount	Appropriated (Annual)	Unused
Grievance	$ 252.15	$ 300.00	$ 47.85
Student loan	14.00	100.00	86.00
Medical legal review		50.00	50.00
Commissions:			
Constitution and by-laws	146.06	150.00	3.94
Interprofessional relations	339.92	350.00	10.08
Legislation	4,524.63	5,000.00	475.37
Public health	1,213.00	2,500.00	1,287.00
Public information	5,141.62	7,000.00	1,858.38
Special activities	73.37	200.00	126.63
Voluntary health agencies	150.12	200.00	49.88
Medical economics and insurance	1,409.29	1,500.00	90.71
Medical education and licensure	939.65	3,000.00	2,060.35
Building	1,432.39	1,750.00	317.61
Governmental medical services	402.75	1,000.00	597.25
Totals	$ 16,038.95	$ 23,100.00	$ 7,061.05

Schedule C-2

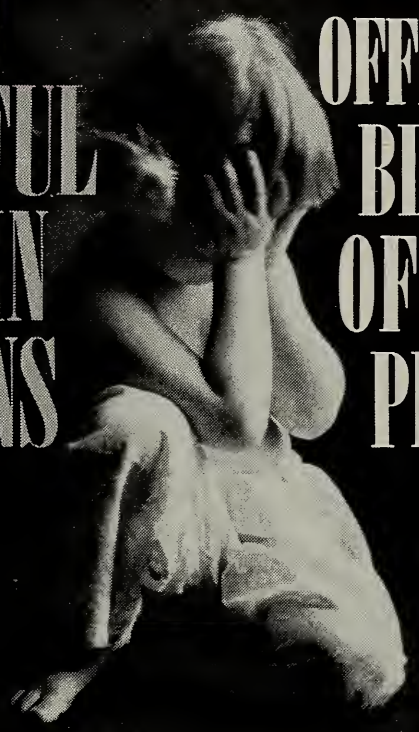
OFFICERS AND COUNCIL

	Amount	Budgeted (Annual)	Unexpended
President	$ 882.13	$ 1,500.00	$ 617.87
President elect	182.16	500.00	317.84
Council chairman	124.27	300.00	175.73
A.M.A. delegates	1,261.17	4,000.00	2,738.83
A.M.A. meetings	945.12	2,000.00	1,054.88
Treasurer, auditing and bookkeeping	1,000.00	1,125.00	125.00
Council travel	709.16	1,100.00	390.84

IN MANY CASES: ENDS THE NEED FOR PAINFUL PENICILLIN INJECTIONS

COMPOCILLIN®-VK
(POTASSIUM PENICILLIN V, ABBOTT)

OFFERS THE HIGH BLOOD LEVELS OF POTASSIUM PENICILLIN V



Available in tiny, easy-to-swallow Filmtabs® and in tasty, cherry-flavored Oral Solution.

001187

®FILMTAB—FILM-SEALED TABLETS, ABBOTT.

ABBOTT

Council meetings	1,366.07	1,700.00	333.93
Better Business Bureau	150.00	150.00	
Executive committee:			
Travel	84.12	120.00	35.88
Meetings	207.94	600.00	392.06
Totals	$ 6,912.14	$ 13,095.00	$ 6,182.86

STATEMENT OF OPERATING EXPENDITURES

For the Nine Months Ended September 30, 1959

Schedule C-3

HEADQUARTERS OFFICE

	Amount	Budgeted (Annual)	Unexpended
Salaries	$ 35,000.76	$ 47,000.00	$ 11,999.24
Supplies	1,270.55	1,250.00	20.55*
Telephone and telegraph	2,199.66	3,000.00	800.34
Postage	1,252.70	1,600.00	347.30
Printing and stationery	1,306.03	1,300.00	6.03*
Travel	7,245.61	8,800.00	1,554.39
Rent and electricity	3,175.48	4,500.00	1,324.52
Organization memberships	420.50	300.00	120.50*
Donations	69.66	80.00	10.34
Insurance:			
Hospitalization	383.14	600.00	216.86
Other	1,078.00	300.00	778.00*
Photographic equipment expense	5.83	25.00	19.17
Extra help	591.81	800.00	208.19
Payroll taxes	776.27	1,200.00	423.73
Depreciation	1,117.84	1,400.00	282.16
Interest	51.64	100.00	48.36
Unallocated	1,805.18	3,000.00	1,194.82
Totals	$ 57,750.66	$ 75,255.00	$ 17,504.34

* Indicates expenditure in excess of budget.

Exhibit D

STATEMENT OF REVENUES AND EXPENDITURES

For the Nine Months Ended September 30, 1959

THE JOURNAL

Revenues: Subscriptions:	Amount	Estimated (Annual)	Unrealized
Members	$ 11,934.00	$ 11,925.00	$ 9.00*
Nonmembers	370.17	275.00	95.17*
Advertising	56,517.40	68,000.00	11,482.60
Other	816.79	1,100.00	283.21
Total revenues	69,638.36	81,300.00	11,661.64

	Amount	Budgeted (Annual)	Unexpended
Expenditures:			
Salaries	6,777.70	14,500.00	7,722.30
Extra help	143.75	220.00	76.25
Office expense	530.34	760.00	229.66
Printing and reprints	46,858.15	54,400.00	7,541.85
Engraving	3,836.99	5,130.00	1,293.01
Travel and meetings	423.45	350.00	73.45†
Bulk mailing	1,012.51	1,330.00	317.49
Other publishing expense	1,341.87	1,640.00	298.13
Payroll taxes	175.16	250.00	74.84
Employe group insurance	30.00	60.00	30.00
Telephone	200.89	260.00	59.11
Rent and electricity	1,596.50	2,150.00	553.50
Unallocated	180.91	250.00	69.09
Total expenditures	$ 63,108.22	$ 81,300.00	$ 18,191.78
Net revenues	$ 6,530.14		

* Indicates revenue in excess of estimate.
† Indicates expenditures in excess of budget.

Exhibit E

STATEMENT OF REVENUES AND EXPENDITURES

For the Nine Months Ended September 30, 1959

MEDICAL DEFENSE FUND

Revenues:		
Transfer of applicable portion of dues	$4,745.00	
Interest earned—U. S. Treasury bonds	657.49	
Amortization of discount—U. S. Treasury bonds	56.60	
Total revenues		$5,459.09
Expenditures:		
Malpractice fees	1,211.61	
Legal fees	1,417.50	
Stationery and printing	5.46	
Total expenditures		2,634.57
Net revenues		2,824.52

Exhibit F

STUDENT LOAN FUNDS

Cash balance, December 31, 1958		$ 48.27
Revenues:		
Collection of student loans	$1,933.45	
Interest earned	38.34	
Transfer from general fund	5,000.00	6,971.79
		7,020.06
Expenditures—loans made to students		5,550.00
Cash balance, September 30, 1959		$1,470.06

DR. FRANK RAMSEY, editor of *The Journal:*

We had an article along this same line mentioned by Dr. Mericle, which I think is going to appear in the February, maybe it's the January number, about the cost of drugs. I wrote it after I had read of the pressure of some health institutes. They pointed out that Americans now spend the some percentage of their disposable income on medical care—that is drugs, doctors, dentists and hospital bills—almost exactly the same percentage now as they did 20 years ago. And on some of the items they went back 30 years ago.

The percentage of our income for expense of medical care is exactly the same; in fact I think it was 1/10 of 1% lower now than it used to be. That's about the best answer you can make to anyone charging that anybody is getting rich selling drugs. If they are getting rich now, they always have. It's been something that's been going on for many years. Nobody used to think that they got too much money.

I'd like to report on the State Medical Journal Conference in Chicago. This is a conference held by the Advertising Bureau every two years in conjunction with the AMA. All the Indianapolis members of the *Journal* staff were in attendance. It was a real fine meeting . . .

a lot of informing papers, two of which were on how to avoid law suits. I took good notes on it. I didn't know there were so many ways to get sued in publishing a medical journal. They had one of their expert lawyers there who lived with it for a long time; it's a complicated and detailed thing.

The appraisal of all the medical journals in the country was done again. This time as well as two years ago we are still on the front row. The front row is a little more crowded than it was two years ago. Then we were one of the best three. Now we're one of the best seven. The remarkable thing about it was that this was done by the same man that did it two years ago and he said that he was surprised at how much everyone had improved. The average has gone way up. The seven that he quoted as being the best were all above 90. Two years ago there wasn't anybody that high. So we are still out in front but the race is getting a little faster. It's like the 500 mile race . . . the average is getting better every year. And we'll have to keep doing better all the time.

I talked to Jim about the business of getting more scientific and social and economic copy for the *Journal.* Jim and I would like to invite each one of the councilors either to write a scientific or social-economic article or to stimulate some member of their district who doesn't ordinarily write for the *Journal;* ride him a little bit, stimulate him to write something so that we would get, in addition to what we usually get every year, one good article from each district. That would have an added advantage of spreading the work out over the state and also get better representation from the state and we'd like to urge each Council member to do that. I think we all have somebody, maybe several doctors in the district who don't write but probably could be urged into it.

Another thing I thought of—we've never had a very complete coverage on is publishing papers that are given in these district medical society meetings. I've been to several of those, have heard good papers, some better than good. I'd like to ask the councilors, whenever they're in contact with their program committee in the district meetings, to suggest to them that in addition to inviting the speaker they invite him to publish his paper in the *Journal;* or if that can't be done, to ask him to kindly give his paper to the committee for publication in *The Journal.* Thank you.

DR. CLEON A. NAFE, member of the Board of Trustees of the AMA, addressed the Council concerning some AMA matters.

DRS. FRANCIS L. LAND and *GORDON B. WILDER,* AMA delegates, reported on the actions taken by the AMA House of Delegates at the clinical meeting held in Dallas, Dec. 1-4, 1959. (See January, 1960, *Journal,* for full report.)

Report of Commission On Medical Economics and Insurance

DR. EDWARD T. EDWARDS, vice-chairman, presented the following matters on which he asked the advice and instructions of the Council:

(1) *Relative Value Study.* The House of Delegates recommended that during the coming year more information be given to the membership of the state medical association on the subject of Relative Value Study. The Commission suggests:

a. That copies of the proceedings of the Third Regional Conference on Relative Value Studies, held in Indianapolis in September 1959, which have been printed, be sent out, either to the entire membership, or to each of the county medical society secretaries to bring before their societies.

b. That a mimeographed sheet be prepared to submit along with the Regional Conference proceedings, to give the membership a better basis for forming an opinion at the next annual meeting.

The matter of cost of obtaining enough of the booklets, preparing the mimeographed material and disseminating it, was presented for consideration of the Council.

(By consent, the Council authorized the Commission on Medical Economics and Insurance to continue its educational program. The executive secretary is to obtain sufficient literature to supply each county medical society. The Commission is to see that each county medical society places this subject upon its agenda and gives the Commission a report on the feeling in each local community. This should also be done on a district level.)

(2) *Special rider on surgical assistants' fees.* Dr. Edwards: The form used in Indiana designates how much the surgeon wishes the assistant to be paid out of the indemnity. Should Blue Shield pay part of the indemnity to the assistant? Yes, No. If "Yes," state the amount. . . . The American College of Surgeons feels that that gives the operating surgeon a chance to offer a little better amount than his colleague with whom he is in competition and therefore becomes a guise for fee splitting. It's the recommendation of the Commission on Medical Economics and Insurance that Blue Shield be requested to omit this part in any new forms and that they stop recognizing that if it is filled in. . . . To try to remove the implied stigma for the surgeons. We think that abandoning this statement about dividing the indemnity for the surgical procedure might be worthwhile. It has not been too popularly used in the state anyway.

Discussed by Drs. Challman, chairman, and Paris, member, of the Liaison Committee with Blue Cross-Blue Shield, and Kintner. Dr. Challman announced that this matter was to be taken up at a meeting of the Blue Shield to be held next week.

(On motion of Drs. Challman and Paris, the Council deferred any action on this matter until its next meeting, when the Council will know what action the Blue Shield Board has taken.)

(3) Does the Council wish the Commission on Medical Economics and Insurance to pursue further the joint studies with the Indiana State Department of Public Welfare as well as Blue Cross and Blue Shield on the possibility of Blue Cross-Blue Shield taking over some of the program in the State Welfare in Aid to Dependent Children's program, primarily hospital care?

(On motion of Dr. Challman, it was taken by consent that this matter also be deferred until after the Blue Shield Board meeting next week.)

Unfinished Business

1. *Headquarters building.* The chairman announced the results of the ballot taken by mail with members of the Council, for membership of the Building Committee, as follows:

John M. Paris, New Albany, chairman
Harry Pandolfo, Indianapolis
Jack E. Shields, Brownstown
R. Case Hammond, Evansville
Frederic W. Brown, Fort Wayne

Following discussion by Dr. Paris, and at Dr. Paris's request, the Council, by consent, removed him from the membership of the Building Committee.

The chairman submitted the name of Dr. Everly; nomination seconded by Dr. Kintner. Dr. Challman's motion that the nominations be closed and that the following individuals be elected by acclamation of the Council was seconded by Dr. Black, and carried:

Ralph V. Everly, Indianapolis
Harry Pandolfo, Indianapolis
Jack E. Shields, Brownstown
R. Case Hammond, Evansville
Frederic W. Brown, Fort Wayne

The chairman announced the appointment of Dr. Everly as chairman of the Building Committee.

THE CHAIRMAN: Mr. Hollowell has pointed out that there are several somewhat conflicting provisions in the Constitution and Bylaws regarding the Council investment of surplus funds, and I'd like quickly to read these to you. The House of Delegates resolution was:

"We move that the Council of the Indiana State Medical Association be empowered by the House of Delegates to proceed with the business of the construction of a headquarters office building at a total cost not to exceed $250,000."

* * * * *

"We move that the chairman of the Council shall appoint, with the concurrence of the Council, a board of five members from the Indiana State Medical Association, who will be known as the 'Building Committee,' with authority to obtain real estate for, and to construct an office building for the Indiana State Medical Association; this committee subject to the help and direction of the Executive Committee. This committee to have a duration of appointment coinciding with the time necessary for the completion of this project."

* * * * *

"We move that the Council be advised by the House of Delegates to implement the financial procedure necessary for the construction of this building."

Now in the Constitution, under Article VI, regarding the Council:

". . . It shall constitute the Board of Trustees of this organization, having full charge and control of all the property of the Association."

Further, in the Bylaws:

Chapter XXIX—Investment of Surplus Funds. "Section 1. The investment of all surplus funds of this Association shall be under the direct control and management of the Executive Committee subject to instructions in regard thereto which may be given by the Council at its option. The Executive Committee shall have the right and is encouraged to obtain the advice and counsel of the investment departments of any bank or trust company of Indianapolis in regard to the discharge of the duties covered by this chapter of the Bylaws."

In addition, under Article VI, the Council has the power of the House between sessions, except legislative functions. Under Chapter IX of the Bylaws—Executive Committee—it is provided:

"It shall make decisions for the Association, including matters pertaining to *The Journal*, during the intervals between the meetings of the Council, and shall report its actions to the Council."

Now, Mr. Hollowell feels that in any transactions that are to be made that we should have a resolution from the Executive Committee empowering the Building Committee to proceed. Mr. Hollowell has prepared a suitable resolution for presentation to the Council. He wants to tie in all the threads so that there are no legal tangles on any financial dealing in going back in retrospect on the records.

On motion of Drs. Everly and Crowder, the following resolution, read by Dr. Everly, was adopted:

Council Resolution

"WHEREAS Article VI of the Constitution of this Association provides that the Council shall constitute the Board of Trustees of this organization, having full charge and control of all the property of the Association; and

"WHEREAS the House of Delegates at the last annual convention adopted a resolution providing for a 'Building Committee' with authority to obtain real estate for and to construct an office building for the Association, subject to the help and direction of the Executive Committee.

"BE IT THEREFORE NOW RESOLVED that the Building Committee be authorized to purchase and acquire, as and for the property of this Association, real estate for the construction of a building."

The following resolution, adopted by the Executive Committee at its meeting on Jan. 9, 1960, was read for the information of the Council:

Executive Committee Resolution

"WHEREAS by Section 1 of Chapter XXIX of the Bylaws, the investment of all surplus funds of this Association is under the direct control and management of the Executive Committee, subject to instructions in regard thereto which may be given by the Council at its option; and

"WHEREAS a resolution of the House of Delegates at the last annual convention provided for a 'Building Committee' with authority to obtain real estate for, and to construct an office building for the Indiana State Medical Association; this committee subject to the help and direction of the Executive Committee.

"BE IT THEREFORE NOW RESOLVED, that the Building Committee be directed and authorized to

select and purchase real estate for a site for the construction of a building."

2. *Student Loan Fund.* Dr. Ross, chairman of the Committee on Student Loan, reported a balance of $1,882.06 in the Student Loan Fund, and that six applicants for loans would be interviewed at a meeting of his committee, following adjournment of the Council.

3. *Report of Liaison Committee between the Council and Blue Shield.* The committee, consisting of Drs. Challman, chairman, Paris, and Neumann (new member replacing Dr. Larson), had no report at this time. Dr. Challman said the committee hoped to meet with Blue Shield (if invited) on Sunday, Jan. 17, 1960, and would have a report to make at the next meeting of the Council.

4. *Medical Care for Military Dependents.* Mr. Waggener announced that effective Jan. 1, 1960, the Medicare program was restored to almost its original form and a complete set of regulations will be mailed to the membership outlining the additions to the program.

5. *Commission on Medical Education and Licensure.* The chairman announced that Dr. A. C. Offutt, state health commissioner, had been invited to discuss some unfinished business of the Commission on Medical Education and Licensure. Dr. Jack Shields, a member of the commission, however, had asked that this report be deferred until the next Council meeting, and by consent it was so ordered.

6. *Election of three Blue Shield Board members at large,* for 3-year term ending March 1, 1963, to succeed following members whose terms expire March 1, 1960:

W. L. Portteus, Franklin, General Surgery At large

Cleon A. Nafe, Indianapolis, General Surgery At large

Bernard D. Rosenak, Indianapolis, Internal Medicine At large

On motion of Drs. Vye and Everly, Drs. Portteus, Nafe and Rosenak were nominated to succeed themselves for another three-year term. On motion of Drs. Webster and Black the nominations were closed and the secretary cast the unanimous ballot of the Council for the above named members.

7. *Grievance Committee.* Dr. Philip B. Reed, chairman of the Grievance Committee, reported that his committee was "continuing to enjoy increasing cooperation from the Association members over the state, as we're doing a better job of getting across our primary function in behalf of public relations and the stress on settling grievances personally and at the local level."

Osteopathic matters also were discussed in detail by Drs. Reed, Challman, Crowder and Mericle.

The chairman appointed the following councilors members of a fact-finding committee of the Council to study this question and to report to the next and succeeding meetings of the Council:

Robert K. Webster, chairman

William B. Challman

K. O. Neumann

Burton Kintner

The chairman suggested that this committee attempt to meet next week (Sunday, Jan. 17, 1960) with the Grievance Committee, when it holds its regular meeting.

8. *Report of Special Committee to Study Award to Physician of the Year.* Committee composed of Drs. Harry Ross, chairman, M. E. Glock and W. B. Challman. Dr. Ross reported that the committee recommended the discontinuance of this award. Following discussion, on motion of Drs. Paris and Webster, the Council voted that this award not be made at the next or succeeding annual conventions.

The chairman of the Council was instructed to refer this for definitive action to the House of Delegates at its next meeting. The discontinuance of this award is to be publicized in *The Journal* and News Flashes to avoid receipt of nominations in the headquarters office.

9. *Anatomical material.* The House of Delegates, at the October 1959 meeting, adopted the recommendation of the Reference Committee on Medical Education and Hospitals that "the Commission on Inter-Professional Relations continue and further increase their efforts to obtain necessary anatomical material for our medical schools."

Following explanatory remarks by the chairman, on motion of Drs. Paris and Challman, this matter is to be referred also to the Commission on Medical Education and Licensure for further implementation.

1960 Annual Convention at French Lick

1. *Dates.* Sunday, Monday, Tuesday and Wednesday, October 2, 3, 4 and 5, 1960.

2. *Entertainment budget.* **On motion of Drs. Paris and Challman, the Council budgeted $2,000.00 for entertainment.**

3. *Scientific exhibit.* **On motion of Drs. Crowder and Wilder, the Council allowed $2,000.00 as a budget for the scientific exhibit.**

1961 Annual Convention at Indiaapolis

The executive secretary was instructed to arrange for the 1961 meeting, that is, to set the dates tentatively and not in conflict with the World Series.

Dr. Owsley reported that he had talked with Dr. Blasingame of the AMA about what could be done to improve the attendance at state medical association meetings and told of the plan used in Texas where the specialty groups meet with the Texas State Medical Association.

At a meeting held several weeks ago, to which all the specialty and general groups were invited, Dr. Mericle made this proposal, and the officers of these groups will present it to their annual meetings this year and decide whether or not to meet with the state medical association in 1961.

Dr. Owsley asked that the councilors take this idea back to their districts and do what they can to encourage these groups to hold their annual meetings in conjunction with the annual convention of the state medical association.

Legislative Matters

DR. DON E. WOOD, co-chairman of the Commission on Legislation, reported on:

1. Meeting to be held Jan. 11, 1960, to which representatives of the various state civic organizations, and state officials are invited, at which Dr. Louis Orr, president of the American Medical Association would speak on the Forand Bill.

2. Establishment of panel of impartial medical experts by the Indiana State Medical Association for use by the United States Federal Court. This matter was discussed in detail by Drs. Wood, Owsley, Vye, Mericle, Judge Hamill and the chairman.

On motion of Drs. Paris and Challman, the Council approved in principle the creation of a board of impartial medical witnesses. The motion, as carried, directed that the matter be referred to a special committee for study and the set-up in tentative form of a plan for presentation to the Council at its next meeting. The attorneys of the Indiana State Medical Association and representatives of the Indiana State Bar Association are to be invited to sit in with this special committee. This question is to be referred also to the major county medical societies in the northern part of the state where this problem exists, for further study and for their recommendations, and to each county medical society in the state for recommendations as to personnel of the panel.

The chairman of the Council named the following committee of the Council on Establishment of Panel of Impartial Medical Experts:

James P. Vye, Burton E. Kintner, and Kenneth O. Neumann; Dr. Vye to serve as chairman.

Economic and Organization Matters

1. *1959 membership report by districts,* as follows, was presented:

MEMBERSHIP REPORT

INDIANA STATE MEDICAL ASSOCIATION

DECEMBER 31, 1959

	MEMBERS		GAIN or LOSS over 1958		REMOVED FROM ISMA MEMBERSHIP ROLES			NON-MEMBERS	
	ISMA	AMA	ISMA	AMA	Non-Payment	Transfer	Death	Eligible	Non-Eligible
First District									
Gibson	17	17						1	
Perry	13	13	+1	+1			1		
Pike	4	5	+1					1	
Posey	11	12							
Spencer	8	5					1	2	
Vanderburgh	212	203	+3		1		5	11	1
Warrick	11	13	—2					4	
Total	276	268	+3	+1	1		7	19	1
Second District									
Daviess-Martin	23	22	—1	—2					
Greene	18	10					2		
Knox	41	39	—1	+1				1	
Owen-Monroe	54	49					1	3	
Sullivan	14	12	—2	—2				1	
Total	150	132	—4	—3			3	5	

	MEMBERS		GAIN or LOSS over 1958		REMOVED FROM ISMA MEMBERSHIP ROLES			NON-MEMBERS	
	ISMA	AMA	ISMA	AMA	Non-Payment	Transfer	Death	Eligible	Non-Eligible
Third District									
Clark	30	32		+2	3		1	7	
Dubois	22	19	—2	—3					
Floyd	39	40		+1			1		
Harrison-Crawford	14	13	+1	+1					
Lawrence	26	23		+1			1	3	
Orange	11	13					1		
Scott	3	3						2	
Washington	7	7							
Total	152	150	—1	+2	3		4	12	
Fourth District									
Bartholomew-Brown	39	38	—1	—1				4	
Dearborn-Ohio	14	14	+1	+1					1
Decatur	14	11	+1	—2			1		
Jackson	19	15	—1				1		
Jefferson-Switzerland	29	27	—1				2	1	
Jennings	8	5		—3				1	
Ripley	13	10					1	1	
Total	136	120	—1	—5			5	7	1
Fifth District									
Clay	14	14					1		
Parke-Vermillion	20	22	—2				2	4	
Putnam	16	16						1	
Vigo	115	114					2	1	
Total	165	166	—2				5	6	
Sixth District									
Fayette-Franklin	20	19	—2	—2			1		
Hancock	21	21	+1	+1				2	
Henry	42	42					1	4	
Rush	16	15	+1				1		
Shelby	16	17	—2	—1			1	3	
Wayne-Union	81	74	—1	—1			2	2	
Total	196	188	—3	—3			6	11	
Seventh District									
Hendricks	19	19						2	1
Johnson	32	32	+6	+5			1	1	
Marion	1067	1070	+31	+34	6	20	14	40	5
Morgan	17	18	—1				1	4	
Total	1135	1139	+36	+39	6	20	16	47	6

	MEMBERS		GAIN or LOSS over 1958		REMOVED FROM ISMA MEMBERSHIP ROLES			NON-MEMBERS	
	ISMA	AMA	ISMA	AMA	Non-Payment	Transfer	Death	Eligible	Non-Eligible
Eighth District									
Delaware-Blackford	113	104	—2	—6			1	3	
Jay	18	16	+1	+1			1	3	
Madison	108	104		+3			2	3	2
Randolph	21	19							1
Total	260	243	—1	—2			4	9	3
Ninth District									
Benton	8	8		+1				1	
Boone	20	21							1
Clinton	22	22	—1	—2				1	
Fountain-Warren	16	16		+1			1		
Hamilton	23	11	+3	+3				2	
Montgomery	29	29	+1	+1		1		2	
Tippecanoe	103	103	+2	+5				5	
Tipton	11	11							
White	11	11							1
Total	243	232	+5	+8		1	1	11	2
Tenth District									
Jasper-Newton	14	14	—1	—1			2	1	
Lake	399	355	+5	+21			3	13	3
Porter	24	24	+3	+3				1	
Total	437	393	+7	+23			5	15	3
Eleventh District									
Carroll	10	11		+1					
Cass	42	39		—1			1	7	3
Grant	62	63	+2	+2			2	9	
Howard	51	52	+4	+4				2	1
Huntington	22	22	—1	—1					1
Miami	21	19		—1		1	1	3	1
Wabash	25	24	+3	+2				5	
Total	233	230	+8	+6		1	4	26	6

	MEMBERS		GAIN or LOSS over 1958		REMOVED FROM ISMA MEMBERSHIP ROLES			NON-MEMBERS	
	ISMA	AMA	ISMA	AMA	Non-Payment	Transfer	Death	Eligible	Non-Eligible
Twelfth District									
Adams	15	14						1	
Allen	260	259	+4	+5			4	4	2
DeKalb	21	19					1	1	
LaGrange	8	8		+1					
Noble	22	22	—1	—1			1		
Steuben	14	14	+1	+1				1	
Wells	34	34	—1	—1			1	3	
Whitley	17	17	—1	—1		1			
Total	391	387	+2	+4		1	7	10	2
Thirteenth District									
Elkhart	106	100	+5	+4			4	4	
Fulton	12	11					1		
Kosciusko	17	17	+2	+2				3	
LaPorte	89	86					4	4	
Marshall	22	22	—1	—1					
Pulaski	7	6	+1	+1				1	
St. Joseph	222	222	—2	—4			2	12	1
Starke	6	6							
Total	481	470	+5	+2			11	23	1
			SUMMARY						
1st District	276	268	+3	+1			7	19	1
2nd District	150	132	—4	—3			3	5	
3rd District	152	150	—1	+2	3		4	12	
4th District	136	120	—1	—5			5	7	1
5th District	165	166	—2				5	6	
6th District	196	188	—3	—3			6	11	
7th District	1135	1139	+36	+39	6	20	16	47	6
8th District	260	243	—1	—2			4	9	3
9th District	243	232	+5	+8		1	1	11	2
10th District	437	393	+7	+23			5	15	3
11th District	233	230	+8	+6		1	4	26	6
12th District	391	387	+2	+4		1	7	10	2
13th District	481	470	+5	+2			11	23	1
Total	4255	4118	+54	+72	9	23	78	201	25

2. *Remission of state dues of a member* of the Marion County Medical Society who has retired because of illness was approved on motion of Drs. Challman and Paris.

New Business

1. *Matters referred to Council by Executive Committee.*

a. *Liasion Committee with State AFL-CIO.* Dr. Wood read a letter received from the State AFL-CIO concerning the establishment of a Liaison Committee between that organization and the state medical association. **On motion of Drs. Crowder and Black, the Council approved the re-establishment of such a liaison committee.** (Some time ago the medical association had such a committee and it worked very well; but the AFL-CIO withdrew; they now realize they made a mistake.)

b. *Life membership cards for senior members.* On motion of Drs. Black and Kintner, the Council approved of the issuance of life membership cards to senior members of the association.

c. *Albert Stump Memorial Lecture.* Dr. Wood announced that the first Albert Stump Memorial Lecture would be given in medical jurisprudence at the I. U. School of Medicine on Wednesday, Jan. 27, 1960, by Mr. Robert Murphy, of Madison, Wisc., legal counsel for the State Medical and State Dental Societies of Wisconsin. This chair at the medical school is sponored by the state medical association in honor of the association's past legal counsel who was the first teacher of medical jurisprudence at the University.

2. *Liaison Committee with I. U. School of Medicine.* Membership of this committee was announced, as follows:

Earl W. Mericle, president (one year)
Guy A. Owsley, president-elect (two years)
Maurice E. Glock, chairman of Council (one year)
Don E. Wood, chairman, Executive Committee (one year)
Joe M. Black (three years)

This committee will be asked to meet with the Executive Committee at its next meeting, to be held on Feb. 17, 1960.

Spring Meeting of The Council

Dr. Owsley announced the AMA had invited the Council to meet in its headquarters office at some future date.

On standing vote, the Council approved of holding the spring meeting in Chicago.

By consent, Sunday, April 10, 1960, was set for the spring Council meeting.

There being no further business, the meeting was adjourned.

NEW MEDICAL SCHOOL FACILITIES

Indiana University last month dedicated its Medical Science Building, a major step in improvement of medical education. Despite these increased facilities and partly due to the depreciating dollar, the medical schools need your financial support. Please help the school of your choice through American Medical Education Foundation.

"Only when people make some kind of financial sacrifice for their schools do they take an active and wholesome interest in education."

Mail your AMEF Contribution to

AMEF—Indiana State Medical Association

1021 Hume Mansur Bldg.

Indianapolis, Ind.

Lighter Vein . . .

A father presented his young son with a $5 bill for his first big adventure alone—at the amusement park.

His mother was somewhat skeptical about this extravagance. "What are you going to eat?" she demanded.

"Well," replied the youngster, "I'm going to have cotton candy, ice cream, candied apple, some peanuts, popcorn . . ."

Then noticing the storm warning building up in his mother's eyes, he hastily added: "And a green vegetable."—Campbell *Brevities*.

———

Two ducks were walking down the road towards the pond when one of them quacked: "Oh, quit trying to walk like a woman wearing slacks."—Campbell *Brevities*.

———



"Gad, Filchby, what kind of a prescription is that?"

———

A service club was holding a business meeting and the discussion of its financial affairs hit a snag on the question of devoting a large sum of club money to a civic project which might not be self-supporting. One notoriously careful member based his opposition on the grounds that the plan was "un-businesslike no matter how much good it might do."

To emphasize his position, he finally snorted, "Let me warn you, before you approve the spending of this money, that I have never yet remained with any organization that was operated with a deficit."

There was a long silence. Then a local wag looked at the other member with a slight smile and asked: "You're still an American citizen, aren't you?"—*Capper's Weekly*.

———

When a man looks a girl straight in the eye, maybe she had better do something about her figure.—Campbell *Brevities*.



"As a physician, my good man, I feel that I should warn you about over-eating!"

———

An apple a day won't keep the doctor away and having him around takes too much lettuce.—Frank J. Pepe.

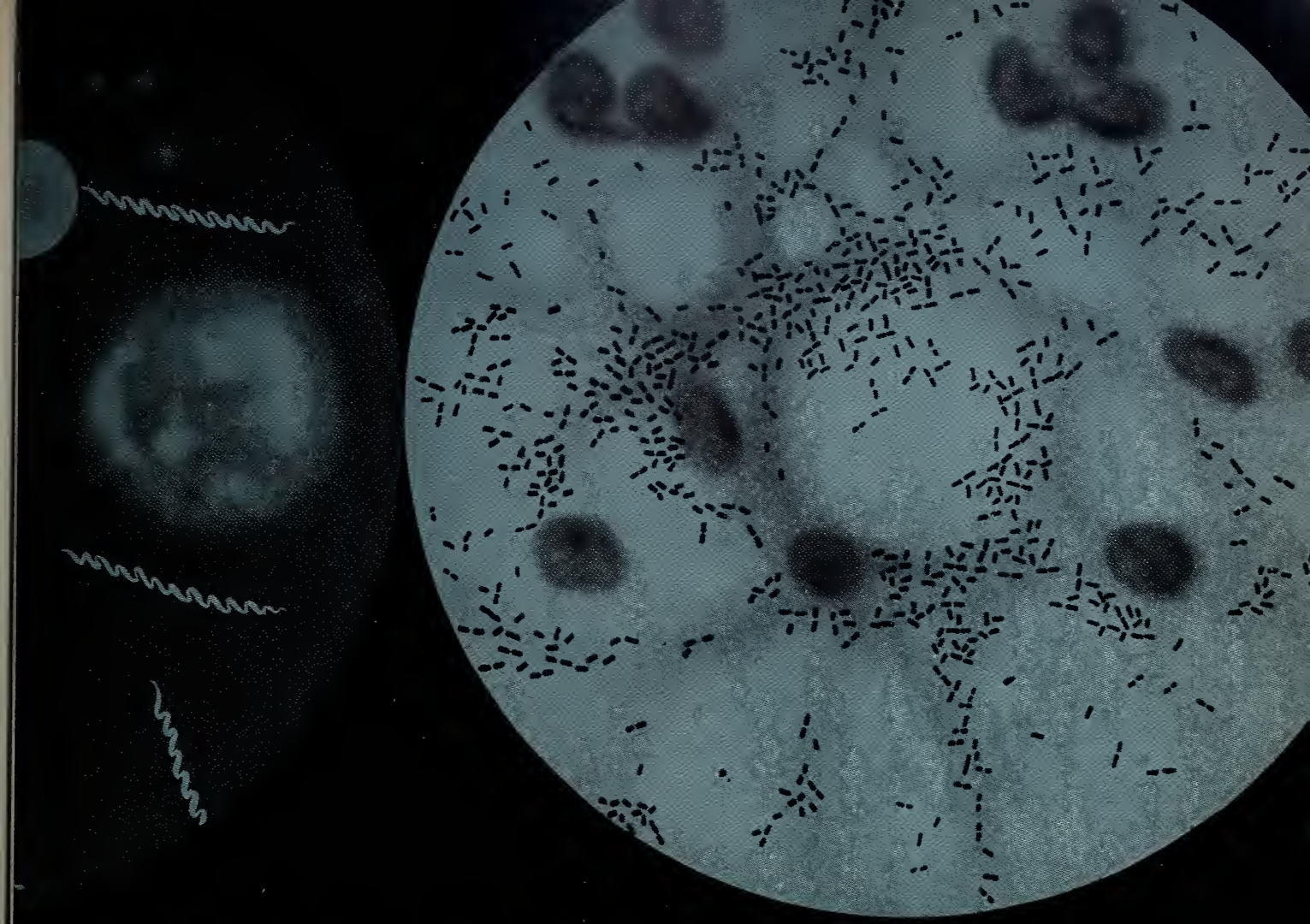
———

In the beginning God created man. Then he had to create women to help control the monster.—David O. Flynn.

———



"Just imagine, Juan, up in the United States they need drugs to put themselves to sleep."



CHLOROMYCETIN®

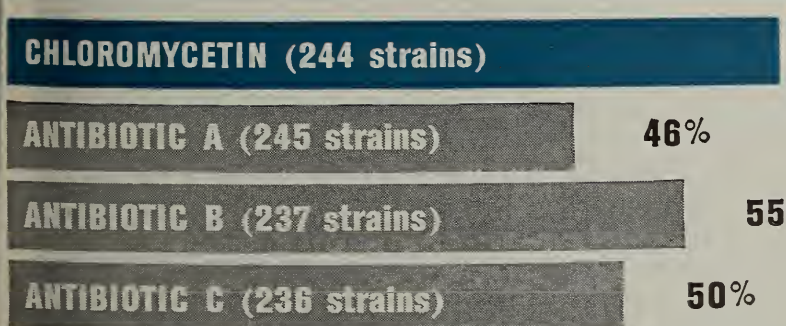
OUTSTANDINGLY EFFECTIVE AGAINST A WIDE RANGE OF PATHOGENS

CHLOROMYCETIN (chloramphenicol, Parke-Davis) is available in a variety of forms, including Kapseals® of 250 mg., in bottles of 16 and 100.

CHLOROMYCETIN is a potent therapeutic agent and, because certain blood dyscrasias have been associated with its administration, it should not be used indiscriminately or for minor infections. Furthermore, as with certain other drugs, adequate blood studies should be made when the patient requires prolonged or intermittent therapy.

References: (1) Morton, J. J.: *Yale J. Biol. & Med.* **31**:397, 1959. (2) Rogers, D. E., & Louria, D. B.: *New England J. Med.* **261**:86, 1959. (3) Leming, B. H., Jr., & Flanigan, C., Jr., in Welch, H., & Marti-Ibañez, F.: Antibiotics Annual 1958-1959, New York, Medical Encyclopedia, Inc., 1959, p. 414. (4) Edwards, T. S.: *Am. J. Ophth.* **48**:19, 1959. (5) Olarte, J., & de la Torre, J. A.: *Am. J. Trop. Med.* **18**:324, 1959. (6) Suter, L. S., & Ulrich, E. W.: *Antibiotics & Chemother.* **9**:38, 1959. (7) Holloway, W. J., & Scott, E. G.: *Delaware M. J.* **30**:175, 1958.

IN VITRO SENSITIVITY OF GRAM-NEGATIVE ORGANISMS TO CHLOROMYCETIN AND TO THREE OTHER BROAD-SPECTRUM ANTIBIOTICS*



*Adapted from Leming & Flanigan.[3]

PARKE, DAVIS & COMPANY · DETROIT 32, MICHIGAN

PARKE-DAVIS

The Journal

April 1960

of the INDIANA STATE MEDICAL ASSOCIATION

Office of Publication:
1019 Hume Mansur Building, Indianapolis, Indiana

$1.00 per copy
except Yearbook
$5.00 per year

Contents

SCIENTIFIC

Malignant Bone Tumors of Childhood, George J. Garceau, M.D., Indianapolis 645
Neoplastic Disorders of the Reticuloendothelial System in Infants and Children, Robert J. Rohn, M.D., William H. Bond, M.D., Marion E. Hodes, M.D., Indianapolis 649
Diagnosis of Malignant Gynecologic Tumors in Infants, Children and Adolescents, Sprague H. Gardiner, M.D., Carl P. Huber, M.D., Indianapolis 655
Ocular Tumors in Children, Robert William Harger, M.D., Indianapolis 662
Genito-Urinary Malignancies in Children, Donald H. Yurdin, M.D., Springfield, Ill. 671
Thyroid Cancer in Childhood and Adolescence, Robert K. Gibson, M.D., Indianapolis 676
Thyroid Malignancy, Goethe Link, M.D., Indianapolis 680
A Case of Seven Primary Malignancies and a Report of 30 Cases of Multiple Malignancies, Edward W. Graham, M.D., Edward B. Smith, M.D., Indianapolis 683
The Case of the Luetic Couple, Arnold Lieberman, M.D., New York, N. Y. 692
Condensed Cardiology: Second Heart Sound, Charles Fisch, M.D., Indianapolis 697

EDITORIALS

AMEF Dollars and Donors Rise 702
Practical Politics-Better Government 702
Cancer of the Colon: Detection or Prevention (From Texas) 703
Kaiser Plan in Honolulu (From Hawaii) 704

SPECIAL FEATURES

Are We Caring for the Old Folks? Emmett B. Lamb, M.D., Indianapolis 709
The Forand Bill, Paul D. Crimm, M.D., Evansville 714
Our Cover Story: Stained Glass Windows 737

REGULAR FEATURES

Month in Washington 624
Fourth Estate 630
Journal Medical Essay Contest 654
President's Page 705
The Woman's Auxiliary 706
Rosemary (A Journal Special) Miki Wilson 712
Blue Shield: A Growing Membership (Blue Cross-Blue Shield Series) 732
Board of Health Report 734
Abstracts & Book Reviews 744
News Notes 750
Changing Concepts Corncerning Cancer Theme of Fourth National Conference 699
Board of Health Announces Duties of New Commission 750
Physicians Mail Journals to Fight Cold War 753
Add 1, by corki 762
Deaths 766
AMEF 792
Advertisers Index 802

BUSINESS

County and District News 770
Commission Meetings 779
Public Health 779
Constitution and Bylaws 780
Legislation 782
Medical Economics and Insurance 786
Association News: Executive Committee, Feb. 17, 1960 787

EDITORIAL AND ADVERTISING INFORMATION

All articles must be typewritten, double-spaced with margins of one inch.

Photographs should be printed on glossy paper. Negatives cannot be used.

Illustrations are desirable. Selection of illustrations submitted at discretion of editor and editorial board members. Cost of color illustrations must be shared by the author.

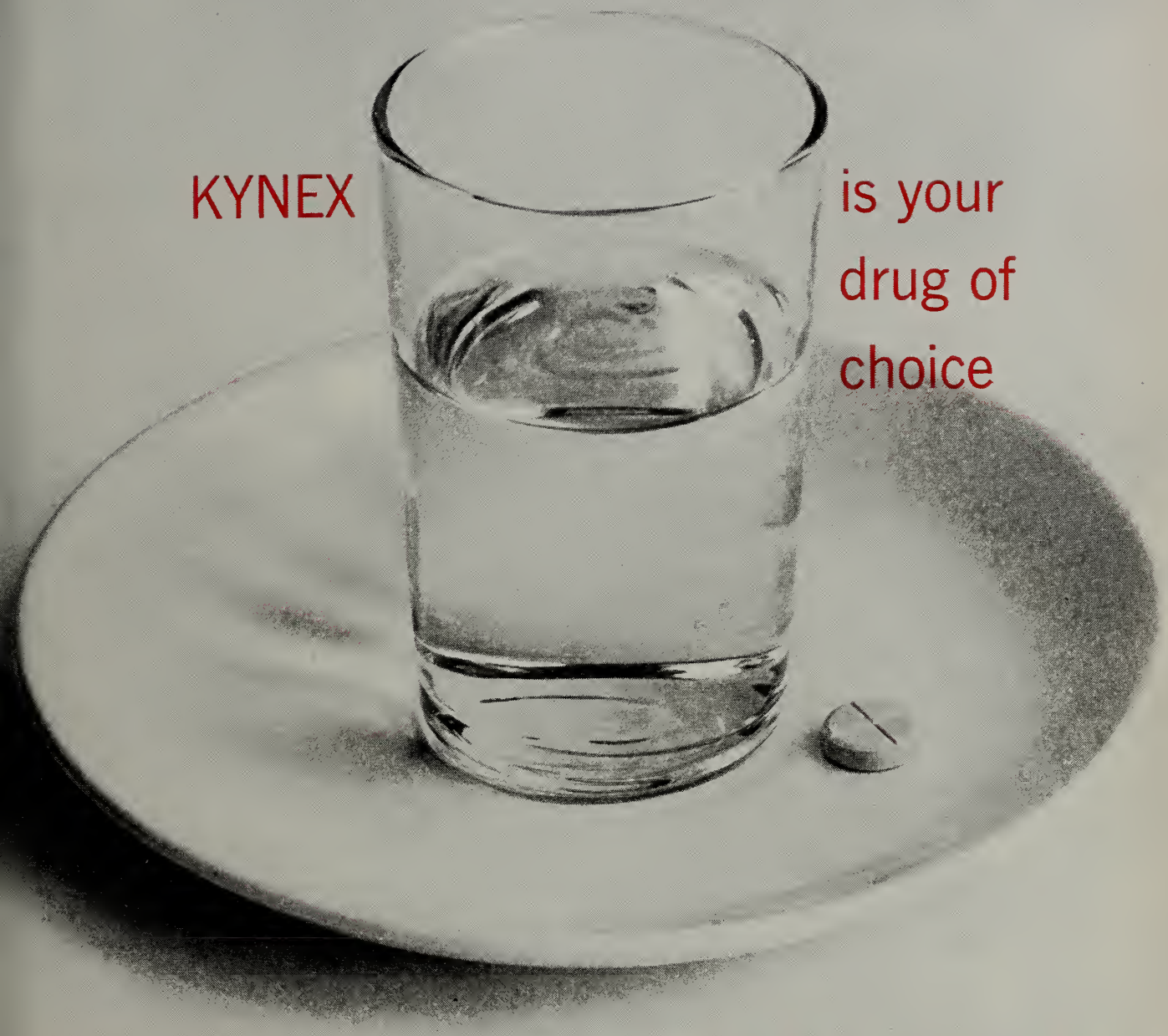
Contributors are responsible for all statements made in their articles. The editors and editorial board members may not be in agreement with all views expressed by authors, but it is desired to give all authors as great latitude as possible. However, the right is reserved to reduce in length or reject any article.

Articles are accepted for publication with the understanding that they are submitted for exclusive publication in THE JOURNAL of the Indiana State Medical Association.

Communications dealing with editorial matter should be sent to Frank B. Ramsey, M.D., Editor, 1802 North Illinois Street, Indianapolis 2, Indiana. All other communications should be sent to THE JOURNAL of the Indiana State Medical Association, 1019 Hume Mansur Building, Indianapolis 4, Indiana.

Advertising rates will be furnished on request. Copy must be received by the 5th of the month preceding month of issue. (Scientific manuscripts must be received at least two weeks earlier if geared for a specific issue.)

Entered as second class matter January 25, 1933, at the Postoffice at Indianapolis, Indiana. Copyright, 1960, by the Indiana State Medical Association. Published monthly at 1019 Hume Mansur Bldg., Indianapolis 4, Indiana.



KYNEX is your drug of choice

once-a-day sulfa...

KYNEX®

Sulfamethoxypyridazine Lederle

NOTE: Investigators note a tendency of some patients to misinterpret dosage instructions and take KYNEX on the familiar q.i.d. schedule. Since one KYNEX tablet is equivalent to eight to twelve tablets of other sulfas, even moderate overdosage may produce side effects. Thus, the single dose schedule must be stressed to the patient.

KYNEX Tablets, 0.5 Gm., bottles of 24 and 100. Dosage: Adults, 0.5 Gm. (1 tablet) daily, following an initial first day dose of 1 Gm. (2 tablets).

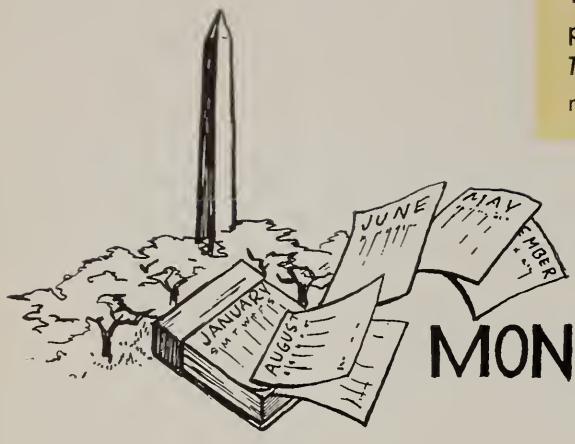
KYNEX Acetyl Pediatric Suspension, cherry-flavored, 250 mg. sulfamethoxypyridazine activity per teaspoonful (5 cc.). Bottles of 4 and 16 fl. oz. Recommended Dosage: Children under 80 lbs.: 1 teaspoonful (250 mg.) for each 20 lb. body weight, the first day, and ½ teaspoonful per 20 lb. per day thereafter. For children 80 lbs. and over: 4 teaspoonfuls (1.0 Gm.) initially and 2 teaspoonfuls daily thereafter. Give immediately after a meal.

NEW—for acute G.U. infection AZO-KYNEX® Phenylazodiaminopyridine HCl—Sulfamethoxypyridazine Tablets, contains 125 mg. KYNEX in the shell with 150 mg. phenylazodiaminopyridine HCl in the core. Dosage: 2 tablets q.i.d. the first day; 1 tablet q.i.d. thereafter.

LEDERLE LABORATORIES, a Division of AMERICAN CYANAMID COMPANY, Pearl River, New York

Lederle

This summary of what is happening in Washington is prepared by A.M.A.'s Capital office and airmailed to *The Journal* on the ninth of each month preceding month of issue.



MONTH IN WASHINGTON

Washington, D. C.—Congress has been warned against acting on legislation to provide health care of the aged before receiving the recommendations of next year's White House Conference on Aging.

Rep. Noah M. Mason (R., Ill.), ranking minority member of the House Ways and Means Committee which handles such legislation, put in the Congressional Record an exchange of correspondence with former Rep. Robert W. Kean (R., N. J.), chairman of the National Advisory Committee supervising preparations for the White House Conference next January.

Rep. Mason said the correspondence "reveals the reason why Congress should await the results of the Conference."

"Let us not waste the $2 million we have already appropriated to bring thousands of good minds together to suggest solutions to problems of our aging population," Rep. Mason said. "Certainly we should get the benefit of their advice rather than enact legislation in haste and without proper study."

Dr. F. J. L. Blasingame, executive vice president of the American Medical Association, also voiced this warning in a radio interview while he was in Washington for conferences with White House aides and Arthur S. Flemming, Secretary of Health, Education and Welfare.

Dr. Blasingame said that it would be "neither practical nor realistic" for Congress to act on such legislation until the White House Conference and other sources had compiled "more conclusive and complete information" on a nationwide basis.

Dr. Blasingame and other AMA representatives emphasized to President Eisenhower's aides and Flemming that the medical profession is unalterably opposed to any legislation, such as the Forand bill, that would use the Social Security system to provide health care for the aged.

STATE AND LOCAL SOLUTIONS SEEM BETTER

In his letter to Mason, Kean predicted that "in all probability" most of the White House Conference's recommendations would be for "state and local activity" in dealing with the problems of the aged. Kean said that action at the state and local level "seems most effective."

The National Association of Manufacturers charged in a pamphlet that supporters of Forand-type legislation have exaggerated the health care



6-10 HOURS
SUSTAINED THERAPY

ONE *and only* ONE
Timed AMO*dex* CAPSULE
PER
DAY *will economically*

control appetite in weight reduction or relieve the nervous symptoms of anxiety and the underlying depression.

Timed AMO*dex CAPSULES* (Testagar) furnish a controlled uniform action. The medications provide prolonged, continuous therapeutic effect from active ingredients over a period of 6 to 10 hours.

Following ingestion of one *Timed* AMO*dex CAPSULE*, small amounts of the medication are released immediately.

Each *Timed* AMO*dex CAPSULE* contains a daily therapeutic dose of:

Dextro-amphetamine hydrochloride	15 mg.,
Amobarbital	60 mg.

AMO*dex* ADVANTAGES

- HIGH-LEVEL ANOREXIGENIC ACTIVITY WITHOUT NERVOUS EXCITATION
- SMOOTH, UNIFORM ACTION
- THERAPEUTIC EFFECT LASTING 6 TO 10 HOURS
- ONLY ONE DOSE DAILY
- CLINICALLY ECONOMICAL TO THE PATIENT

PROTRACTED THERAPEUTIC EFFECT

Before the development of *Timed* AMO*dex* (Testagar) the usual dose of Dextro-amphetamine hydrochloride, for the control of appetite, was one 5 mg. tablet two or three times a day. The usual dose of Amobarbital ranged from 20 to 40 mg., two or three times a day. On such a dosage regimen the absorption of the drugs, after ingestion, takes place quite rapidly. The therapeutic activity occurs within one-half to one hour. When the therapeutic peak is reached, a gradual decline takes place. At this point, the patient should receive another dose of medication . . . the cycle is then repeated.

Patients frequently fail to follow the physician's instructions. They take medication at irregular intervals. When this occurs with drugs such as dextro-amphetamine sulfate, phosphate or hydrochloride, excitation may result. A balanced combination of Dextro-amphetamine hydrochloride, **the preferred salt,** plus a balanced daily dose of Amobarbital will give the expected therapeutic results *without* excitation.

Timed AMO*dex*, after ingestion, releases Dextro-amphetamine Hydrochloride and Amobarbital steadily and uniformly over a period of 6 to 10 hours. Therefore, the physician may dispense with the usual dosage schedule thereby *attaining better control of therapy*. The patient will receive the benefits of even and sustained therapeutic effects. Side reactions such as anxiety and excitation are greatly minimized.

ACTION AND USES

Timed AMO*dex CAPSULES* (Testagar) supply the antidepressant and mood-elevating effects of Dextro-amphetamine hydrochloride and the calming action of Amobarbital. *Timed* AMO*dex* elevates the mood, relieves nervous tension, restores emotional stability and the capacity for mental and physical effort.

INDICATIONS

Timed AMO*dex* is the preferred treatment in anxiety states and in the management of obesity. *Timed* AMO*dex* may also be used in the treatment of Depressive states, Alcoholism, Nausea and Vomiting of Pregnancy.

DOSAGE The Daily Dose of *Timed* AMO*dex* (Testagar) IS ONE CAPSULE ON ARISING OR AT BREAKFAST.

SUPPLIED Bottles of 100 and 1000 capsules, available at all pharmacies. Also supplied in half strength as *Timed* AMO*dex*, Jr.

Timed AMO*dex CAPSULES* are manufactured under these patent numbers:
2,736,682 — 2,809,916
2,809,917 — 2,809,918
Which provide prolonged, continuous therapeutic effect over a period of 6-10 hours

SAMPLES AND LITERATURE UPON REQUEST

Testagar & co., inc. 1354 W. Lafayette Blvd. Detroit 26, Michigan

needs of the nation's older people. The NAM pamphlet also said the Forand bill was an entering wedge for a cradle-to-grave compulsory health insurance plan.

Meantime, supporters of the Forand bill—particularly the AFL-CIO—continued an intensive pressure campaign aimed at Congressional approval of the legislation in this national election year when Congressmen are more susceptible to such pressure.

Another Democratic presidential hopeful, Sen. Hubert H. Humphrey (D., Minn.), reiterated his support for Forand-type legislation. He proposed a six-point program for aid for the elderly, including "an extension of the Social Security system to cover the cost of hospital and nursing-home care for senior citizens."

KENNEDY INTRODUCES LEGISLATION

Sen. John F. Kennedy (D., Mass.), a leading contender for the Democratic nomination for President, has introduced similar, but even broader, legislation.

Elsewhere on the national legislative front, prospects brightened for Congressional passage this year of a bill to permit physicians and other self-employed persons to set aside money for retirement.

The Administration, which last year opposed a bill with such provisions, appeared in mid-March to be ready to support it with modifications.

The Administration shift improved the already favorable odds that both the Senate Finance Committee, where a House-approved bill was pending, and the Senate would approve such legislation this session.

GENERIC VS. TRADE NAMES

The issue of generic names vs. trade names in doctors' prescriptions came to the forefront in the Senate Monopoly Subcommittee's investigation of the drug industry.

Dr. Austin Smith, president of the Pharmaceutical Manufacturers Association, testified at a Subcommitee hearing that "behind brand names lies the reputation, reliability and skill of the manufacturer." He said use of generic terms would restrict a physician's choice as to drugs and would transfer some of the physician's responsibility to the pharmacist.

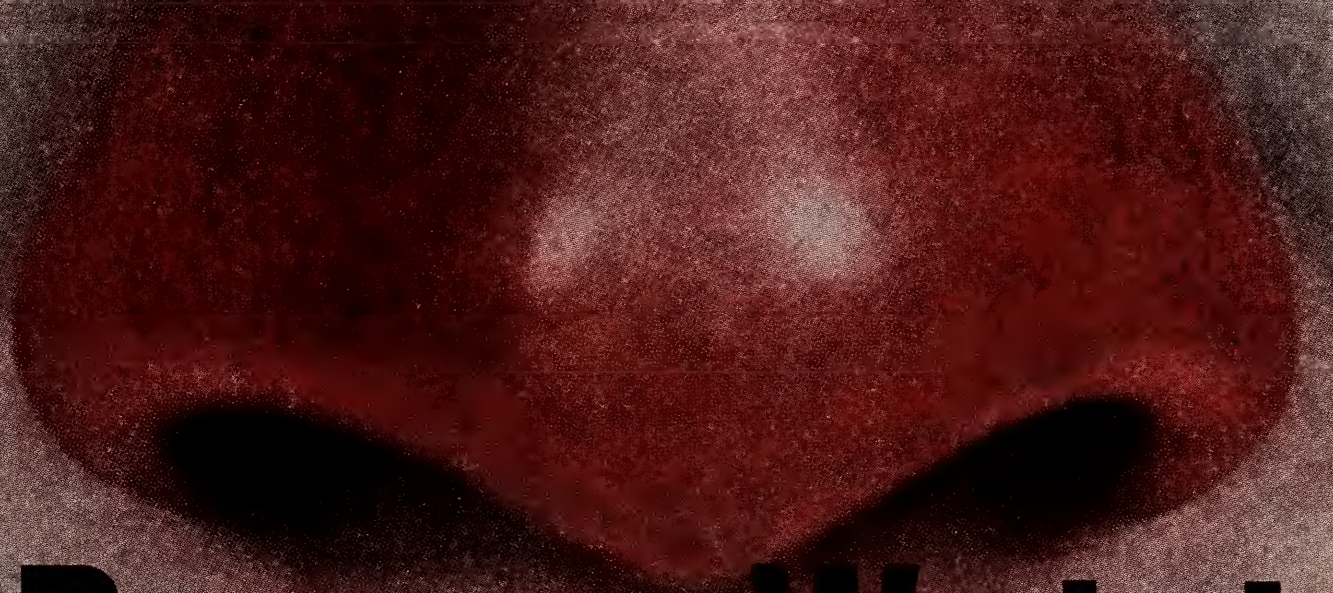
"By brand name prescription, the doctor orders for a patient a specific product in which he has absolute knowledge of quality, purity and any side effects that might have importance for a particular patient," Dr. Smith said.

Dr. R. B. Robins of Camden, Ark., who accompanied Smith at the hearing, submitted a similar statement. He said he used trade names because: "It is simpler to write such a prescription and I can be assured that no substitution will be made by the druggist—this assures me that the patient will get top quality."

Dr. Robins appeared before the Subcommittee as a private practicing physician and not in his capacity as a member of the AMA Board of Trustees.

Continued

allergic nose?



Dimetane® Works!

with side effects as few as placebo

—New England J. Med. *261*:478, 1959 (Schiller, I. W. and Lowell, F. C.)

Dimetane works with an effectiveness of 91% in respiratory allergies —NEW YORK J. MED. *59*:3060, 1959 (Fuchs, A. M. and Maurer, M. L.). In allergic and pruritic dermatoses the effectiveness rate of Dimetane is 94.6% —ANTIBIOTIC MED. & CLIN. THERAPY *6*:275, 1959 (Lubowe, I. I.). The A. M. A. Council on Drugs characterizes Dimetane as demonstrating "...a high order of antihistaminic effectiveness and a low incidence of side effects." —J.A.M.A. *170*:194, 1959.

for your next allergic patient Rx DIMETANE Extentabs® (12 mg.), Tablets (4 mg.), Elixir (2 mg./5 cc.), new DIMETANE-TEN Injectable (10 mg./cc.) or new DIMETANE-100 Injectable (100 mg./cc.).

Robins

A. H. ROBINS CO., INC., RICHMOND 20, VIRGINIA / ETHICAL PHARMACEUTICALS OF MERIT SINCE 1878

Despite this testimony, Sen. Estes Kefauver (D., Tenn.), the Chairman of the Subcommittee, said he hoped physicians would give "serious thought" to use of generic terms. He contended that doctors thus could bring down drug prices by opening the way for small manufacturers to give the major companies "some good, honest, old-fashioned price competition."

URGE STRONGER X-RAY LEGISLATION

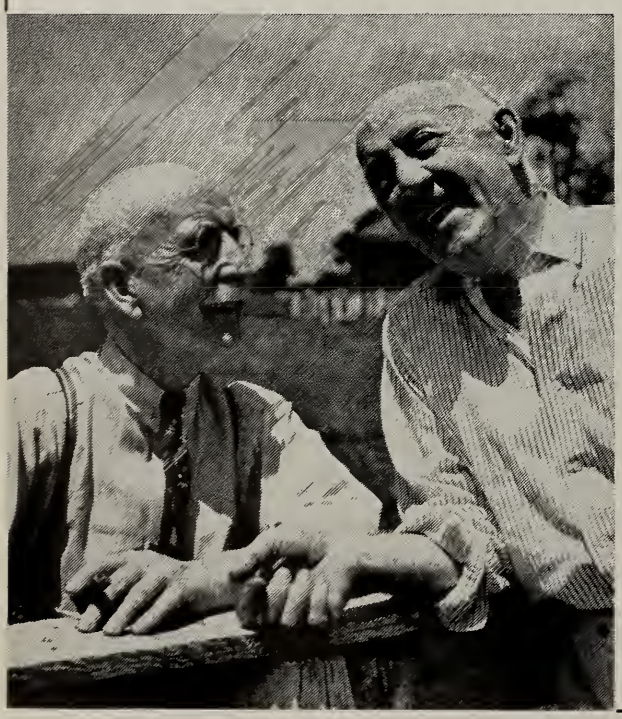
President Eisenhower's Conference on Occupational Safety urged stronger x-ray legislation by the states with an aim of protecting consumers and workers against too much radiation.

The three-day Conference also said there is need "for effective educational programs to reduce both consumer and occupational exposures to x-rays used for diagnosis and therapy, x-ray installations in industry for product control and related purposes and various x-ray devices, such as shoe-fitting fluoroscopes."

The Conference also recommended intensive efforts to develop better ways of determining safe exposure levels of radiation. ◄

PSYCHIC ENERGIZER

For Your Geriatric Patients



Metalex®

Pentylenetetrazol w/ Nicotinic Acid

METALEX is a vasodilator, a respiratory and central nervous system stimulant. It helps overcome the hypoxia frequently present in athero-arteriosclerosis of old age, its analeptic action increases nerve impulse transmission.

"TONIC" EFFECT—Ameliorates mood, paranoid delusions, loss of memory, confusion, depression, anxiety, apathy, vertigo, insomnia, headache and anorexia due to athero-arteriosclerosis.

IN TINNITUS—When cerebral function and oxygen supply can be improved, visual and auditory improvement is often noticeable.

SUPPLIED: Tablets—bottles of 100.
Elixir—pint bottles.

Composition: Each tablet and each 5 cc. elixir contains 100 mg. Pentylenetetrazol, and 50 mg. Nicotinic Acid.

Send for samples and literature.

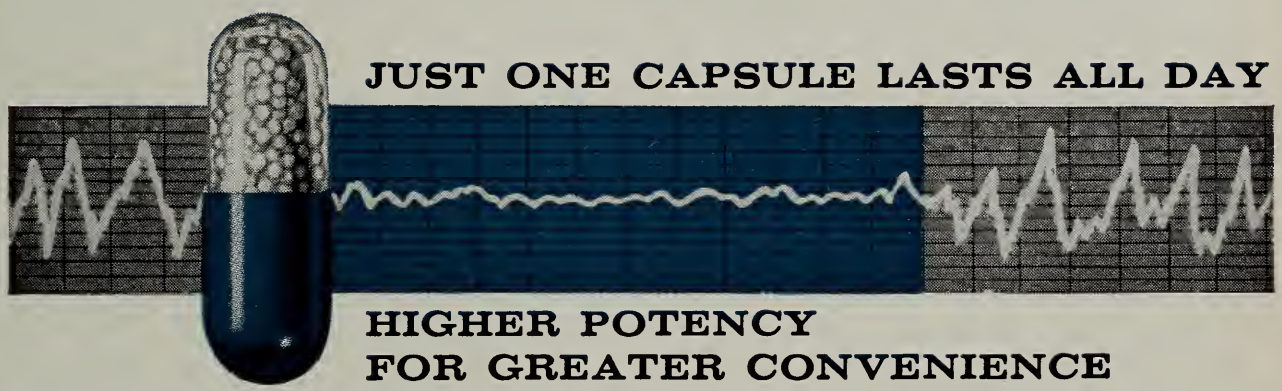
STORCK **Pharmaceuticals,** 2326 Hampton Blvd., St. Louis 10, Mo.

NEW AND EXCLUSIVE

FOR SUSTAINED TRANQUILIZATION

MILTOWN® (*meprobamate*) now available in 400 mg. continuous release capsules as

Meprospan®-400



JUST ONE CAPSULE LASTS ALL DAY

HIGHER POTENCY FOR GREATER CONVENIENCE

- relieves *both* mental and muscular tension without causing depression
- does not impair mental efficiency, motor control, or normal behavior

Usual dosage: One capsule at breakfast, one capsule with evening meal

Available: *Meprospan-400*, each blue capsule contains 400 mg. Miltown (meprobamate)
Meprospan-200, each yellow capsule contains 200 mg. Miltown (meprobamate)

Both potencies in bottles of 30.

®WALLACE LABORATORIES, *New Brunswick, N. J.*

CME-8426



LOOKS AT MEDICINE

This section of THE JOURNAL is devoted to the presentation of opinions which appear on the editorial pages of the public press, and which are of interest to the medical profession. Its function is to review comments which may be favorable or unfavorable to medicine. Members are invited to submit editorial clippings for this column.

Reflections on the Forand Bill . . .

Side-Door Attempt

A crisis in health and medicine is presented by the Forand Bill, now before Congress. It also represents a side-door attempt to saddle socialized medicine upon the nation.

The bill, which gets its name from its author, Rep. A. J. Forand, of Rhode Island, is a scheme to provide medical benefits to recipients of social security. "Free" hospitalization and nursing care would be established for 180 days out of the year, at a cost estimated as $1 billion to $2 billion the first year, up to $7 billion by 1980.

Social security taxes would be increased one-fourth of one per cent on each worker and employer, plus three-eights of one per cent from the self-employed, on the first $4,800 of an individual's income.

It is admitted that many of the aged have acute and serious problems which need attention. But there are many objections to the Forand Bill. It is not surprising that Walter Reuther has come out strongly in favor, since about 90% of the population over 65 would be brought under socialized medicine.

There long has been an effort in some quarters to completely socialize the country's medicine. The Forand plan would get a foot in the door. The next step would be to lower the age eligibility and broaden the field of coverage, and then on and on to include everybody, ending up with a government-run, compulsory health program, which could be expected to be expensive and inefficient.

The plan is a major deviation from the original cash benefit of the social security system. Without the added Forand costs, social security tax increases are scheduled to reach 9% of payroll in the years ahead. The inflationary effects are evident.

The aged would be deprived of the privilege of making their own expenditures. Those on public assistance, including those with the lowest incomes, would not be helped at all. Health insurance has increased amazingly and is estimated will cover 90% by 1970.

The program would restrict the aged in their choice of hospital and physician. The professional relationship between patient and physician would be disturbed or severed. Only hospitals, nursing homes and physicians entering into agreements with the government would participate.

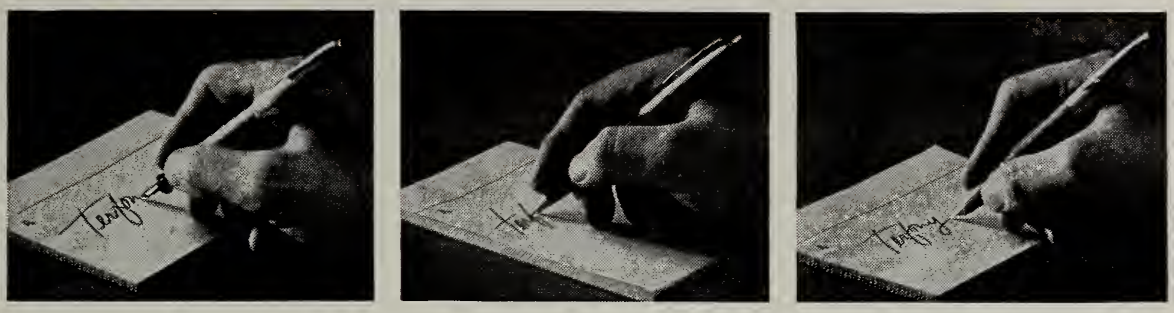
Experience in other countries has shown many weaknesses in such programs. Overcrowded hospitals and long waits for admission, resulting from demands by those often without real medical necessity, are indicated. General health might well be set back instead of improved, not to mention the excessive cost.

It is to be suspected, too, that the program represents a raw attempt to buy the votes of America's aged.

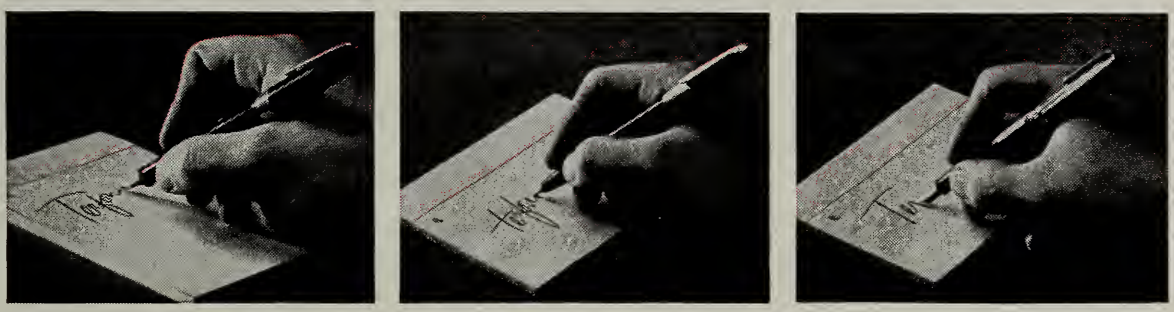
The country needs steadily improving medical care, not deterioration, as seems likely under any such plan as that set up by the Forand Bill. It should be rejected.

Lafayette Journal and Courier

Continued



more and more physicians are prescribing this triple sulfa



TERFONYL

Squibb Triple Sulfas (Trisulfapyrimidines)

Clinical experience continues to prove that TERFONYL provides many special advantages fundamental to successful antibacterial therapy.

• specificity for a wide range of organisms • superinfection rarely encountered • soluble in urine through entire physiologic pH range • minimal disturbance of intestinal flora • excellent diffusion throughout tissues • readily crosses blood-brain barrier • sustained therapeutic blood levels • extremely low incidence of sensitization

SUPPLY: Tablets, 0.5 gm. • Suspension, raspberry flavored, 0.5 gm. per teaspoonful (5cc.).

SQUIBB *Squibb Quality—the Priceless Ingredient*

'TERFONYL'® IS A SQUIBB TRADEMARK

Fourth Estate

Continued

Federal Health Bill

It will be interesting to note how Indiana congressmen vote on the Forand Bill which proposes that the federal government pay medical benefits to recipients of social security.

This is a bill that congressmen ought to oppose, for two strong reasons. One is that a growing number of people 65 and older who want health insurance will be getting it through private programs. The other reason is that paying these benefits with federal funds will add billions of dollars to the national debt, and whether congressmen believe it or not, one of these days the people who pay taxes are going to rebel against the tendency to saddle more and more taxes on them.

Not only are we paying heavily (in the form of taxes) for these additional benefits which Congress keeps voting, but we are leaving an increasing burden on our children and grandchildren. It's fine to have a good many things coming from the government, but it doesn't sit very well (or shouldn't) in one's conscience to be receiving those benefits at the expense of our children.

Take the Forand Bill. It would supply free hospitalization and nursing care for 190 days out of the year and push federal taxes upward by $1 billion to $2 billion the first year, and around $7 billion by 1980.

The American Medical Assn. has a selfish interest in health legislation, to be sure. But it has some things to say about the Forand Bill that make pretty good sense. Dr. Louis Orr, president of the AMA points out that the Forand bill does not help the indigent minority, because people on public assistance rolls, ineligible for social security, are not covered by it. He also notes that by the end of 1960 an estimated 60% of those 65 and over who want health insurance will have it through private programs, and a further estimate is that by 1970 some 90% of those 65 and older will be covered by private insurance.

Why, then, should the government go into the health insurance business when private means are moving gradually to meet the need? Why should the government add to the already heavily taxed American citizenry when the government is unable even to pay off any of its staggering debt?

The British experiment with government-subsidized medicine offers a lesson for America. In a decade there has been no major hospital construction in Britain, the waiting list for surgical attention is said to total half a million, and a trend to private medical programs is reported.

In the light of this analysis, the vote of congressmen from Indiana, when the Forand Bill comes up for decision, will be noted with special interest.

Kokomo Tribune-Dispatch
Jan. 17, 1960

Medical Costs

Social Security reports show that, for the first time in history, drugs and medical appliances are costing more than doctor bills.

The figures are $4,362,000,000 a year for drugs, $4,290,000,000 for doctors. That's billions in each case.

The total health bill last year climbed to nearly $16.4 billion.

These figures represent a lot of money but the benefits also are great—the gradually lengthening of the average life span, elimination of formerly lethal diseases, etc.

And just to keep the costs in perspective, here are some other figures:

—The annual alcoholic beverage bill is $9.2 billion. Taxes on beverages alone amount to almost half of this, or $4 billion, which is only a little less than the doctor bill.

—For tobacco the annual expenditure is $6 billion.

—Recreation costs almost $17 billion.

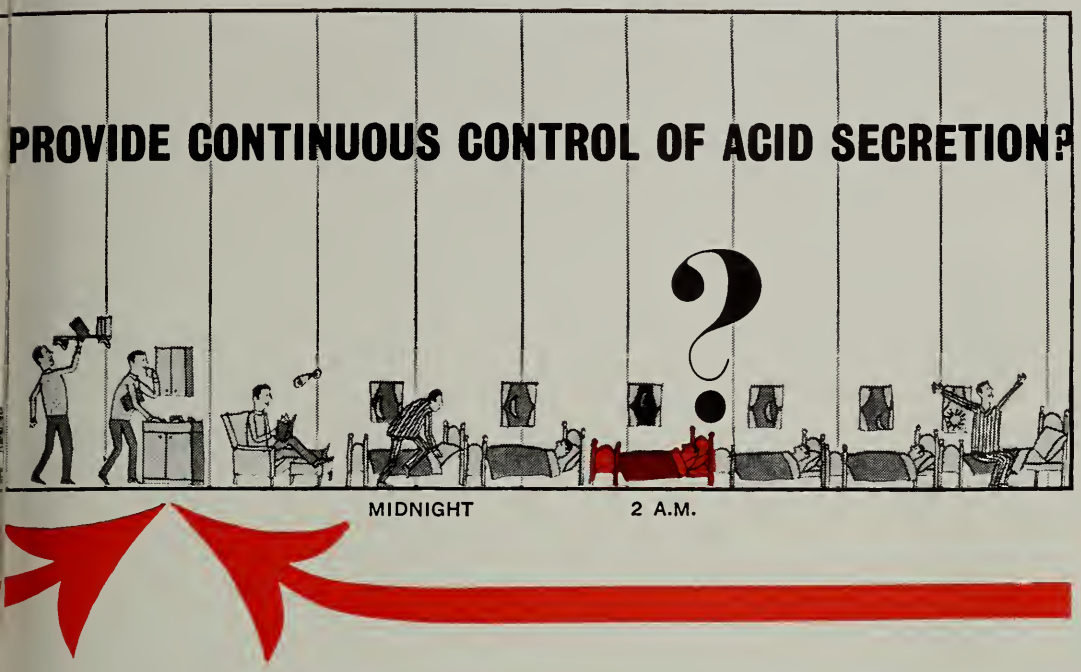
—Personal care, including toilet articles, cosmetics, haircuts, beauty treatments cost $4.2 billion.

We certainly imply no criticism of any of these expenditures. Any citizen has a right to spend as he pleases, whatever he may have left after taxes. But even if the expense of keeping well goes higher than it has, it looks as though the country could afford it.

Evansville Courier-Press
Dec. 27, 1959

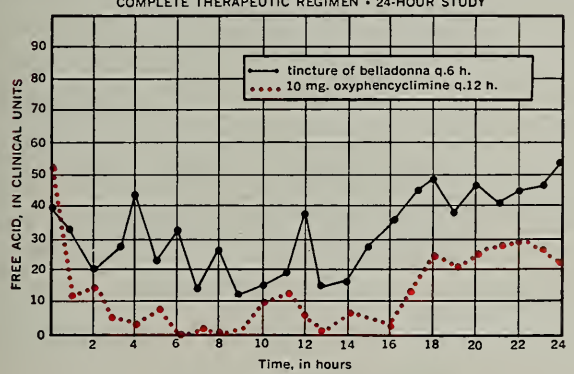
Continued on page 636

PROVIDE CONTINUOUS CONTROL OF ACID SECRETION?



"Prolonged periods of achlorhydria" after 10 mg. oxyphencyclimine q. 12 h.[2]

MEAN GRAPH OF GASTRIC ACIDITY IN 4 PATIENTS RECEIVING COMPLETE THERAPEUTIC REGIMEN • 24-HOUR STUDY



Clinical Diagnosis: Peptic Ulcer—Gastritis—Gastroenteritis—Colitis—Functional Bowel Syndrome—Duodenitis—Hiatus Hernia (symptomatic)—Irritable Bowel Syndrome—Pylorospasm—Cardiospasm—Biliary Tract Dysfunctions—and Dysmenorrhea.

Clinical Results: Effective in over 92% of cases.

As for Safety: "Side reactions were uncommon, usually no more than dryness of the mouth...."[4]

Each ENARAX tablet contains:

Oxyphencyclimine HCl ..... 10 mg.
Hydroxyzine (ATARAX®) ..... 25 mg.

Dosage: One-half to one tablet twice daily—preferably in the morning and before retiring. The maintenance dose should be adjusted according to therapeutic response. Use with caution in patients with prostatic hypertrophy and with ophthalmological supervision only in glaucoma.

Supplied: In bottles of 60 black-and-white scored tablets.

References: 1. McHardy, G., et al.: J. Louisiana M. Soc. 111:290 (Aug.) 1959. 2. Steigmann, F.: Study conducted at Cook County Hospital, Chicago, Illinois, in press. 3. Kemp, J. A.: Antibiotic Med. & Clin. Therapy 6:534 (Sept.) 1959. 4. Leming, B. H., Jr.: Clin. Med. 6:423 (Mar.) 1959. 5. Data in Roerig Medical Department files.

ROERIG Rx

New York 17, N. Y.
Division, Chas. Pfizer & Co., Inc.
Science for the World's Well-Being™

immortals of chinese mythology:



Ho Hsien-Ku

This gentle maiden became an immortal by her unique diet of moonbeams and mother-of-pearl

TODAY...

this steroid of unsurpassed safety and effectiveness holds an enduring place in the medical armamentarium

METICORTEN

METICORTEN,® brand of prednisone, 5 mg. tablets.

SCHERING CORPORATION • BLOOMFIELD, NEW JERSEY

You will soon receive in your mail a handmade, four-color three-dimensional figure of this Chinese Immortal, mounted and suitable for framing.

5-3468

Schering

Fourth Estate

Continued from page 632

Americans Pay For Health

Five years ago the typical American family spent 42% less money on health services. Now that same family spends $294 a year, with more than half of the increase accounted for by greater use of health services. Higher charges took care of less than half of the nearly $150 hike in the family's annual bill for health.

Another interesting fact is that children and older members of the family have increased their use of medical services by about 45% during the five years from 1953 to 1958. This additional use may have been in the form of special treatment, early attention to ward off disease, or more complicated forms of medication.

More people than ever are now protected by some form of health insurance. This is particularly true among the people over 65.

These facts seem to lead to the conclusion that Americans are willing to spend more for personal health, and that they are capable of paying the bill through individual, voluntary means. Certainly there is no comfort here for those who want to open the sidedoor to a government health program through the Social Security system.

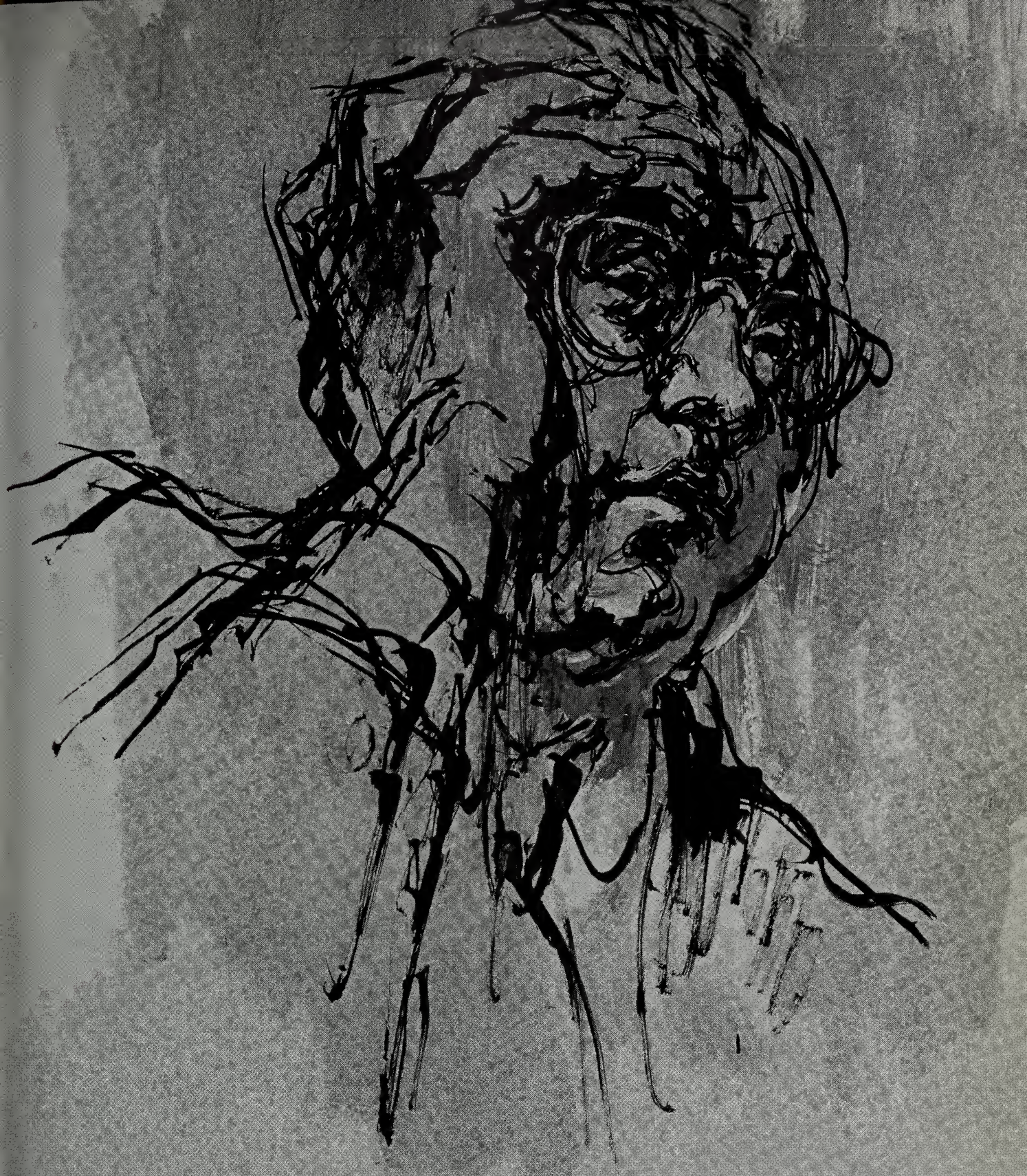
Indianapolis Star
Feb. 24, 1960

Future Happenings

The future of this or any other nation, to say the obvious, depends on the mental and physical well-being of its youth. What will happen or not happen tomorrow will be determined by the quality or lack of quality of the young people of today.

This truism gives significance to the National Youthpower Congress which is to be held in Chicago on February 11 through 13. Preparations for the Congress have been going on for months, and it has been given much national publicity and news attention. It is the climax of a nation-wide program designed to give high school students a better understanding of nutrition and good eating habits. Scientific survey after scientific survey, made by universities and other qualified institutions and organizations, have shown beyond doubt that an ominously high percentage of our teen-age boys and girls pursue diets which are seriously and often grossly inadequate.

Continued



When blood pressure must come down

When you see symptoms of hypertension such as dizziness, headache, and fainting your patient is a candidate for Serpasil-Apresoline. Even when single-drug therapy fails, Serpasil-Apresoline frequently can bring blood pressure down to near-normal levels, reduce rapid heart rate, allay anxiety.

SUPPLIED: Tablets #2 (standard-strength, scored), each containing 0.2 mg. Serpasil and 50 mg. Apresoline hydrochloride; Tablets #1 (half-strength, scored), each containing 0.1 mg. Serpasil and 25 mg. Apresoline hydrochloride.

SERPASIL®-APRESOLINE®

hydrochloride (reserpine and hydralazine hydrochloride CIBA)

CIBA
SUMMIT, N. J.

2/276SMK

Fourth Estate

Continued

Youthpower has the National Food Conference as its sponsor. This Conference, under the chairmanship of the president of the American Farm Bureau Federation, is made up of associations and companies representing every phase of the great food industry. Among them, for example, are the American Meat Institute, the American Bakers Association, the National Dairy Council, the National Association of Food Chains and so on. During the last school year the story was brought to teen-agers through the work of committees organized on state, county and regional basis. The pending meeting in Chicago is the culmination.

The seriousness of the problem has been brought out by many authorities. For instance, Dr. W. W. Bauer, Director of Health Education of the American Medical Association, recently contributed an article to *Family Weekly* entitled, "Why Teen-Age Girls Don't Eat Properly." The main reason, he found, was a fear of getting fat—"Slenderness, often to the point of emaciation, is a must with them." Also, he went on, part of the blame can be attributed to a wrong approach on the part of adults. They nag the young person, and that brings out the mule in the disposition.

Dr. Bauer provides six basic tips in good nutrition—and, though he is talking specifically about girls, they obviously apply to the opposite sex as well. Here they are: "Eat a good breakfast; you need morning energy for good work. There are many varieties of food, so choose the kind you like among fruits, vegetables, meats, fish, eggs, and other important foods. Go easy on sweets; no need to cut them out, but don't substitute them for more essential foods. Take enough time to enjoy your meals. Put worries and problems aside while you eat; keep mealtimes happy. Learn to like as many varieties of food as possible to make sensible eating fun. But don't din *your* ideas about diet into *their* ears. If we give young people a scientific basis for good dietary practice, they'll pick them up themselves without nagging."

The whole point is, of course, that young people need a balanced diet—one that provides them with the protein, vitamins, minerals and

Nation's Leading Designers and Builders of prefab "Medical Buildings"



An Erdman prefabricated medical building

• *designed to insure efficiency*

An efficient suite for medical use is not just a group of rooms. It has to be engineered to make the best use of space. Erdman prefabricated medical offices are individually designed for the selected building site and with your specific needs in mind, just as we have done for more than 275 doctors throughout the country.

• *prefabricated to save money*

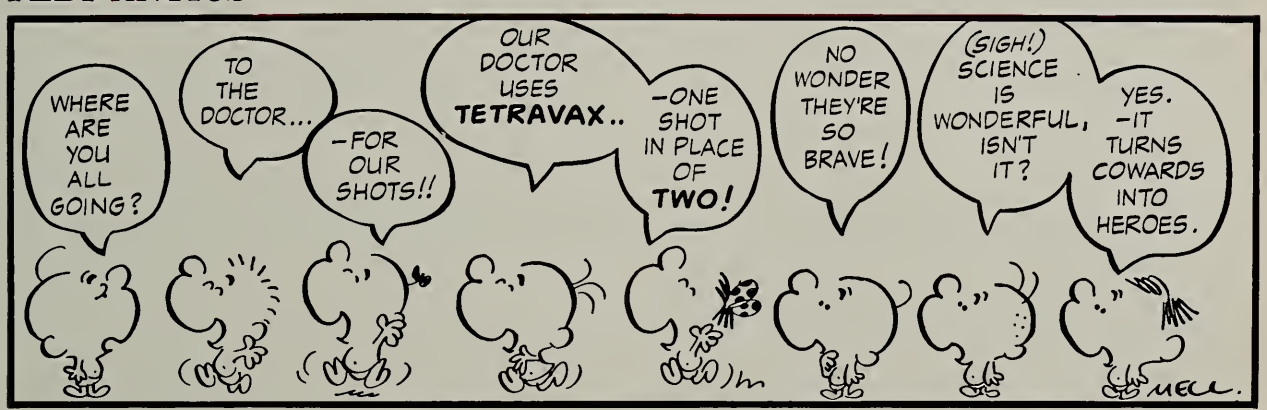
Because of standardized plans, mass-produced parts and materials, and experienced craftsmen — Erdman saves much in costs, minimizes construction time and insures an ideal building.

If you are interested in a medical building, write Marshall Erdman and Associates, Inc., 5117 University Ave., Madison 5, Wisconsin.

FOR SIMULTANEOUS IMMUNIZATION AGAINST 4 DISEASES:

Poliomyelitis-Diphtheria-Pertussis-Tetanus

PEDI-ANTICS



TETRAVAX®

DIPHTHERIA AND TETANUS TOXOIDS WITH PERTUSSIS AND POLIOMYELITIS VACCINES

now you can immunize against more *diseases...with* fewer *injections*

Dose: 1 cc.
Supplied: 9 cc. vials in *clear plastic* cartons. Package circular and material in vial can be examined without damaging carton. Expiration date is on vial for checking even if carton is discarded.



For additional information, write Professional Services, Merck Sharp & Dohme, West Point, Pa.

TETRAVAX IS A TRADEMARK OF MERCK & CO., INC.

MERCK SHARP & DOHME, DIVISION OF MERCK & CO., INC., PHILADELPHIA 1, PA.

Continued

other elements a body needs if it is to achieve maximum and lasting health. That is the goal of the Youthpower campaign. If it enjoys the success it so abundantly deserves, that will augur well for the American future.

Greenfield Democrat
Feb. 4, 1960

Just Window-Dressing

The proposal by the U.S. Treasury to permit doctors, lawyers, farmers and small businessmen to build up a retirement fund is mostly window-dressing. On the surface, this latest idea would let self-employed persons put off paying income tax on money they use in building up a retirement fund.

A string that is as big as a manila hawser is tied around the plan, however.

In order to obtain this "tax break," the self-employed person must provide anyone who works for him with a pension plan. This means that the doctor's receptionist, the lawyer's secretary, the farmer's hired-hand and the groceryman's delivery boy must be given a pension plan. Such a pension would doubtless have to be paid out of the pocket of the doctor, lawyer, farmer or small businessman. This is a practical and financial impossibility.

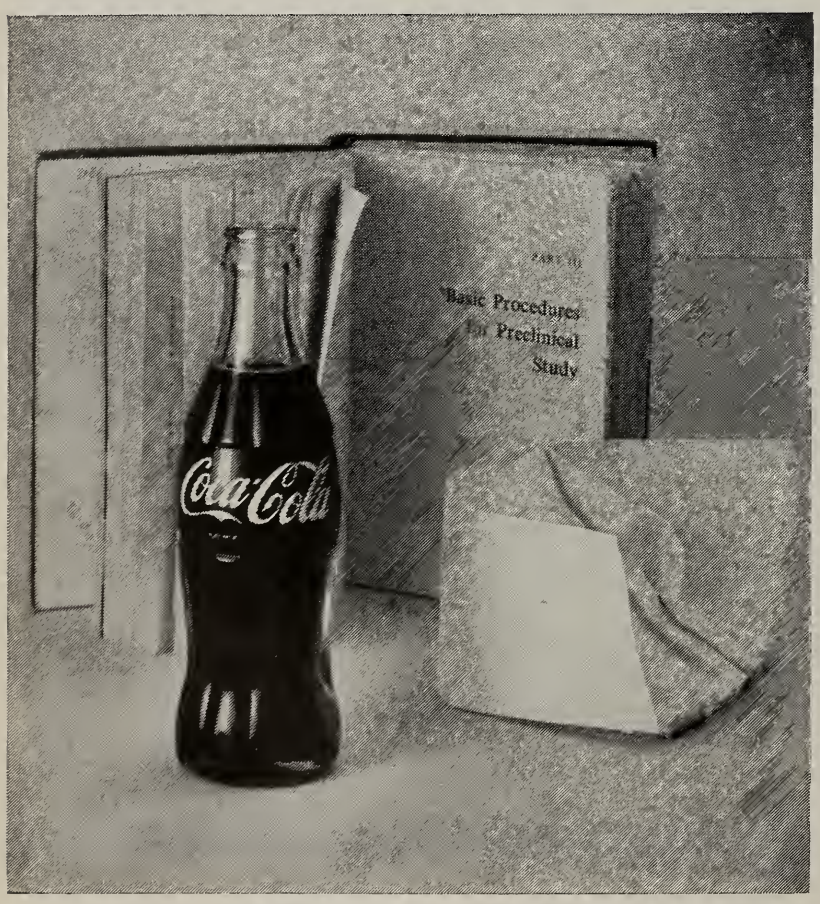
The Treasury proposal is transparently designed so that only a limited number would or could take advantage of its provisions.

With all this talk of pensions, no one has mentioned the general reflection cast on Social Security. All self-employed persons have to pay tax to the Social Security system which supposedly makes provisions for exactly the situation covered by any pension system. Yet, there are enough self-employed persons who want to take care of their future outside the Social Security system to bring on action in the House of Representatives, and a proposal on the matter by the Treasury.

Congress should not pass a self-employed pension plan law which is so drawn that it would be little more than meaningless. It might well use the discussion regarding pensions for self-employed persons as a launching platform to start a thoroughly honest and hard-headed review of Social Security itself.

Indianapolis Star
Feb. 25, 1960

◄



When too many tasks
seem to crowd
the unyielding hours,
a welcome
"pause that refreshes"
with ice-cold Coca-Cola
often puts things
into manageable order.

DRINK
Coca-Cola
REG. U.S. PAT. OFF.

The Journal of the INDIANA STATE MEDICAL ASSOCIATION

Supervised by THE COUNCIL

Volume 53 — April 1960 — Number 4

Annual Cancer Issue

Malignant Bone Tumors of Childhood

GEORGE J. GARCEAU, M.D.

Indianapolis

OF THE malignant bone tumors which occur in childhood and adolescent period, three types predominate. Osteogenic sarcoma, Ewing's sarcoma and reticulum cell sarcoma account for over 90% of malignant bone tumors observed on the service of the James Whitcomb Riley Memorial Hospital.

Osteogenic Sarcoma

Osteogenic sarcoma is by far the most commonly encountered malignant tumor. It is most frequently found affecting the ends of long bones and it especially prefers the distal end of the femur. The proximal end of the tibia and the proximal end of the humerus are also favorite locations for this lesion.

Early symptoms are aching and pain associated with swelling of the affected part. Early signs may progress rapidly and in a few weeks the pain becomes more severe.

Local swelling increases and the superficial veins over the tumor and surrounding areas become more prominent. Local tenderness is present. Loss of weight now becomes noticeable as does the secondary anemia. Deterioration is progressive and death occurs in from 12 to 18 months after discovery of the lesion. We have observed a few patients who have survived three to five years and one patient survived seven years following resection of the clavicle. It is apparent that the prognosis is extremely poor. We do not have a single patient who has survived this lesion regardless of the type of treatment.

X-ray appearance of these tumors varies a great deal. The sclerosing type of osteogenic sarcoma presents an x-ray picture which arouses one's suspicions immediately.

Very dense shadows in the metaphysis with evidence of cortical destruction and extra-cortical and subperiosteal new bone formation are so typical that the diagnosis of a malignant tumor is usually correct.

However, the roentgen diagnosis is not so easily reached when one is confronted with the osteolytic type of the tumor. The films show areas of decreased density interspersed with small areas of increased density. The cortical



FIGURE 1

OSTEOGENIC SARCOMA of femur. Note sclerotic bone in metaphysis of femur, and erosion of tumor through the cortex. Ewing's sarcoma in diaphysis of the proximal half of the femur. Sclerosis is not present in the cancellous bone. Note "onion peel" appearance of the subperiosteal new bone formation.

destruction will be a clue as with the subperiosteal soft tissue shadow. There usually are areas of increased density in the soft tissue shadow. One never feels secure in making a diagnosis in this type.

Gross pathology varies with the size of the tumor. Almost always the tumor has broken through the cortex and frequently invaded the surrounding soft tissues by the time amputation is performed.

Microscopic sections should always be studied by a competent pathologist and frequently such sections are sent to two or more pathologists. Unfortunately, such a pattern of study requires a period of several days between biopsy and definitive treatment by amputation or local resection as in a case of a tumor of the clavicle or rib. With the present knowledge of this tumor it appears that metastasis occurs through the blood stream. Dissemination of the tumor by biopsy is therefore possible. If such is true then amputation should be performed at the time of biopsy if improved survival results are to be expected. This means competent diagnosis based on examination of frozen sections.

The only other laboratory work of significance is the alkaline serum phosphatase when it is elevated. If it is normal it is of no significance. Elevation of serum alkaline phosphatase is only an indication of bone formation activity.

Treatment of osteogenic sarcoma is so disappointing that we wonder if it should better be called palliative management. Complete removal of the primary tumor before metastasis has occured should achieve a cure. Metastasis to the lungs is the usual complication. Lung metatasis must occur very early although x-ray evidence may not be present. Such metastasis may remain dormant for several years. As evidence we refer to our patient who survived seven years after resection of the clavicle. Nevertheless we should not be nihilistic in our approach to this lesion. Complete ablation of the tumor by amputation when possible or resection are the best types of management. Roentgen therapy may be used although it is of doubtful value. Such management will at least remove a visible and horrible tumor and thus remove a site of discomfort and pain. Amputation undoubtedly has cured some patients. Many series of patients have been reported with survival of 10% or more. At present early diagnosis and extirpation of the tumor appears to be the only hope of securing cures.

The chemical attack on the tumor may offer something worthwhile but to date has been disappointing.

Ewing's Sarcoma

Ewing's sarcoma has aroused a great deal of controversy, but we believe that such a lesion entity exists. The clinical course of this tumor is sufficiently clear and characteristic to allow us to make a diagnosis when the roentgen and microscopic picture supports it.

This tumor is encountered most frequently in the second decade of life, although we have observed it under 10 years of age and in patients over 20 years old. Males are more prone to it than females. In our series the long bones—the femur, tibia, humerus and fibula—have most frequently been the site of the presenting complaint. However, we have followed patients with the presenting tumor in the flat bones and one patient with the presenting tumor in the calcaneus.

Pain is the most common complaint and has usually been increasing. If the lesion is in the lower extremity the patient will limp and may complain of stiffness in the knee. The tumor will not be visible or palpable in the early stages.

Almost all of our patients have presented themselves late and therefore the tumor was palpable and often visible. This usually implies that the tumor has broken through the cortex and has invaded the surrounding soft tissues. The veins over the area are usually dilated. Tenderness to pressure was present in almost all of our cases. The clinical picture deteriorates rapidly. Fever up to 101 degrees is often recorded. Secondary anemia, leukocytosis and an elevated sedimentation rate may confuse the condition with osteomyelitis.

X-ray appearance is said by some observers to show no diagnostic characteristics. We agree with this opinion when the films are made early in the disease when the destroyed area is small. However, we believe the x-ray changes in the moderately advanced case show rather typical alterations from the normal. The tumor cell is essentially destructive and forms no osteoid. Destroyed areas reveal spaces of increased radiolucency. The periosteal activity produces new bone formation which appears to be laid down in layers—the so-called "onionpeel." This laminated appearance is observed in other bone tumors and in osteomyelitis but is seen especially often in Ewing's sarcoma after the cortex has been broken through. All of these changes are usually seen in the diaphysis of the long bones.

Microscopic Picture

The microscopic picture is said to have a characteristic appearance, and Ewing did describe a typical microscopic picture. However, we should leave the interpretation of the microscopic finding to the pathologist. Very few busy surgeons have the time to devote to the microscope necessary to make them proficient in microscopic bone pathology of bone tumors. The surgeon should study the section, although he should not amputate without competent opinion.

Differential Diagnosis

X-ray changes and microscopic appearance of the tumor may be confused with neuroblastoma and reticulum cell sarcoma. Since the neuroblastoma in bone is usually metastatic and reticulum cell sarcoma is similar to Ewing's sarcoma, the clinician is not necessarily confused with regard to management.

Prognosis in Ewing's sarcoma is extremely poor. Almost all of our patients were first observed after the cortex had been broken through.

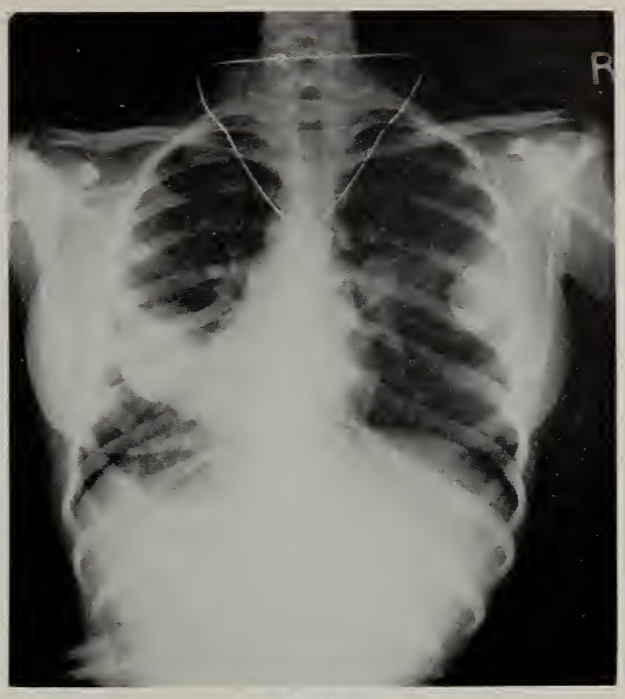


FIGURE 2

OSTEOGENIC SARCOMA of distal end of femur. Metastasis to lungs. Note round masses visible in both lungs.

Much earlier diagnosis is necessary if we are to report any survivals.

Treatment

We have performed primary amputation followed by x-ray therapy to the lungs, and radiation of the tumor immediately after biopsy followed by amputation. None of our patients have survived over two years and the majority have succumbed less than a year after first seen.

Reticulum Cell Sarcoma of Bone

Reticulum cell sarcoma has been recognized since about 1939 and therefore large series have not been gathered for statistical evaluation. The more recent literature suggests the lesion to be an entity and that the prognosis appears to be better than in other malignant tumors of bone.

This tumor has been observed in patients of any age. However, we have seen this lesion most frequently in children and young adults. Two of our patients were under 10 years of age.

Presenting symptoms of several months duration have been pain and aching, swelling of the involved area. Usually the patient appears to be in good health. Bones of the lower extremities are most frequently involved although in one of our patients the lesion was in a rib. The swollen area may be slightly tender, very firm and unquestionably is in the bone. There are no signs of inflammation even when the tumor is rather diffuse in the involved bone. The regional lymph

nodes may be enlarged and reveal the first sign of metastasis.

The diagnosis can be made only by biopsy. This tumor may be confused with Ewing's tumor. Since the prognosis in Ewing's tumor is very bad it is rather important to make a differential diagnosis between these two lesions.

X-ray appearance is one of osteolysis and bone destruction of a mottled or spotty pattern. Reactive proliferative bone formation surrounding the area is frequently observed. Osteogenic osteolytic sarcoma may be easily confused because the x-ray appearances are similar.

Treatment

We have employed radiation alone, radiation with local resection as in the patient with the tumor in a rib and radiation with amputation. In one case we used radiation with chemical treatment. Our small series suggest, that amputation offers the best prognosis, although we are aware of others who believe radiation is sufficient. At this time we prefer biopsy, radiation of the tumor and lymph nodes and amputation as soon as the diagnosis is definitely established.

Summary

The purpose of this paper is to stimulate an interest, hoping that earlier diagnosis may be made. Prognosis in malignant tumors of bone remains most discouraging. Early diagnosis and complete removal of the tumor offers the only hope of achieving an improved survival rate. Of the malignant bone tumors, the reticulum cell sarcoma has the better prognosis and early ablation of the tumor should improve the survival rate. ◄

Mark Your Calendar Now

ANNUAL ISMA CONVENTION

OCTOBER 3-5, 1960

AT THE FABULOUS

FRENCH LICK SHERATON HOTEL

Neoplastic Disorders of the Reticuloendothelial System in Infants and Children

ROBERT J. ROHN, M.D.
WILLIAM H. BOND, M.D.
MARION E. HODES, M.D.
Indianapolis

IN CONSIDERING those malignancies which occur in childhood, none occur more frequently nor are less amenable to therapeutic efforts than those which arise in the hematopoeitic tissues. Dorn and Cutler[1] note that the leukemias and lymphomas account for approximately 40% of the cancer cases in the 0-14 year age range. This is contrasted in the 45-65 year age group where leukemias and lymphomas constitute only 3.5% of all cancers reported.

Since reticuloendothelial malignancies affect many organs, these children will be brought to the attention of general practitioners, pediatricians, urologists, neurologists, orthopedists and other sub-specialty groups.

Since such patients require a great amount of specialized care from a wide segment of the medical population, it would seem to be of some interest to briefly outline our experiences with these diseases as we have encountered them at the James Whitcomb Riley Hospital and describe our philosophy of the therapy of such diseases and our attempts to understand the causation of such disorders.

Malignancy in 154 Children

From June 1951 to January 1960, we have had occasion to see and diagnose a malignancy of the reticuloendothelial system in 154 children from infancy to 16 years. Our reason for selecting 16 years as a cut-off point is that beyond this age these children are admitted to our adult facilities and are no longer regarded as pediatric patients.

It has been our custom to make a "cell-type" diagnosis in these children whether they suffer from a leukemic process or a malignant lymphoma. The incidence and variety of cases as we have seen them is listed in Table I. By adhering to a specific "cell-type" diagnosis three facts emerge:

1. Acute leukemias of lymphocytic origin overwhelmingly predominate in this age group of patients.
2. There is a definite relationship between cell type and survival.
3. There is a partial relationship between cell type and selection of therapeutic agents.

We have found that the ratio of males to females is 88 to 66, which essentially agrees with that reported by Dorn and Cutler[1] who noted an approximately 30% greater mortality of boys than girls in this age group. A much smaller series from a Pennsylvania survey[2] revealed a 16% greater mortality in boys than girls.

It is of some interest that we have established a diagnosis of leukemia in only one Negro child admitted to the inpatient or outpatient services of the James Whitcomb Riley Hospital. Negroes constitute only approximately 5% of the total admissions to this hospital and this may account for the infrequency with which we encounter this association.

From The Department of Medicine, Indiana University School of Medicine.

This work was supported in part by grants from the James Whitcomb Riley Memorial Association, "The Little Red Door," and Eli Lilly and Company.

Some Diagnoses Difficult

Establishing a diagnosis of leukemia or malignant lymphoma in these children may, in some instances, be a relatively simple matter, whereas in other situations extreme difficulties may be encountered in establishing such a diagnosis and several months may elapse between the onset of symptoms and examination of a definitive tissue. It is helpful if a high index of suspicion exists in the mind of the physician who has the responsibility for the care of these children.

If one considers the ubiquity of reticuloendothelial tissue it is possible for leukemia to mimic a variety of infectious or inflammatory disorders. It is conversely true that some infectious disorders—histoplasmosis, disseminated tuberculosis, infectious mononucleosis, streptococcal lymphadenitis, cat scratch fever and others —may closely mimic such malignancies. It should also be noted that systemic allergies will frequently be associated with prolonged, generalized lymphadenopathy. Aplasia of the marrow from any cause may be extremely troublesome in differential diagnosis and, indeed, leukemia may be observed after a prolonged period of marrow aplasia.

When leukemia or malignant lymphoma is suspected, a careful and complete examination of the peripheral blood elements by an experienced examiner is mandatory and may be virtually diagnostic in some cases of leukemia. While the number of leukocytes may be greatly increased to levels of 700,000 to 1,000,000 per cu mm, the majority of patients with acute leukemias will show levels below 50,000 leukocytes per cu mm. Normal or leukopenic levels may be encountered at any time in the disease process, with or without cytolytic therapy. Large numbers of patients will present initially with leukopenic counts.

Because the white cell level is so variable, qualitative evaluation of the leukocytes, platelet levels and the presence or absence of anemia will be helpful in evaluating the patient. While not invariable, thrombocytopenia occurs rather early in most pediatric patients suffering from acute leukemia and maintenance of normal platelet levels over a period of several months is fairly strong evidence against such a diagnosis. Such an alteration does not occur as early in those children suffering from malignant lymphomas, of course, and is a very late manifestation of those rarely encountered chronic leukemias.

Anemia is eventually a problem in all of these patients, but, in the absence of bleeding, may be a relatively late manifestation of such disorders.

All these children should be given the benefit of a bone marrow examination. It has been our custom[3] to culture all marrows of pediatric patients and we have had the pleasure of being able to change the diagnosis to a potentially curable one in a rare patient where the cellular reaction to bacterial or mycotic organisms mimicked a malignancy of reticulum cells. In most cases of leukemia, and many cases of lymphosarcoma or reticulum cell sarcoma in infants and children, the findings of the bone marrow will be diagnostic very early in the disease process.

At times the infiltration of the marrow will be intense and great force will be required to obtain even a drop of marrow in the tip of the needle. The uninitiated will often erroneously call this a "dry tap," or an aplasia of the marrow, and fail to examine the minute content of the needle which is obtained. Such examination is, however, quite rewarding and it is usual, under these circumstances, to find solid sheets of neoplastic cells in such preparations.

Use Supravital Stain Technic

It is our custom to examine all of our marrows with supravital stain technic.[4] We find this stain most suitable for differentiation of the various leukemic types. Wright's and Wright's-Giemsa stained preparations are quite satisfactory under most circumstances, but H & E stains of centrifuged bone marrow "buttons" are of little help in identification of specific cell types of the various leukemias.

Lymph node biopsy may be necessary to establish a definitive diagnosis when the peripheral blood and bone marrow are non-revealing. It should be noted here that culture of portions of the lymph node is quite feasible and occasionally proves effective in establishing a diagnosis where other measures have failed.

Under particular circumstances specialized studies of specific organ systems (genitourinary, pulmonary, musculoskeletal or central nervous system) may be required when localized infiltration of these organs represents the presenting manifestation of the disease.

Occasionally, after a detailed and competent investigation the diagnosis may still remain

Disorder	Males	Females	Total
Acute Lymphocytic Leukemia	62	43	105
Monocytic Leukemia	10	10	20
Hodgkin's Disease	8	2	10
Non-Leukemic Reticuloendothelioses	3	3	6
Myeloblastic Leukemia	0	3	3
Extramedullary Lymphosarcoma	2	1	3
Reticulum Cell Sarcoma	2	0	2
Chronic Myelocytic Leukemia	1	1	2
Leukemic Reticuloendotheliosis	0	2	2
Erythroleukemia	0	1	1
	88	66	154

TABLE 1

Neoplastic disorders of the Reticuloendothelial System in infants and children seen at the James Whitcomb Riley Hospital from June 1, 1951 to January 1, 1960.

doubtful. Under these circumstances, we feel that it is better to allow a period of observations during which repeated hematological examinations may be obtained. It has been our experience in this group of patients that longevity is not materially altered by the rapidity with which the diagnosis is established and therapy instituted, and considerable emotional damage may be caused if such a diagnosis is prematurely made and subsequently proved erroneous. If cures could be reasonably anticipated by early diagnosis and treatment, it would be reasonable to treat an occasional patient who did not suffer from such a disease in the interest of providing early treatment for all patients with leukemia. We have not, however, seen any patient cured in whom a diagnosis of malignancy of the reticuloendothelial system was, with certainty, established.

Problem of Therapy

Once a diagnosis of leukemia or malignant lymphoma has been definitely established the problem of therapy must be entertained. Some parents and some physicians are reluctant to undertake the treatment of such patients because of the incurability of such disease processes. Such reluctance is a problem particularly in those instances where the diagnosis is that of an acute leukemia.

It is true that no cures have been achieved in such patients, and it is further true that the treatment of these children demands a great deal of the physician's time and effort, not only in the medical problems attendant upon treatment of the disease, but also in providing emotional support to both the patient and responsible relatives of the patient.

It is our feeling, nevertheless, that such patients merit active care. It has been demonstrated that the life of these patients can be prolonged[5, 6] by proper use of various cytolytic agents. Since no one can, with certainty, predict if or when a cure for leukemia will become a reality, we feel the obligation to sustain life in these children as long as is possible. It has further been our observation that when treatment is denied these children by the physician, the parents will often consult ethical and non-ethical practitioners until they find one who will offer help to them.

While it is obvious that those children suffering from chronic leukemias and lymphomas may enjoy relatively long periods of well-being, it is equally true that a great many children with acute leukemias may also be restored to a state of well-being for many weeks or months. Indeed, in those patients enjoying a good, therapeutically-induced remission, both clinical and hematological evidence of the disease may be eradicated and the child may pursue all of his usual pursuits for months.

It is usually possible with cooperative parents and a responsive patient to keep hospitalization to a minimum. In this connection, it should be noted that the liberal use of antibiotics and outpatient blood transfusions does much to minimize hospitalization periods.

In addition to such supportive measures, certain specific cytolytic agents have demonstrated an ability to suppress leukemic activity for varying periods of time. There are hundreds of such agents[7] undergoing laboratory and clinical trial at this time and neither space nor time permits detailed study of all of them. We have,[8] in some detail, described the use of a number of these agents. It might be pertinent, though, to briefly outline here our customary use of some of them.

X-Ray Therapy

In children with reticuloendothelial malignancies, there are two indications for x-ray therapy:

(1) It is a most useful agent in the management of localized extramedullary malignant lymphomas and, in those situations where there is a considerable mass of tumor tissue, no other agent can equal its effectiveness.

(2) Rarely, in acute leukemias where *localized* infiltrative disease produces progressing discomfort and/or threatens life, very small, repeated x-ray doses may prove quite useful. In overall control of acute leukemia we have obtained little help from x-ray and it may even considerably worsen the clinical status.

We have not found in pediatric leukemias and lymphomas that radioactive isotopes can accomplish anything that cannot be accomplished better with other agents.

Corticosteroids

No one corticosteroid agent is markedly superior to any other, though, since those children who are started on steroids will be receiving them for long periods of time, we prefer using those that have minimal mineral-corticoid effect. These agents have proved most effective for us in acute lymphocytic leukemia and Hodgkin's disease, and, though we may use them for supportive effect in the course of any of these neoplasms, it is only in acute lymphocytic leukemia and Hodgkin's disease that these agents demonstrate oncolytic effects.

Since all of the corticosteroid agents have undesirable side effects which tend to be cumulative with time, we have a tendency to defer the use of such agents until late in the course of such disorders or where the patient is acutely threatened by the disease process. We have not been impressed that heroic doses of such agents offer any sustained beneficial effect and we rarely exceed a prednisone dosage of 80 mgm/day or equivalent doses of other corticosteroids, and such dosages are employed only for short periods of time.

Metabolic Antagonists

Though a great many of these agents have had extensive clinical trial we have found none that is clearly superior in ease of administration and effectiveness of producing remission to the folic acid antagonist aminopterin[9] and the purine antagonist 6-mercaptopurine. Since easily detectable toxic manifestations occur with aminopterin and serve as an accurate point for termination of therapy, and since the remission periods are more prolonged, we tend to employ this agent first in the treatment of children suffering from acute lymphocytic and monocytic leukemia. 6-mercaptopurine is well tolerated and will, in many instances, effect remissions after refractoriness to aminopterin has developed. We have not observed any advantage in using these agents concomitantly, though we will often administer either one of them in combination with a corticosteroid agent.

Alkylating Agents

These agents have been most useful in controlling disseminated extra-medullary lymphomas. We tend to manage these children much as we do our adult patients with such disorders. When Hodgkin's disease shows extensive progression we tend to rely on nitrogen mustard in a total dose of 0.4-0.5 mgm/kg of body weight. When Hodgkin's is less aggressive but still disseminated, we use an oral alkylating agent —usually TEM—in a total dose of 15 mgm administered orally on an outpatient basis.

Myleran, because of its ease of administration and effectiveness of action, is clearly the present-day drug of choice for chronic myelocytic leukemia.

We have, on an experimental basis, used a new agent, Epoxypropidine,* which in initial trials has demonstrated oncolytic activity against reticulum cell sarcoma, Hodgkin's disease and monocytic leukemia. This agent has also proved effective and well tolerated when injected intracavitarily into malignant fluid accumulations. With other agents we have either not had extensive experience or have found them inferior to the above mentioned agents.

Other Agents

We are currently using a new plant alkaloid, Vincaleukoblastine,* in a variety of hematological disorders[10, 11] and in some patients with acute leukemia who have become refractory to the effects of metabolic antagonists and steroid agents we have been successful in re-establishing hematological remission. There has been some suggestion that this agent might be more effective

* Supplied to us through the generosity of the Eli Lilly and Company.

than any other we have tried in acute myelocytic leukemia.

A large number of children with acute leukemias have been followed by us throughout the entire course of their disease. These children have shown great variability in survival, but in general those with acute lymphocytic leukemia have had an overall average survival of 24.5 weeks. Nine children (8.6%) have survived more than one year. The survival in monocytic leukemia has averaged 16.2 weeks, with one patient (5%) surviving more than one year. Only three children were treated for myeloblastic leukemia. Two of these died in one week while the remaining one survived 34 weeks.

We have seen only a relatively small number of children with chronic myelocytic leukemia, malignant lymphomas and reticuloendothelioses, but in survival, in response to therapy and in progression of the disease activity these children seem to resemble their adult counterparts. It is of interest that we have not encountered any children suffering from chronic lymphocytic leukemia.

Acute Leukemias

We have had certain experiences with the acute leukemias that have provoked our research interests. It was noted above in this presentation that many of the children who presented with a picture of aplasia of the bone marrow evenually demonstrated a picture of acute leukemia, months after the onset of this process. One is tempted to speculate, under these circumstances, that the patient was suffering from the leukemic process throughout the course of the processes, as was postulated by Block.[12] An alternative possibility existed that this aplasia was caused by an agent, known or unknown, which was leukemogenic, such as has been demonstrated following exposure to high energy agents.

Recently, however, one of our patients who, along with two other members of his family, suffered from Fanconi's syndrome with profound prolonged leukopenia developed a classical acute monocytic leukemia. This association has been observed elsewhere[13] and raises a question whether prolonged suppression of myelopoeisis will, in itself, in some way, promote a leukemic process. This is currently the subject of study.

Of even greater interest is the morphological resemblance between acute lymphocytic leukemia in children and the acute leukemia of mice. The fact that mouse leukemia can be induced with viruses has led us to obtain cell-free extracts of DNA and RNA from bone marrow and lymphatic tissues of pediatric patients with various leukemias and malignant lymphomas which we are inoclulating into various strains of inbred mice. This project is well underway and in a few years should be most informative.

In an attempt to obtain more effective chemotherapeutic agents we have sought new agents for trial from two sources. As a participant in a cooperative chemotherapy group we have had the opportunity to obtain new agents from the National Institutes of Health for blind trial. From the Eli Lilly and Company we have had opportunity to obtain new agents for very early clinical trial in phase I and II studies.

It is hoped that through these efforts more effective methods for caring for these unfortunate children will be elaborated.

Summary

1. We have presented our experiences with neoplastic disorders of the reticuloendothelial system in infants and children seen at the James Whitcomb Riley Hospital from June 1, 1951 to Jan. 1, 1960.
2. Problems in diagnosis and methods of management have been discussed.
3. Current and proposed research activities have been outlined.

REFERENCES

1. Dorn, H., Cutler, S. J.: Morbidity From Cancer In The United States. *Public Health Monograph,* 56: 1959.
2. Pennsylvania Cancer Coordinating Committee: *Annual Report Bulletin,* 11: 1957.
3. Rohn, R. J., Bond, W. H.: The Value of Routine Bone Marrow Culture for Histoplasma Capsulatum in Pediatric Hematology. *Blood,* 8:329-335, 1953.
4. Rohn, R. J., Bond, W. H.: Some Supravital Observations on the "L. E." Phenomenon. *Am. J. Med.,* 12: 422-432, 1952.
5. Haut, A., Altman, S. J., Cartwright, G. E., Wintrobe, M. M.: The Influence of Chemotherapy on Survival in Acute Leukemia. *Blood,* 14:828, 1959.
6. Burchenal, S. H., Murphy, L. M., Tan, C. T. C.: Treatment of Acute Leukemia. *Pediatrics,* 18:643, 1956.
7. Greenstein, J. P., Haddow, A.: *Advances in Cancer Research,* 4: 1956.
8. Rohn, R. J., Bond, W. H.: Some Indications for the Use of Chemotherapy in Neoplastic Disorders. *J. Ind. S. M. A.,* 50:417-428, 1957.

9. Farber, S.: Proceedings of the Second Conference on Folic Acid Antagonists in the Treatment of Leukemia. *Blood,* or Supplements, 109: 1952.
10. Hodes, M. E., Rohn, R. J., Bond, W. H.: Effect of a Plant Alkaloid, Vincaleukoblastine, in Humans. *J. Lab. Clin. Med.,* 54:826, 1959.
11. Hodes, M. E., Rohn, R. J., Bond, W. H.: Preliminary Studies on the Therapy of Acute Leukemia with Vincaleukoblastine. *Proc. Am. Assn. Cancer Res.* 4: (in press) 1960.
12. Block, M., Jacobson, L. O., Bethard, W. F.: Preleukemic Acute Human Leukemia. *J. A. M. A.,* 1018: 1953.
13. Garriga, S., Crosby, W. H.: The Incidence of Leukemia in Families of Patients with Hypoplasia of the Marrow. *Blood,* 14:1008, 1959. ◄

The Journal of the Indiana State Medical Association

MEDICAL ESSAY CONTEST

for

Interns and Residents of Indiana Hospitals

During the intern and resident year of 1959-60 The Journal is sponsoring a medical essay contest open to interns and residents of hospitals in Indiana. The subject matter will be limited to clinical experience observed primarily in the teaching hospital of the author. Presentations may contain up to 4,000 words and preferably should be illustrated with clinical pictures, graphs or tables.

A first prize of $100.00, a second prize of $75.00 and a third prize of $50.00 will be awarded. All entries are eligible for consideration for publication in The Journal.

Manuscripts will be judged by a prize award committee selected by the Editorial Board of The Journal and by the Dean, Indiana University School of Medicine.

Manuscripts should be prepared in accordance with the specifications outlined on the masthead page of The Journal.

Entries must be submitted prior to May 1, 1960.

The manuscript itself is to be identified only by the title. The author's name must not appear in the manuscript. Instead, a special title page bearing the title and the author's name and address should accompany the paper. Mail entries to Mr. James A. Waggener, 1021 Hume Mansur Bldg., Indianapolis 4.

Diagnosis of Malignant Gynecologic Tumors In Infants, Children and Adolescents

SPRAGUE H. GARDINER, M.D.
CARL P. HUBER, M.D.
Indianapolis

IN CONTRAST to the high incidence of cancer of the female reproductive organs in adults, malignant gynecologic tumors are seldom found in infancy, childhood or adolescence. Deaths from gynecologic malignancies represent less than 1% of all cancer deaths in children under 15 years of age.[1] During the last 20 years, only one in every 3,731 female patients, under the age of 20, admitted to the Indiana University Medical Center was found to have a malignant gynecologic tumor.

Though infrequent in occurrence, the possible existence of a gynecologic malignancy must be considered in young patients presenting any of the following problems:

1. Vaginal spotting or bleeding in the preadolescent or irregular vaginal bleeding in the adolescent.
2. Young girls with abdominal or pelvic pain associated with a questionable lower abdominal or pelvic mass.
3. The appearance of female secondary sex characteristics before age nine.
4. Those infants or children whose external genitalia appear to be ambiguous as far as determination of sex is concerned (Pseudohermaphroditism).

This presentation is based upon a review of cases at the Indiana University Medical Center during the past 20 years with the following diagnoses:

1. Malignant gynecologic tumors in patients 18 years of age or younger.
2. Precocious puberty in girls before the age of nine years.
3. Female pseudohermaphroditism in infants and children.

MALIGNANT GYNECOLOGIC TUMORS

Gynecologic tumors are much more apt to be malignant in these young patients than is the case in the adult. Seventy per cent of the malignant gynecologic tumors in children and adolescents are of ovarian origin, whereas, in the adult, 80% of the malignant gynecologic tumors arise in the uterus. In general, the prognosis for a malignant gynecologic tumor occurring in young patients is poor, the malignancy usually being far advanced when the diagnosis is first established.

The frequency and type of benign and malignant gynecologic tumors in infancy, childhood and adolescence at the Indiana University Medical Center may be seen in Table I.

It may be seen that one-third of the gynecologic tumors were malignant. The types of benign tumors are similar to those found in the adult. Of the malignant variety, however, dysgerminoma, malignant teratoma and sarcoma botryoides may be considered as characteristic of the young gynecologic patient.

Ovarian Malignancies

Unfortunately, most ovarian malignancies produce no symptoms until the disease is well advanced. When symptoms do appear they usually

From the Department of Obstetrics and Gynecology, Indiana University School of Medicine, Indianapolis.

Gynecologic Neoplasms in Children and Adolescents
at the Indiana University Medical Center

BENIGN		Cases 23	MALIGNANT		Cases 10
OVARY		20	OVARY		7
Benign teratoma	9		Adenocarcinoma	3	
Serous cystadenoma	6		Dysgerminoma	2	
Pseudomucinous cystadenoma	4		Malignant teratoma	3	
Fibroma	1		(Granulosa cell carcinoma—0)		
UTERUS		1	UTERUS		1
Stromal endometriosis	1		Adenocarcinoma	1	
VAGINA		0	VAGINA		2
VULVA		2	Sarcoma botryoides	2	
Lipoma	1		VULVA		0
Hemangioma	1				

TABLE I

consist of lower abdominal and pelvic pain and discomfort often radiating to the back and legs; gastrointestinal symptoms of nausea, vomiting and diarrhea; enlargement of the lower abdomen; weakness and weight loss. Precocious puberty is rarely a manifestation of ovarian malignancy.

1. Ovarian adenocarcinoma:

The symptoms, physical findings and pathological types are similar to those in the adult. The three patients we are reporting were all adolescents, the youngest being 14 years of age. All three patients had matured normally. The duration of symptoms of the ovarian malignancy was three weeks, two months and six months prior to the first examination by a physician. Each patient had a large, easily palpable abdominal mass when first seen. Two patients succumbed to their malignancy within one and a half years of the onset of symptoms after having received only external radiation because the extent of the metastatic disease made surgical removal impossible. The third patient was asymptomatic and free of evidence of pelvic disease two years after the surgical removal of an incapsulated ovarian tumor, the size of a "seven months pregnancy." Surgery had been followed by external radiation.

2. Malignant teratoma:

Teratomas are more often malignant in the young patient than is the case in the adult. Two of the 11 teratomas in this series were of the malignant variety. In each of the two cases, aged 8½ and 11, large abdominal masses were present when first seen by a physician. Death occurred in each case within a few months in spite of palliative surgery and external radiation.

Although neither of these patients showed any evidence of precocious puberty, the urine of both patients produced a positive "pregnancy" test due to the chorionic gonadotropic hormone produced by the embryonal cells of the tumor. Several cases of precocious puberty in association with malignant teratomas have been reported.[2] The explanation has been given that the gonadotrophin produced by the embryonal cells stimulated the development of multiple ovarian follicles with the resultant excessive estrogen production.

3. Dysgerminoma.

This unusual ovarian tumor is found more frequently in the younger patient. Of the reported cases, 16 to 25% have occurred in those under the age of 14.[3] These tumors arise from mesenchymal cells in the ovary which date back to the undifferentiated (asexual) stage of gonadal development. Dysgerminomas must be considered malignant because the over-all 5-year survival rate in all age groups is only 27%.[3] In the prepubertal patient, the survival rate is even lower. The dysgerminoma tumor produces no hormone and, thus, differentiation from other ovarian malignancies cannot be made preoperatively.

Although most children develop normally until the onset of symptoms of the ovarian neoplasm, a few cases have been reported of dysgerminoma coincidentally associated with female pseudohermaphroditism.[3,4] Several cases have also been reported of dysgerminoma associated with ovarian choriocarcinoma and malignant teratoma

in which the urine has given a positive pregnancy test.[3,5]

Two Case Findings

The findings in the two cases of dysgerminoma in our series are as follows:

Case 1. Development had been normal in this young girl until the age of nine at which time an encapsulated left ovarian tumor had been removed, preceded by a week of nausea and vomiting. Microscopic examination revealed a typical picture of a dysgerminoma. The patient remained well until the recurrence of nausea and vomiting two years and three months later, at which time exploratory laparotomy revealed an extensive malignancy filling the pelvis. There were pulmonary metastases and bilateral ureteral obstruction. She was referred to the Indiana University Medical Center for external radiation but died of her extensive disease before a course of x-ray therapy could be completed.

Case 2. This 17-year-old girl had developed normally until the onset of lower abdominal pain and weight loss. Three months later, an exploratory laparotomy revealed a firm, fixed tumor filling the entire right side of the pelvis. A biopsy of the tumor revealed dysgerminoma. The patient was referred to the Indiana University Medical Center for further treatment. Following external radiation, the pelvic mass showed remarkable resolution. However, within two months there was wide-spread pelvic recurrence. The patient's course progressed rapidly down hill and death from the malignancy occurred before the second course of external radiation could be completed.

4. Granulosa cell carcinoma:

Although this estrogen-producing ovarian neoplasm is rarely found in the prepubertal patient (5% of all granulosa cell carcinomas),[2] its possible presence is immediately considered by every physician in a young patient with premature female sex development. Granulosa cell tumors arise from the primitive granulosa cells in the mesenchyme of the ovary and, since they produce estrogen, are spoken of as "feminizing mesenchyomas of the ovary."[4] Characteristically, they occur as a unilateral encapsulated ovarian enlargement of moderate size. They are of a relatively low-grade malignancy as recurrence is reported in less than one-third of the cases following unilateral oophorectomy.

We have reviewed all cases of granulosa cell carcinoma and all cases of female precocious puberty admitted to the Indiana University Medical Center during the past 20 years and no case of granulosa cell carcinoma occurring before the age of 9 has been discovered.

Pedowitz, Felmus and Mackle[2] reviewed the data on the 63 cases of granulosa cell carcinoma in prepubertal children reported up to 1955. Their analysis of these cases emphasized the following important clinical characteristics of the granulosa cell carcinoma in prepubertal patients:

1. Well-developed female secondary sex characteristics were present in all but two cases (these two case histories contained no statement). In most instances of granulosa cell carcinoma, the development of the breasts, external and internal genitalia, axillary and public hair were comparable to the development expected in an adolescent girl.

2. Vaginal bleeding was present in all but nine cases. The bleeding may be cyclic or acyclic but is always anovulatory and results from estrogen stimulation.

3. An abdominal mass was found preoperatively in all but four cases and a pelvic mass (by combined abdominal vaginal or abdominal rectal examination) was found in *all* cases. Therefore, the failure to find a pelvic mass in a patient with female precocious puberty when examined under anesthesia, rules out for all practical purposes, the existence of granulosa cell carcinoma.

4. The bone age as determined by x-ray was advanced in two-thirds of the cases so studied.

5. Removal of the granulosa cell carcinoma was followed by a prompt regression of the precocious female sex characteristics to a level commensurate with the chronological age of the patient.

Adenocarcinoma of the Cervix

While squamous cell carcinoma of the cervix has not been observed below the age of 12, a considerable number of adenocarcinomas have been reported in much younger children, the youngest being a seven-months infant.[4] The symptoms, findings and treatment of cervical carcinoma in these young patients are the same as in the more adult patient. This points up the potential value of a Papanicolaou smear being taken even on the young patients.

Case Report. Pelvic examination of this 16-year-old girl who had had a moderate, profuse,

yellow-brown vaginal discharge for the preceding five months revealed a large, polypoid, cauliflower-like mass protruding through the external cervical os and filling most of the vaginal canal. The corpus and adnexae were normal and there was no evidence of parametrial extension. The biopsy of the tumor revealed undifferentiated adenocarcinoma of the cervix.

A course of external radiation therapy was followed by two intracavitary and intravaginal radium applications. Because of the patient's young age, a marked departure from the usual treatment of adenocarcinoma of the cervix was made and, six weeks after the second radium application, the ovaries, tubes and entire uterus with a wide vaginal cuff were removed surgically. Pathological examination of this tissue revealed residual adenocarcinoma along the cervical canal extending partly through the cervical wall. At a recent follow-up examination nine years later, the patient, age 25, was asymptomatic and free of disease.

Sarcoma Botryoides

This rare but highly malignant neoplasm is found most frequently in infants and young children.[6,7] Sarcoma botryoides is a mixed mesodermal malignancy originating from primitive Mullerian mesoderm and contains both epithelial and connective tissue elements. Grossly, these tumors appear as multiple, swollen, pinkish, polypoid masses arising from the cervix or vagina. Early in the disease, the polyps may appear innocuous and biopsy may reveal only myxomatous tissue covered by normal squamous epithelium, thus masking the highly malignant nature of the tumor.

The local recurrence rate is high and practically all cases have terminated fatally. Since the only hope of a cure has resulted from early diagnosis followed by very radical surgery,[8,9] the finding of a polyp protruding through the introitus or found lying in the vagina of an infant or young child should constitute a provisional diagnosis of sarcoma botryoides.[7]

Case Report. Our two patients were 2½ and 3½ years of age respectively and both had been taken to their family physician because of a bloody vaginal discharge with fleshy polyps protruding through the introitus. In one child, examination on admission at the Indiana University Medical Center revealed extensive involvement of the vagina and cervix with cauliflower-like growths and wide-spread pelvic involvement.

The other patient had received x-ray therapy six months previously because of a polypoid mass protruding from the vagina. After a brief improvement, she was admitted to the Indiana University Medical Center, at which time examination revealed multiple, pinkish, polypoid masses arising from the posterior vaginal wall. In view of the duration of the disease and the extent of the local involvement, cure by radical surgery was considered unlikely.

Both patients received external radiation therapy but succumbed to the malignant disease within six months. The pathological report of tissue from each patient showed a mixed mesodermal malignancy.

DIFFERENTIAL DIAGNOSIS OF PRECOCIOUS PUBERTY

Precocious Feminization

Although rarely found responsible, the possible existence of an ovarian malignancy must be eliminated in those patients under the age of nine who show evidence of precocious feminization. All granulosa cell carcinomas and some ovarian malignant teratomas and choriocarcinomas produce precocious feminization.[3,5]

Normal puberty in girls may begin at any time between the ages of 9 and 17. Precocious puberty implies the appearance of female secondary sex characteristics in girls before the age of 9.

1. *Constitutional or idiopathic precocious puberty.*

The great majority of cases of precocious puberty (estimated by Novak to be 90%) are the result of constitutional or idiopathic premature activation of the anterior pituitary gland. Studies of these youngsters have revealed no pathology; they remain well and mature into normal adult women.[10]

As is found in normal adolescent development, the age of appearance of premature feminization, the speed of development and the pattern it follows varies from case to case. The following information is taken from six cases of constitutional female precocious puberty at the Indiana University Medical Center in whose studies we have had the opportunity of participating. These data will illustrate the clinical characteristics of the constitutional variety and the methods employed to eliminate the possible existence of ovarian malignancies.

Summary of Six Cases of Constitutional Precocious Puberty studied at the Indiana University Medical Center

a. The average age of these patients when seen was 5 years (21 months-10 years), the average age of onset of precocious puberty was 2½ years (2 months-6 years) and the duration of these changes from onset to the first Indiana University Medical Center visit was two years (6 months-4 years).

b. Breast development. In most cases, this was the first manifestation of precocious feminization, appearing at an average age of 2½ years (2 months-6 years). There was a wide variation in the degree of breast enlargement.

c. Pubic hair. In several, this appeared simultaneously with the breast development. The average age of appearance was 3½ years (14 months-6 years). The amount and texture of the hair varied. Axillary hair appeared later, the amount proportional to the degree of development of the pubic hair.

d. Menstruation. The age of onset of periodic (cyclic or acyclic) vaginal bleeding in four patients was 14 months, 4 years, 6 years and 6 years. Two patients had not begun menstruation when first seen. As in normal adolescents, the first year of menstruation in these precociously developed children is probably anovulatory, but at any time the cycles may become ovulatory and, if exposed, pregnancy may result (18 instances of pregnancy in girls between 5 and 10 years of age have been reported).[10] These ovulatory menstrual cycles are in contrast to the periodic uterine bleeding associated with ganulosa cell carcinoma, which is always anovulatory in type.[4]

e. External and internal genitalia. The degree of maturation varied considerably but the relative development of the clitoris, labia, vagina and uterus was similar to that of the normal adolescent. (Fig. 1.)

f. Ovaries. No evidence of an ovarian tumor was found in any of these cases. Because of the difficulty of a pelvic examination in these young patients, two were examined under anesthesia and exploratory laparotomy was performed on three others only to find normal ovaries and adrenals. This is in contrast to the reported cases of precocious puberty associated with granulosa cell carcinoma, ovarian malignant teratomas and choriocarcinoma for, in every case, pelvic examination revealed an adnexal tumor.[2]

g. General body growth. In all but one of these patients, the general physical growth was advanced for the chronological age.

h. Neurological findings. Neurological histories and examinations in these patients were normal. While precocious puberty may be associated with central nervous system tumors and developmental anomalies, in all the reported cases the symptoms and signs of neurological disease have been prominent.[10]

i. X-ray studies. The skull and sella turcica were reported as normal in each case. X-ray



FIGURE 1

EXTERNAL GENITALIA of a 4¾ year-old girl with idiopathic precocious puberty.



FIGURE 2

CONGENITAL ADRENOGENITAL syndrome (Female pseudohermaphroditism) in a girl 5½ years of age.

evidence of advanced osseous development (bone age) was reported in all but one case.

j. Hormonal studies.

1. Pituitary gonadotropin and estrogen determinations were negative or slightly elevated for the chronological age but proportional to the degree of sexual maturation. In granulosa cell carcinoma, there is characteristically a pathologic elevation of the estrogens.[2]
2. Chorionic gonadotropins. Tests for this hormone were negative in each case, the tests being positive only in malignant teratomas, ovarian choriocarcinomas and pregnancy.
3. 17-Ketosteroids. The results of this test, a measure of the degree of adrenal androgenic activity, were normal in each case. The amount of 17-ketosteroids present (0.5-5 mgm /24 hrs) appeared to be correlated with the degree of precocious development. None of the cases showed any evidence of masculinization.

k. Follow-up studies. Patients with constitutional precocious puberty should be followed at regular intervals, for only in this manner can the diagnosis be established with certainty. To date, the six patients we have reported have remained well and, with understanding on the part of the parents, are growing up normally.

Masculinization Before Puberty

Ovarian malignancies are practically never responsible for masculinization in the prepubertal girl. While several cases of ovarian gynandroblastoma causing masculinization before puberty have been recorded, the more common virilizing arrhenoblastoma has not been reported before the age of 15.[4] Novak has emphasized the not infrequent coincidental appearance of female pseudohermaphroditism in cases of dysgerminoma.[4] We believe that a careful gynecologic evaluation is indicated in all patients who at birth have abnormal genitalia or who during infancy or childhood develop evidence of masculinization.

Recent contributions by Wilkins,[10] by Jones and Scott,[11] and others, have shown the most common type of all sexual aberrations, female pseudohermaphroditism, to be the result of adrenal hyperplasia. If this condition develops before birth, the infant possesses external genitalia which appear masculine. The clitoris is hypertrophied, resembling a hypospadic penis and the labial folds are fused in the midline with a single small meatus located at the base of the penis-like structure. (Fig. 2.)

The diagnosis of adrenal hyperplasia can be established by the demonstration of female chromosomal sex arrangement of a smear made from the buccal mucosa, the presence of elevated urinary 17-ketosteroids and the suppression of the 17-ketosteroid levels by cortisone (cortisone

will not suppress the elevated 17-ketosteroids due to adrenal tumor). Normal serum sodium and potassium levels eliminate the existence of the serious electrolyte disturbance which, in some cases, is associated with adrenal hyperplasia. Continued cortisone therapy and the early institution of plastic surgery to remove the enlarged clitoris and establish normal vaginal and urethral orifices by incision of the fused labial folds, will prevent the harmful metabolic changes and tragic psychologic consequences formerly associated with this condition.

We have had the opportunity of participating in the management of a small group of these patients in cooperation with the Department of Pediatrics at the Indiana University Medical Center. The results have been most gratifying.

The initial appearance of masculinization during a girl's prepubertal years may be the result of adrenal hyperplasia or an adrenal neoplasm. The diagnostic criteria are the same as for the congenital type mentioned above. Early recognition with prompt institution of cortisone therapy in these cases caused by adrenal hyperplasia returns these girls to normal feminine development.

Conclusions

1. Though infrequent in occurrence, the possible existence of a gynecologic malignancy must be considered in young patients with irregular vaginal bleeding, pelvic pain, precocious puberty and masculinization.

2. During the last 20 years, 10 cases of gynecologic malignancy have been admitted to the Indiana University Medical Center (one in every 3,731 female patients under the age of 20). Seven of the 10 malignancies originated in the ovary. The poor prognosis can be improved only by earlier diagnosis and the more prompt institution of adequate surgical and radiation therapy.

3. The diagnosis and treatment of dysgerminoma, malignant teratoma and sarcoma botryoides, all gynecologic malignancies characteristic of young patients, are presented.

4. Feminizing precocious puberty, in most cases, is the result of constitutional premature activation of the anterior pituitary gland. Six illustrative cases are analyzed, emphasizing the features which differentiate them from the rare-occurring cases of precocious puberty associated with granulosa cell carcinoma of the ovary.

5. Masculinization of the prepubertal girl due to ovarian malignancy is most rare. The most common cause has been shown to be the result of adrenal hyperplasia. Recent advances in diagnosis and treatment in this adrenogenital syndrome have produced most gratifying results.

BIBLIOGRAPHY

1. *Vital Statistics of the United States 1956,* Vol. 2. National Office of Vital Statistics, U. S. Public Health Service, 1958.
2. Pedowitz, Paul, Felmus, L. B., Mackle, A.: Precocious Pseudopuberty Due to Ovarian Tumors. *Obst. and Gynec. Surv.* 10:633, 1955.
3. Pedowitz, Paul, Felmus, L. B., Grayzel, D. M.: Dysgerminoma of the Ovary—Prognosis and Treatment. *Am. J. Obst. and Gynec.* 70:1284, 1955.
4. Novak, Emil, Novak, E. R.: *Gynecologic and Obstetric Pathology,* 4th Ed. W. B. Saunders Co., 1958.
5. Neigus, I.: Ovarian Dysgerminoma with Chorioepithelioma. *Am. J. Obst. and Gynec.* 69:838, 1955.
6. Taylor, C. W.: Mesodermal Mixed Tumors of the Female Genital Tract. *J. Obst. & Gynec., Brit. Emp.* 65:177, 1958.
7. Duncan, A. S., Fahmy, E. C.: Sarcoma Botryoides of the Vagina and Cervix in Children. *J. Obst. and Gynec., Brit. Emp.* 60:87, 1953.
8. Ulfelder, H., Quan, S. H.: Sarcoma Botryoides Vaginae, Complete Removal of Tumor in Infant by Combined Abdominal and Perineal Approach. *S. Cl. North America* 27:1240, 1947.
9. Shackman, R.: Sarcoma Botryoides in Genital Tract in Female Children. *Brit J. Surg.* 38:26, 1950.
10. Wilkins, L.: *The Diagnosis and Treatment of Endocrine Disorders in Childhood and Adolescence,* Ed. 2. Charles C. Thomas, Springfield, Illinois, 1957.
11. Jones, H. W., Jr., and Scott, W. W.: *Hermaphroditism, Genital Anomalies and Related Endocrine Disorders.* The Williams & Wilkins Co., Baltimore, 1958. ◄

A Review of Current Teachings. Infant and childhood malignancies of the eye and adenexa are rare. The major tumor in this group is retinoblastoma, and the prognosis for treatment of the remaining eye has risen sharply by combining radiomimetic drugs with radiation. Pseudotumors are mentioned in differential diagnosis, and illustrations of a case with persistent hyperplastic vitreous are submitted to emphasize the value of physical examination with dilated pupils.

Ocular Tumors in Children

ROBERT WILLIAM HARGER, M.D.

Indianapolis

OCULAR TUMORS IN CHILDREN are extremely rare; the incidence is between 1:25,000 and 1:35,000 births.[1,3] This suggests that in Indiana we should expect only four or five cases each year. As a matter of experience it is much more common to make the diagnosis of "no tumor or pseudotumor" (and spend some anxious months afterwards waiting to be sure that enucleation had not been needed).

The findings associated with ocular tumors are not hard to establish, as the eyes present asymmetric physical signs. Because so much depends on early diagnosis and adequate followup, examination of the fundi through dilated pupils cannot be over-emphasized. It is small wonder that ocular defects can be overlooked by the average "small pupil" examination. Ten percent Neosynephrine, 1% Paradrine, 1-4% Homatropine and 1% Cyclogel are all excellent mydriatics and can be obtained as self-sterilizing solutions in small plastic containers. Early physical findings which precede the typical *Amaurotic Cat's Eye* are the "hoped for" signs where ocular malignancy is concerned, and their rapid progression in children makes every suspected tumor an emergency.

Whether the case be early with equivocal signs, or far advanced with diagnosis obvious, the ophthalmologists will usually group together and freely exchange the wisdom of experience and the security of consultation. The accurate interpretation of unusual cases has kept our best teachers at their offices many hours overtime, long after we, the referring colleagues, have gone home to our families. This of course is common to all communities and in every branch of medicine.

We are always concerned for the infant with some ocular asymmetry such as: inequality of palpebral fissures, one eye larger, one globe pushed farther forward than the other, motility imbalance (not always esotropia), differences in corneal diameters, iris color, and markings, size and reaction of the pupils, and differences in shadows of the red reflex of the dilated pupil. The depth of the anterior chamber is important, as is transparency of the lens, opacities in the immediate retrolental space and the presence or absence of enlarged ciliary processes. Physical signs in the posterior portion of the globe include opacities in the vitreous, and changes in the optic nerve, vessels and retina—both posterior pole and periphery.

Must Prove It Is Solitary

The position and amount of neovascularity is significant, as is the presence of degenerative effects such as deposits of calcium. If a tumor is found we must prove that it is solitary and that other sites of origin do not exist either in the same or the fellow eye. A tumor spreading into the vitreous will not detach the retina as

does one which is growing beneath the rods and cones, or into the choroid. Any extraocular extension of tumor is usually a very grave sign in children's malignancies.

In this paper, specific mention will be made of the various occular tumors, differential diagnoses and current ideas on therapy. Most of these remarks are taken in condensed form directly out of our best existing tests[1, 2] with a few references to some interesting recent publications. The subject matter is largely concerned with retinoblastoma because that makes up the greatest incidence. Other tumors will be noted and special emphasis will be made regarding the group of pseudotumors. This will include illustrations of a case with persistent hyperplastic vitreous.

Retinoblastoma

Retinoblastoma is defined as a congenital malignant tumor from the nuclear layers of the retina, characterized by onset early in childhood, involving the posterior part of the retina. This tumor often occurs at multiple sites of origin, so that it may involve one or both eyes, more than one site in the same eye, and/or portions of the optic pathways, even before metastasis has occurred. It is extremely rare after childhood, and it is very uncommon in the Negro. The cells are small, closely packed, round or polygonal, with large, darkly stained nuclei and scanty cytoplasm.

Presence or absence of rosette formation is an important pathological finding. The tumors tend to outgrow their blood supply, so that blood vessel cuffing (not the same as rosette formation) may be found in sections showing areas of necrosis, with the still viable cells located around blood vessels. Because of the tendency to necrosis and degeneration, calcification plaques may be found frequently as an important differential feature. Metastasis occurs not only by direct extension, but to abdominal viscera, bones, lymph nodes, brain and spinal cord. The present treatment of this disease is enucleation in unilateral cases, and in bilateral cases one eye (the least involved) may be spared by employing tumor destroying therapy. Satisfactory treatment for extraocular recurrence of this tumor has not been reported.

When these tumors were first described, they were thought to be true gliomas, arising from glial cells. However, since 1926, the term retinoblastoma has been accepted because of origin from the retinoblast cell. This cell actually is highly undifferentiated and may form either neurons or glial cells, similar to the medulloblast of the central nervous system, and the sections are similar to medulloblastoma and sympathicoblastoma (neuroblastoma). Sometimes these tumors are classified simply according to the presence or absence or true rosette formation, and in some centers three specific types are considered: retinoblastoma, neuroepithelioma and astrocytoma. Rosette formation occurs with the more differentiated tumors which are slightly less malignant.

There are probably a hundred cases of retinoblastoma each year in the United States. The age of onset varies from one month to age 11 years, with the average being around age two. Cases have been reported in persons older than age 11, but they are noted simply as the remarkable exception. Approximately one third of the cases are bilateral and there is a definite hereditary feature in this disease.[3]

Hereditary Features

The trait is an irregular dominant, so there are many instances of collateral affection in siblings and many instances of tumor in both parent and offspring. The hereditary form is not in the majority, however, as sporadic incidence in infants with normal parents and siblings is more common. It is because of the possibility of a somatic mutation that sporadic cases can transmit the disease as a dominant feature.

In the class of hereditary cases which survive to maturity, the chance of passing the affected gene is 50%. In one small series of 10 children from retinoblastoma survivor parents, nine of the offspring had the disease in both eyes and only one of the 10 children was without tumor.

In the class with normal parents and no previous history of the tumor in their families, the chances of a second child (or more) with retinoblastoma has been estimated between 1 and 7%.

In the class of positively sporadic incidence who have grown to maturity, having survived the disease, it is felt that these may be somatic mutations representing isolated instances of the disease rather than the hereditary type. A very high number of survivors are in unilateral cases and it has been estimated that only one fourth of these persons will have affected offspring.

Although the ophthalmologist is rarely consulted in matters of birth control where hereditary disease may be a factor, we are certainly taught to fear for the offspring of the retinoblastoma survivor group, for their chances of also having the tumor are excellent.

Pathology

Further comment about cellular structure is interesting. From the retinoblast come highly undifferentiated tumors, whereas the spongioblast gives rise to neuroepithelioma with the more mature cells and true rosette formation. These cells are from the nuclear cell layers of the retina, which are derivatives from the inner wall of the primary optic vesicle.

The typical case grows into the vitreous cavity (endophytum) and multiple seedings are common. Seedings occur on the iris, choroid, ciliary body, other points in the retina and the posterior portion of the cornea. It has even been reported that the tumor grew on donor cornea used for keratoplasty. In some cases the tumor grows deep beneath the retina into the subretinal space (exophytum), causing a typical tumor detachment. Not only is the tendency to metastasis rapid, but the tumor can also arise from multiple sites of origin. With necrosis and calcification of the degenerative tissues, such calcium will show in x-ray with the usual foreign body technic.

Where true rosette formation is found, the cells are tall, columnar, grouped around a central circular lumen, and protoplasmic processes can be seen extending into the lumen. These processes have sometimes been likened to the rod and cone layer of the retina. In other tumors the cells may be found in palisade formation, considered to be incomplete rosette formation. Pseudorosettes occur with small areas of central necrosis, leaving a degenerative area with clear space and cellular debris. Microscopically this should not be confused with the grouping of growing cells around blood vessels in cases with necrosis of the less well nourished portions of the tumor.

Distant metastases occur to the bones of the skull, distal bones, brain, spinal cord, lymph nodes and viscera. This tumor is highly malignant and the mode of spread is by direct extension through the orbit, blood stream, lymph and cerebral spinal fluid. The untreated case can present with secondary glaucoma, buphthalmos, secondary cataract and endophthalmitis. The basis for inflammation is the same as that encountered in adults where necrosis has occurred in melanomas, although in retinoblastoma it is less severely manifest. Cases of spontaneous regression (with necrosis of the tumor) have been reported but they are extremely rare.

Adequate study of a suspected tumor must be stressed. Not only is it necessary to call for consultation, but examination under general anesthesia is routine. For this the short fluothane technic is excellent.

The physical findings in retinoblastoma[4] are usually a white reflex from the affected pupil (leucocoria), creamy white vascularized mass in the retina, strabismus of the affected eye and dilated pupil on the side of the tumor. Detachment of the retina occurs rarely, as the tumor usually grows into the vitreous. The presence of calcium may be noted in the tumor itself by ophthalmoscopy and can be demonstrated by x-ray in 75% of cases. Extension of this tumor into the optic nerve can occur, but enlargement of the optic canal due to the tumor is quite rare and only occurs if there is pronounced advancement of the disease.

The decision about unroofing the optic canal[5] in the surgery for this condition depends upon the occasional finding of tumor in the optic nerve even without direct extension from the affected eye. However, once the tumor has been located that far back, the prognosis is especially poor and more complicated surgery cannot achieve the desired result.

Additional Aids to Diagnosis

Radioactive phosphorus[6] may be used in the detection of retinoblastoma, but it is not a positive test. It can indicate tumor, but when negative, it is still possible for tumor to be present. An interesting report[7] about the use of anterior chamber puncture for differential diagnosis in a case of uveitis with hypopyon indicates that degenerative cells and many with mitotic figures can establish the diagnosis of tumor rather than panuveitis. There is also a recent case report[8] in which the tumor was masked by a history of trauma and the presence of intraocular hemorrhage (hyphemia).

It is felt that extreme photobia, conjunctival injection, hypotony, unusually large or small globe, absence of calcium, visible dentate proc-



FIGURE 1

A CASE of persistent hyperplastic primary vitreous in a full-term infant.

esses from the ciliary body and eosinophilia all usually do not favor diagnosis of retinoblastoma. However, there are many cases recorded where tumor has been present with any of these signs.[4]

The differential diagnosis to be considered in these cases is with other causes of a "white pupil" in infants (leucocoria). When the opacity behind the lens is far anterior, developing about the third to fifth month in prematures that have required prolonged use of oxygen, the eyes are usually smaller and the anterior chambers quite shallow. The mass is usually gray and opaque, with obvious blood vessels and traction on the ciliary processes. This is usually the case with retrolental fibroplasia, incidence of which has been greatly reduced in the past six years. Incomplete forms of RLF may have opacity in one quadrant far out in the periphery. There may also be associated retinal folds, iris atrophy, posterior synechae, pupillary membranes and an absence of calcium. If the anterior chamber is shallow enough, the lens may touch the cornea, causing a corneal opacity.

Pseudo-Gliomas

Pseudo-gliomas in children are ordinarily found to be persistent hyperplastic vitreous,[9, 9a, 9b] organized vitreous mass, chorioretinitis, exudative retinitis, massive retinal fibrosis, retrolental fibroplasia or other tumors. Recently a new miscroscopic finding[10] has been established in persistent hyperplastic vitreous, that of general hyperplasia of the retinal astroglia.

Persistent hyperplastic primary vitreous causes a white reflex, which can usually be noted immediately after birth in one eye of full term infants. This structure can prevent growth of the eye, so that the affected side may be smaller than the normal eye. The posterior lens surface ordinarily shows an opacity which is more dense centrally than towards its periphery. Also vascularity may be noted to arise from the central area. With traction of the central membrane the ciliary processes are elongated and the anterior chamber may be quite shallow. Damage to the posterior lens capsule may result in cataract formation and some cases may demonstrate remnants of the hyaloid artery. There is an absence of calcium in these cases.

Microscopic sections of persistent hyperplastic primary vitreous have indicated preretinal proliferations of glial tissue in 13 of the 14 cases studied.[11] The remaining one case had direct continuity between the PHV and the retina. It is felt that this tissue is quite similar to the preretinal growth noted in the 35mm embryo. This means that PHV is not "persistent tunica vasculosa lentis or persistent posterior fetal fibrovascular sheath of the lens." It is derived from the primary vitreous and does not have a mesodermal origin.

Figure 1 illustrates a case of persistent hyperplastic primary vitreous in a full term infant. This case is in the process of treatment now, so a full report cannot be submitted. When first seen the eye was quiet and the membrane was thin enough that a fairly prominent red reflex was obtained. However, over the next four months of observation the anterior chamber became more shallow and more blood vessels appeared on the membrane which was located immediately behind the lens. Although enucleation was strongly considered, a needling of the membrane was attempted, so the hemorrhage and the lens material is being absorbed at this writing. The success of this treatment depends upon whether or not openings in the membrane can be maintained in spite of the scar tissue formation and a secondary membrane. The pictures were taken with and without dilation of the pupils.

Treatment

In the treatment of retinoblastoma, enucleation is the only sure method of removing the tumor. In cases of unilateral tumor, this treatment is very effective and great care is taken to remove as much of the optic nerve as possible. In order to get 10mm or more of the optic nerve, it may be necessary to put extra traction on the globe at the time of enucleation, or just after the enucleation has been completed, it is possible to dissect out more of the optic nerve. When tumor is found in the optic nerve, radon seeds and x-ray therapy for the apex of the orbit are required. It is just as well to use the ordinary implants designed for enucleation cases, which are commonly placed in the muscle cone.

Since intracranial extension is not greater in incidence than blood borne metastases, there is no need to open the head and remove the optic nerve back through the intraosseous portion of the optic canal.[1] Radiation therapy or other tumor destroying treatment to the exclusion of enucleation is not recommended for the unilateral case. Ordinarily the tumor is too far advanced when it is recognized in the unilateral case, so that either preservation of vision or the eye is not possible by treatment. We are urged to assume that every case is bilateral unless proved otherwise by prolonged followup of the fellow eye.

In bilateral cases, the more advanced eye is enucleated and the fellow eye should also be removed unless vision can be preserved. This is cosmetically more desirable than the disfiguring changes expected from severe irradiation. There are various forms of tumor-destroying therapy including radiation, diathermy, light coagulation, chemotherapy and combinations of these. Each has its advantages and disadvantages, and successfully treated cases have been reported from all. Radon seeds have been implanted in the tumor through the sclera; radon and cobalt plaques have been attached to the sclera[12, 12a] overlying the tumor.

Diathermy coagulation has been used both on the surface and penetrating small lesions both single and multiple. The tumor is located in the same manner as are retinal tears in retinal detachment, and additional diathermy is placed in the tumor itself for the tumor destroying coagulation.[13, 14, 14a] A new and fascinating approach to heat coagulation has been the use of photocoagulation by high intensity Xenon arc.[15, 16] Regardless of the type of tumor-destroying treatment, enucleation is recommended for the second eye unless the tumor is smaller than one quadrant of the retina. A posterior position of the tumor is also more favorable for this type of treatment if it is not too close to the optic nerve, and it is much better if the tumor is not already highly elevated.

The rate of cure for 195 patients between 1936 and 1952 was 36%. Of the survivors, one-third had only partial vision, while two-thirds survived with useful vision. Recent advances in technic[17] have improved the tumor dose application, so less total irradiation has been used. In this way the intractable complications, especially vitreous hemorrhage, have been reduced to a minimum. Instead of more than 10,000 r being given, the dose has been reduced to almost 3,000 r. By combining this with radiomimetic drugs such as nitrogen mustard, and triethylene melamine (TEM), the cure rate has risen as high as 90%.

No TEM Cures Alone

Thus far, there have been no TEM cures alone, but in combination with x-ray there seems to be synergistic action. The Betatron supervoltage may offer some technical advantages, but apparently the biological result is very little different than with orthotherapy. TEM has a strong bone marrow depressing action so the prolonged oral doses first used have been replaced by intramuscular or intra-arterial routes. At first the dose was 0.1 mgm/kg, but now it is 0.08 mgm/kg except in tiny infants under six months of age when it may be only 0.06 mgm/kg.

Between the third and fourth weeks of treatment, the tumor mass seems to disintegrate, leaving a central framework of calcium. Only minimal skin reaction of atrophy and telangiectasia are expected, with nothing like the severe side effects from higher doses of radiation. Intra-arterial injections of TEM have resulted in such dramatic improvement that the technic is felt to be most useful even though it requires surgical approach to the internal carotid. With a new suction device, the Picker "Flexicast," the head can be immobilized during therapy so the parent no longer has to hold the infant in position. Also treatment is usually given without general anesthesia or strong sedation in most

cases. So far there is no report on the effect of combined therapy for recurrences outside the eye, but this jump from 60% to 90% cure rate for intraocular retinoblastoma is certainly exciting.

Previously the radiation factors for retinoblastoma were 220 KV, 20 ma, 50 cm, 0.5mm cu, 400 r three times a week with a total dose up to 8,000 r for both of the special nasal and temporal ports or cones. Such therapy required a three-month period, and no further radiation could be used. The earliest cases treated got over 10,000 r. Recurrences were usually enucleated.

Therapy

The description of a radiation-treated lesion is most interesting. A gray clouding occurs in the retina about the lesion, associated with edema, and sometimes flat detachment. After one or two months the border of the lesion itself regresses and the height flattens. Calcium deposits increase in the degenerative tumor tissue so that a typical cottage cheese mass results. There is adjacent chorioretinal atrophy, pigment proliferation, and the end state is an elevated chalky white mass when the necrotic material is all absorbed.

The side effects of irradiation include cataract, atresia of blood vessels followed by neovascularity and necrosis from massive doses. There may be keratinization of the surface epithelium with punctate erosions of the cornea, loss of eyelid cilia, atrophy of the tarsus and elastic tissue of the lids, iridocyclitis with secondary glaucoma, proliferation and migration of pigment, sector atrophy of the iris, occlusion of arterioles or veins with hemorrhages and associated retinopathy. Shrinkage of the conjunctiva can occur with symblepharon formation. In addition, the centers for bone growth may be damaged, and it is possible to have post irradiation sarcoma.

All of these dangerous side effects can be practically eliminated by the new combined treatment with TEM and x-ray. The chief objections to TEM therapy are the side effect of bone marrow depression, and the need for dissection of the neck to expose the internal carotid when intra-arterial route is needed.

Much has been written about the treatment of residual and recurrent tumor. Residual tumor is defined as that which is found in the stump of the optic nerve when an incomplete excision is noted. In such cases the muscle cone implant should be removed, radon seeds can be planted in the orbit, intra-arterial TEM and x-ray therapy to the apex of the orbit should be given. The treatment for recurrent tumor, although heroic, is always unfavorable when the growth has recurred outside the eye. Such cases have had uniform fatality.

For recurrence confined to the inside of the eye, enucleation has been followed by continued life. Some cases have responded to diathermy, photocoagulation and TEM with more x-ray. Ordinarily treatment for metastases is directed toward the comfort of the patient and for the most acceptable cosmetic result. The eventual prognosis for retinoblastoma is far better now than it was when the tumor was first discovered 100 years ago. The cure rate has risen from six to 60%, and with our latest advances up to 90%. Favorable outcome depends entirely on early diagnosis and immediate treatment. There can be no period of watchful waiting in this disease.

Ordinarily the outlook for unilateral cases seems better, but with early and vigorous treatment of the remaining eye in bilateral cases, the prognosis is almost as good in both groups. In general one must emphasize that once the tumor cells have escaped the eye, the case is apt to be fatal. It is because of this that ocular tumors in children are handled as emergencies. At the time of surgery, frozen sections and washings of the orbit for Papanicolaou stains may be used to reach a decision about immediate exeneration of the orbit.[18] All cases with fairly large tumor arising near the optic nerve are considered to have further involvement into the optic nerve behind the lamina cribrosa, and as much of the nerve is removed as possible.

There is no question but that in bilateral retinoblastoma cases, early bilateral enucleation is the most effective way of preventing a fatality, but certainly tumor destroying therapy will be used in most cases where the tumor involves less than one quadrant of the retina and vision can be preserved. Retinoblastoma is quite rare in Negroes, and it is most uncommon in phthisical eyes.[19] However, phthisis can result after tumor necrosis and the shrunken eye may still harbor the malignancy. Such cases should not be confused with spontaneous regression, the phthisical eye suspected of tumor should be enucleated immediately.

Other Tumors

Other tumors of the eye and adenexa found in children will be listed briefly, for they are rare. These include adenoid epithelioma from

glandular structures and xeroderma pigmentosa. In this latter condition there is an abnormal reaction to light, with precancerous skin lesions. They get acute sunburn from unusually low exposures to ultraviolet, diffuse freckle-like pigmentation and, later, dry atrophic skin.

Epithelioma of the lens has not been described, but this tumor has been induced chemically in the crystalline lens of mice. Nutritional factors are thought to prevent this growth in man.

In children around the age of five, the counterpart of retinoblastoma from the ciliary epithelium has been found[20, 20a]—the medulloepithelioma (Diktyoma, embryonal type). It appears as a flat white lesion growing from the ciliary body out over the iris, posterior cornea and face of the lens. This tumor causes glaucoma, buphthalmos and is unilateral. The best treatment is enucleation.

Other Tumors

Malignant melanoma of the iris has been reported in children only with great exception,[21, 24] and in the choroid not at all. In the iris they are classified[22] with or without nests as nevoid, spindle cell and melanoblast types. Because they can originate from pre-existing benign nevi in the iris, we may be called upon to watch the cases from childhood. The typical iris and conjunctival[23] freckle seen in younger patients may show apparent growth and darkening in color without being abnormal. This occurs around the years of puberty and is not a sign of malignancy. But it is especially important when associated with darkening of the iris as a whole or with the appearance of satellite growths. These lesions may interfere with iris motility and should they invade the filtration angle, unilateral glaucoma can result. Excisional biopsy should be used when necessary, but enucleation for this tumor can often be avoided.[21]

Orbital Tumors

Tumors of the orbit are important in all ages and the differential diagnosis in exophthalmos is always a problem. Benign hemangioma of the lids and orbit are common and we must recognize that (thyrotropic) malignant exophthalmos can occur in children just as well as adults with the same serious threat to vision.

Glioma of the optic nerve[25, 26, 27, 27a, 27b] is a slowly progressing unilateral cause of exophthalmos. Three fourths of these occur in the first 10 years of life, and by x-ray, enlargement of the optic foramen can be noted. The typical neck-like shadow in the x-ray of the chiasm may be seen and visual field loss will occur as with any other chiasmal lesion. It is most difficult to remove glioma involving the optic nerve without also excising the nerve itself, and this is a procedure which may be done in conjunction with the neurosurgeon. Glioma may occur, associated with Von Recklinghausen's disease, and true glioma have been reported from both the retina and orbit (astrocytoma).

The incidence of meningioma in children under age 14 is quite rare,[28, 28a] but this tumor can involve the optic nerve with optic atrophy and exophthalmos. It may arise from the sphenoid ridge with exophthalmos, hyperostosis, optic atrophy and papilledema. Meningioma in the orbit can be removed with preservation of both the optic nerve and extraocular nerves.

Neurofibromatosis is a most serious problem and usually has its onset in childhood. Although it is commonly located elsewhere, cases have been reported in the choroid, eyelids and orbit. The treatment ordinarily is local excision with necessary plastic surgery and the recurrence rate is high. Mention should also be made of ganglioneuroma, sympaticoblastoma and paraganglioma.

Angiomatous tumors in children are usually benign, but in very rare instances angiosarcomas have been reported.

Rhabdomyosarcoma[29, 30] is a tumor of the orbit in the age six to seven group, which is highly malignant and usually fatal. Cases have been reported which responded favorably to surgery plus radiation and the necessary exenteration of the orbit may be technically improved by filling the defect with temporalis muscle and such space-taking items as a 20 mm gold ball.[31] This tumor has a characteristic polymorphism, with the predominant cell being elongated and spindle-shaped. There are giant cells present with fibrils extending into adjacent cell cytoplasm. Metastases occur rapidly to local lymph nodes, simulating lymphosarcoma, and there is a strong tendency to recurrence after treatment. It is felt that an orbital tumor in a child that is reported as sarcoma, and not specifically lymphosarcoma, is usually rhabdomyosarcoma and should have exeneration of the orbit followed by irradiation.

Fibrosarcoma, myxosarcoma and osteogenic sarcoma are all quite rare. The lymphomas[32, 33]

will not be discussed in this section of the symposium, except to note that occasionally the primary site can be in the orbit of children. In this group are the cases of lymphosarcoma, reticulum cell sarcoma, giant follicle lymphosarcoma, Hodgkin's disease, myeloma and chloroma. It has been stated that reticulum cell sarcoma of the orbit is so typical that biopsy is almost unnecessary prior to x-ray treatment.

Because radiation therapy is so necessary in the treatment of tumors of the eye and orbit, it is interesting to note that there is a 50% chance of cataract with a lens dose of only 700 r as determined by experimental therapy.[32] Also with the usual radiation therapy for paranasal sinuses, orbit, and globe, the lens got from 150 to 400 r, and in some cases it is as high as 1000 to 1500 r.

Reports of metastatic ocular lesions[34] are much more common for adults than for children. The order of frequency is choroid, orbit and then retina. The primary sites of origin are: breast, lung, gastrointestinal tract, kidney, adrenal gland, liver and bone.

804 Hume Mansur Bldg.
Indianapolis 4

REFERENCES

1. Reese, A. B.: *Tumors of the Eye.* P. B. Hoeber, Inc., New York 16, New York, 1951 and 1953.
2. Duke-Elder, W. S.: *Textbook of Ophthalmology,* Vol. III, C. V. Mosby Co., St. Louis, 1945.
3. Macklin, Madge T.: Inheritance of Retinoblastoma in Ohio, *Arch. Ophth.,* 62:5, pp. 842-851, Nov., 1959.
4. Carbajal, U. M.: Observations of Retinoblastoma, *Am. J. Ophth.,* 45:3, pp. 391-402, Mar. 1958.
5. Dekaban, A., Drager, G.: Metastases of the Retinoblastoma to Central Nervous System, *AMA Arch. Ophth.,* 61:2, pp. 239-245, Feb., 1959.
6. Hollenhorst, Robert W.: Diseases of the Retina and Optic Nerve, *AMA Arch. Ophth.,* 59:5, pp. 759-784, May, 1958.
7. Kuchle, H. J., Remky, H., Sattlee, R.: Diagnosis of Gliomatous Pseudo Uveitis, *Am. J. Ophth.,* 45:3, pp. 349-352, Mar., 1958.
8. Egleston, DuBose, McPherson, S. D. Jr., Perry, Robert: Retinoblastoma, *Am. J. Ophth.,* 46:2, pp. 201-205, Aug., 1958.
9. Duke, J. R.: Pseudoglioma in Children: Aspects of Clinical and Pathologic Diagnosis, *Southern M. J.,* 51, pp. 754-759, June, 1958.
9a. Kauffman, M. Luther: Retinal Hemorrhages in the Newborn, *Am. J. Ophth.,* 46:5, pp. 658-660, Nov., 1958.
9b. Thornfeldt, Paul R., Reeh, Merrill J.: Congenital Retinal Detachment, *Am. J. Ophth.,* 46:5, pp. 742-744, Nov., 1958.
10. Wolter, J. R., Flaherty, N. W.: Persistent Hyperplastic Vitreous, *Am. J. Ophth.,* 47:4, pp. 491-503, Apr., 1959.
11. Manschot, W. A.: Persistent Hyperplastic Primary Vitreous, *AMA Arch. Ophth.,* 59:2, pp. 188-203, Feb., 1958.
12. Boberg-Ans, J.: Retinoblastoma and Its Treatment, *Am. J. Ophth. Abstracts,* 47:1, p. 131, Jan., 1959.
12a. Joyce, Arthur: Technique of Treatment of Intraocular Tumors With Radon Seeds, *Am. J. Ophth.,* 46:5, pp. 649-653, Nov., 1958.
13. Dunphy, Edwin B.: Report on the Diathermy Treatment of Retinoblastoma, *Am. J. Ophth.,* 45:4, pp. 95-99, Apr., 1958.
14. Schepens, C. L., Schwartz, A.: Intraocular Tumors, *AMA Arch. Ophth.,* 60:1, pp. 72-83, July, 1958.
14a. Guerry, DuPont III, Wiesinger, H., Ham, W. T. Jr.: Photocoagulation of the Retina, *Am. J. Ophth.,* 46:4, pp. 463-466, Oct., 1958.
15. Meyer-Schwickerath, G., Helferich, E.: Treatment of Retinoblastoma, *Am. J. Ophth. Abstracts,* 47:1, p. 133, Jan., 1959.
16. Guerry, D., Wiesinger, H.: Light Coagulation, *Am. J. Ophth.,* 49:1, Jan., 1960.
17. Reese, A. B., Hyman, G. A., Tapley, Norah duV., Forrest, A. W.: The Treatment of Retinoblastoma by X-ray and Triethylene Melanine, *AMA Arch. Ophth.,* 60:5, pp. 897-906, Nov., 1958.
18. Carbajal, U. M.: Metastasis in Retinoblastoma, *Am. J. Ophth.,* 48:1, Part I, pp. 47-69, July, 1959.
19. Sherman, H. S.: Significance of Phthisis Bulbi In Retinoblastoma, *Am. J. Ophth.,* 47:3, pp. 403-405, Mar., 1959.
20. Fair, John R.: Tumors of Retinal Pigment Epithelium, *Am. J. Ophth.,* 45:4, pp. 495-505, Apr., 1958.
20a. Wolter, J. Reimer, James, Burton R.: Adult Type of Medullo-Epithelioma of the Ciliary Body, *Am. J. Ophth.,* 46:1, pp. 19-26, July, 1958.
21. Rones, Benjamin, Zimmerman, Lorenz: The Prognosis of Primary Tumors of the Iris Treated by Iridectomy, *AMA Arch. Ophth.,* 60:2, pp. 193-205, Aug. 1958.
22. Cleasby, Gilbert W.: Malignant Melanoma of the Iris, *AMA Arch. Ophth.,* 60:3, pp. 403-417, Sept., 1958 .
23. Lewis, Philip M., Zimmerman, Lorenz: Melanomas of Bulbar Conjunctiva, *Am. J. Ophth.,* 45:4, pp. 536-543, Apr., 1958.
24. Duke, James R., Dunn, Shepard N.: Primary Tumors of the Iris, *AMA Arch. Ophth.,* 59:2, pp. 204-214, Feb., 1958.
25. Jaensch, P. A.: Tumors of The Optic Nerve, *Abstract Am. J. Ophth.,* 47:1, Part I, p. 136, Jan., 1959.

26. Boles, W. M., Naugle, T. C., Samson, C. L. M.: Glioma of the Optic Nerve, *AMA Arch. Ophth.*, 59:2, pp. 229-231, Feb., 1958.

27. Trzcinska-Dabrowska, Zovia: Neurinoma Orbitae Genus Verocay, *Am. J. Ophth. Abstracts,* 48:3, Part I, p. 430, Sept., 1959.

27a. Beuerman, Virgil A., Tabor, Geo. L. Jr.: Primary Tumors of the Orbit, *Am. J. Ophth.*, 46:4, pp. 501-508, Oct., 1958.

27b. Spaulding, Wm. L. Col.: Glioma of the Optic Nerve and Its Management, *Am. J. Ophth.*, 46:5, pp. 654-658, Nov., 1958.

28. Newell, Frank W., Beaman, Thos. C.: Ocular Signs of Meningioma, *Am. J. Ophth.*, 45:1, pp. 30-40, Jan., 1958.

28a. Edwards, Thomas, Finlay, John R.: Meningioma of the Optic Nerve, *Am. J. Ophth.*, 46:5, pp. 745-747, Nov., 1958.

29. Blaxter, P. L., Smith, J.: Rhabdomyosarcoma of the Orbit, *Ophth, Soc. United Kingdom,* 78: pp. 83-97, 1958.

30. Lemoine, Albert N. Jr., The Orbit, *AMA Arch. Ophth.*, 60:3, pp. 513-516, Sept., 1958.

31. Reese, A. B.: Exeneration of the Orbit, *Am. J. Ophth.*, 45:3, pp. 386-390, Mar., 1958.

32. Winter, Frank C.: Review of Literature: The Orbit, *AMA Arch. Ophth.*, 62:3, p. 508, Sept., 1959.

33. Mathur, S. P.: Chloroma of the Orbit, *Am. J. Ophth.* 47:1, p. 91, Jan., 1959.

34. Amdur, J., Leopold, I. H.: Metastatic Hypernephroma to the Orbit, *Am. J. Ophth.* 48:3, pp. 386-388, Sept., 1959.

35. Mayer, Leo L., Nassar, Janiel G.: Metastatic Carcinoma of the Iris, *Am. J. Ophth.*, 45:5, pp. 707-712, May, 1958.

36. Stevens, Ralph W., Reeh, Merrill J.: Bilateral Metastatic Carcinoma of the Choroid, *Am. J. Ophth.* 45:5, pp. 654-658, May, 1958.

37. Dickson, Robert J.: Choroidal Metastases from Carcinoma of the Breast, *Am. J. Ophth.* 46:1, pp. 14-18, July, 1958. ◄

Remember This Date

On May 12, the public is invited to view exhibits at the 1960 National Science Fair—International, to be held in Indianapolis at Butler Fieldhouse. Doors will open at 9 a.m. and close at 10 p.m. This event is dedicated to inspiring greater interest among students in the fields of pure and applied science . . . winners of some 200 regional fairs will be spending much of their time exchanging ideas with scientists, educators and fellow students. They'll be seeking a clearer picture of what the future holds—a few minutes talking with them and answering their questions would be time well spent.

The cure rate for genito-urinary malignancies in children, and especially for Wilm's tumor, is improving.

Genito-Urinary Malignancies in Children

*DONALD H. YURDIN, M.D.**

Springfield, Ill.

THE RECENT DECLINE of infectious diseases as a prime cause of death in infants and children has focused attention on cancer as a leading source of mortality and morbidity in the pediatric age group. Campbell[1] points out that kidney and bladder tumors rank second to leukemia as a cause of cancer deaths in children under two years of age. Anderson,[2] in an analysis of 175 malignant tumors in children, records one-third of them as lymphomas and almost one-third of renal or adrenal origin. These latter two groups of cancer are amenable to cure by methods presently available.

Although the total number of afflicted children is relatively small and, therefore, such cases are infrequently seen in a general practice, the inevitable tragic outcome inherent in untreated or poorly treated malignancies of this nature impose on all of us an obligation to institute prompt diagnostic and therapeutic measures in a child suspected of harboring such a tumor. That such efforts are being rewarded by an increasing survival rate is apparent from data published for several medical centers.

A brief review of the recent literature on these subjects will be presented as well as a report of those cases seen at the Indiana University Medical Center.

In an analysis of 653 abdominal tumors in children, Lattimer *et al.*[3] found 281 to be of surgical significance. Of these, one-half were of renal origin. The major pathologic entities being: hydronephrosis 40%, Wilms' tumor 30%, and cystic disease 22%. Of the extra-renal masses 33% were neuroblastoma, 40% were intraperitoneal lesions and 20% were primary miscellaneous retroperitoneal tumors.

Wilms' Tumor

One of the commonest abdominal malignancies of children is Wilms' tumor, comprising approximately 20% of malignant tumors in children.[1] Mass is usually found in the upper abdominal quadrants or flanks; it is often smooth, firm, non-tender, ballotable and does not transilluminate light (as does an occasional hydronephrotic kidney). Pain and hematuria are uncommon and when present occur late in the course of the disease and adversely affect the prognosis. Frequently overlooked is the remarkably high incidence (60-80%) of hypertension in these children.[3, 4]

Accurate pre-operative diagnosis depends primarily on an adequate pyelogram, intravenous or retrograde (Fig. 1). This usually shows a large mass which rarely calcifies in contrast to neuroblastoma. In contrast, too, is the intrinsic calyceal deformity characteristically seen in Wilms' tumor but rarely noted in neuroblastoma.

It is imperative that treatment be instituted as soon as the diagnosis is made and the child prepared for surgery. The aim of therapy is complete extirpation of the tumor with as little handling of the mass as possible, both pre-operatively and during surgery. These are friable neoplasms and spread readily by venous emboli as well as by lymphatic and local invasion. To prevent this most surgeons advocate transab-

* Formerly of the Department of Urology, Indiana University Medical Center.

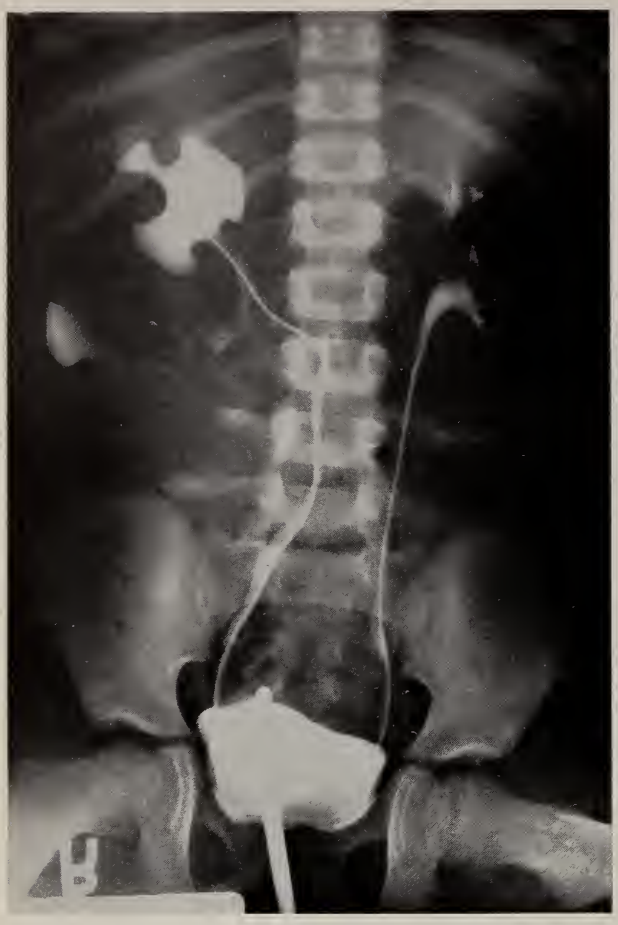


FIGURE 1

WILMS' TUMOR showing large right flank mass with flattening and distortion of the calyces.

dominal exposure with early ligation of the renal vasculature.

Several unresolved issues remain regarding optimal treatment. Certainly surgery is the keystone of the therapeutic attack. The place of pre-operative radiation is still controversial, however.[6] Klapproth,[7] in a review of a collected series of 1351 cases of Wilms' tumors was unable to substantiate by statistical analysis of the cure rates the beneficial or harmful effects of pre-operative irradiation. Many urologists feel it should be given only to reduce the tumor size sufficiently so that at the time of surgery access to the renal pedicle is swift and accomplished without needless handling of the kidney.

Most authors agree on the merits of post-operative x-ray therapy directed to the tumor bed. Indeed, radiation therapy to established metastasis should be pursued with vigor because of the occasional excellent response.[8]

It has become increasingly clear as the results of several series of cases have been published that the prognosis in Wilms' tumor correlate closely with the age of the child at the time of initial treatment—a reflection of earlier diagnosis of what is almost certainly a congenital lesion.[3, 5, 9] The two year survival rate (which is almost synonymous with cure rate) in children under one year varies in most reports from 40 to 80% whereas in older children the rate ranges from 20 to 50%.

Neuroblastoma

Of about equal frequency with Wilms' tumor is abdominal neuroblastoma.[4] Most often taking its origin from the adrenal gland it may, however, arise from ganglia anywhere in the body. One-third occur during the first year of life and 80% before the age of five years.

Here again, the physician is often confronted with an otherwise healthy child presenting with a fortuitously discovered abdominal mass. More frequently, though, the child is brought to the doctor because of symptoms arising from secondary tumor deposits.[10, 11] Here the nature of the symptoms depends entirely on the location of the metastatis, but a solid, often pebbly, non-tender, abdominal mass can often be readily palpated.

In contrast to Wilms' tumor, neuroblastoma frequently give rise to calcification within the tumor (25%), are rarely associated with hypertension, usually do not distort the calyceal pattern of the pyelogram, but do displace the renal shadow—usually inferiorly and laterally. (Fig. 2.) The avidity with which neuroblastoma metastasizes to bone is well known and a preoperative search for these, particularly in the long bones and skull, is important in the over-all evaluation of the patient.

Treatment is directed at the early complete removal of the mass, often even in the face of known metastasis. All too often this is impossible because of the extension of the tumor to involve vital structures and the surgeon must be satisfied with a subtotal resection or merely a biopsy.

Even in these circumstances cure is possible because of the remarkable radiosensitivity of neuroblastic tumors. The literature is replete with case reports of cures following surgery and x-ray therapy or x-ray alone even with rather

extensive soft tissue metastasis.[12, 13, 14] Good results in the face of bony involvement are quite uncommon.

Survival Figures Vary Greatly

Although spontaneous cures have been recorded without treatment, presumably on the basis of infarction of the tumor mass or of maturation to a less malignant ganglioneuroblastoma and thence to a benign ganglioneuroma, prior to 1940 neuroblastoma was regarded as almost invariably fatal. Farber[15] was the first to record a substantial number of cures resulting from aggressive treatment. Since then over 600 cases have been reported but the survival figures vary so greatly from hospital to hospital, that analysis and correlation with other data including modalities of treatment is extremely difficult.

Sutow[11] in an analysis of 496 collected cases concluded that no statistical difference in survival was discernable among the various treatment groups, i.e. surgery, x-ray and a combination of the two. Other authors disagree, pointing to an 88% cure rate in that small group in whom complete excision of the tumor could be accomplished in the absence of demonstrable metastatic disease.[13] Seamon, reporting a 3-year cure rate of 26%, stressed the fact that all of his survivors were less than 18 months old at the time of their initial treatment.[16] Most workers agree that the younger the patient the more favorable the prognosis.

But what of the 60% or more of these children with metastatic disease at the time of initial examination? Wittenborg has stressed the rewards of vigorous treatment in these cases. He reported 60% 3-year survivals with incomplete excision of the tumor followed by x-ray therapy, and 100% cures in six cases with liver metastasis! He had no cures in those cases in which bone lesions were demonstrable, however.

The various technics of radiation therapy used with neuroblastoma and with Wilms' tumors are beyond the scope of this paper but in general a dose of 1500 to 4000 r's has been used. A word of caution should be added regarding extensive radiotherapy in these young children. Several authors have reported total pancytopenias, fatal radiation nephritis, as well as distressing bone growth arrest. This certainly indicates the need for very close supervision during the period of radiotherapy and close cooperation between the radiotherapist and the urologist throughout and following the treatment period.

Retroperitoneal Neoplasia

Primary retroperitoneal tumors are most often sarcomas or teratocarcinomas. Their onset is insidious. The child presenting with an accidently discovered abdominal mass or because of inanition and gastrointestinal symptoms resulting from pressure on an adjacent viscus by the huge mass. As is the case with neuroblastoma these tumors often displace the kidney without distorting the pyelographic pattern.

The composition of these tumors is quite variable; often they are highly malignant both histologically and clinically. Cure rests on complete surgical extirpation—a difficult task because of extensive tumor spread in the retroperitoneal tissues. As a group they are not very radiosensitive.

Sarcoma

Sarcoma of the bladder and prostate are not common lesions, but do occur more often in children.[17] Derived from a large variety of



FIGURE 2
NEUROBLASTOMA showing large right flank mass displacing an otherwise normal kidney.

mesodermal precursors, the most common is rhabdomyosarcoma—so called sarcoma botryoides. Its presence in an infant or young child is usually heralded by hematuria, dysuria, urinary infection, and urinary retention as well as a large doughy suprapubic or perineal mass. These sarcomata tend to invade contiguous pelvic structures rapidly but distant metastatic spread generally occurs late in the disease.

Accurate pre-operative diagnosis is dependent on thorough abdominal and rectal palpation of the mass, cystoscopy, and in adequate biopsy. A rather benign miscroscopic appearance often belies the invariable malignant nature of the tumor.

Because of the misleading histologic picture conservative surgical measures are often tried initially, but results from less than radical therapy have been dismal. The few reported cures have occurred following total cystoprostatectomy.[18]

Testis Neoplasia

Testicular neoplasms in children as in adults are almost all malignant. In contrast to adults, however, in children these tumors are primarily teratomatous; seminomas are practically unknown before puberty.

The presence of a curable testicular tumor can only be appreciated by careful routine palpation of the infants' scrotal contents, searching for hard, heavy, non-tender masses which do not transilluminate.

Further evaluation of such a case should include a search for abdominal and chest metastatis and an estimation of urinary gonadotropins.

Radical orchiectomy affords the only reasonable chance for cure, but the recorded results are not good, presumably because treatment has been instituted late.[1, 19]

Series Analysis

The results of treatment of Wilms' tumor and retroperitoneal neuroblastoma at the Indiana University Medical Center are graphically illustrated below. All other urologic tumors are listed for completeness. All of these latter children died of their disease but because of the small number of such cases an analysis of them does not seem warranted at this time.

Since 1925, 44 cases of Wilms' tumor have been treated at the IUMC, 23 of these have previously been reported.[8] Of these 44 cases, eight were referred for x-ray therapy or terminal care following primary treatment elsewhere. All of these children are dead.

Three of the remaining 36 were operated on within the past 18 months and will not be included in the survival statistics. This leaves 33 children of whom 11 are living without evidence of tumor two or more years post-operatively—a cure rate of 33%.

It is interesting to note that the survivors averaged 12 months younger than the total cases and only three exceeded three years in age at the time of the discovery of their tumor; once again pointing up the decided advantage of the younger patient with this disease.

All of the cases treated since the time of the previous report from this Center have had transabdominal nephrectomies and post-operative irradiation Seven of these 14 cases had pre-operative irradiation including all of the survivors.[3] Four children in this group had pulmonary metastasis at the time of initial examination and received, in addition, x-ray therapy to their lung lesions—all succumbed.

From 1945 to the present, 32 cases of neuroblastoma in children have been seen at the IUMC with the primary site of origin as listed below:

Retroperitoneal	26*
Spinal	3
Thoracic	3
Total	32

* One case of ganglioneuroblastoma.

Considering the retroperitoneal neuroblastomas only, survival was closely correlated with the age of the patient.

Survival

Age	Dead within 2 yrs.	Alive less than 2 yrs.	Alive more than 2 yrs.
0-2 yrs.	8	3	3*
2-5 yrs.	10	0	0
over 5 yrs.	2	0	0

* One case of ganglioneuroblastoma.

As previously indicated metastatic disease does not invariably indicate a fatal outcome but no survivors are recorded in the group with bone involvement.

Survival

Extent of tumor* at time of initial treatment	Dead within 2 yrs.	Alive less than 2 yrs.	Alive more than 2 yrs.
Localized tumor	1	1	2
Local spread only	4	1	0
Liver metastasis	2	0	1
Soft tissue metastasis outside abdominal cavity	1	1	0
Bone or Bone marrow metastasis	11	0	0
Unknown extent	1	0	0

* In cases where numerous metastasis existed at the time of initial therapy the case is counted only in the lowest corresponding heading under "Extent of Tumor."

The type of therapy employed has changed considerably since the start of this series. Therapy is also influenced, of course, by the local and distant extent of the tumor and the condition of the child.

Survival

Therapy	Dead within 2 yrs.	Alive less than 2 yrs.	Alive more than 2 yrs.
Total excision with p/o x-ray	2	1	2
Subtotal excision or biopsy only	2	0	0
Biopsy plus x-ray	11	2	1
None (including biopsy of metastatic lesions only)	5	0	0

Excluding the more recent cases alive less than two-years since treatment, the two-year survival rate is 13%. Earlier diagnosis and aggressive treatment would almost certainly improve this poor salvage rate.

Other Tumors

Organ	Histologic Type	Number of Cases
Bladder	Rhabdomyosarcoma	1
	Sarcoma, indifferentiated	1
Testis	Embryonal cell carcinoma	1
Retroperitoneal	Teratoma	1
Renal Cell Carcinoma		2

Summary

The presence of a flank, abdominal or scrotal mass in an infant or child demands immediate attention. Hematuria, pyuria, dysuria and urinary retention, although more often seen in non-neoplastic diseases in the pediatric age group nevertheless requires prompt investigation too.

Proper diagnostic examination and commonly accepted modalities of treatment have been outlined for the most common genito-urinary tumors seen in children.

Although the cure rate in these children has improved considerably in the past 20-years, we can certainly achieve better results by earlier discovery of these tumors, prompt diagnostic studies and more aggressive surgical and radiological therapy.

1000 S. 6th St.
Springfield, Ill.

ACKNOWLEDGMENT

The author wishes to express his appriciation to Dr. Robert Rhamy for his help in compiling the statistics on the neuroblastoma cases.

REFERENCES

1. Campbell, M.: *Clinical Pediatric Urology.* Saunders, 1951.
2. Andersen, D.H.: *Cancer,* 4:890, 1951.
3. Lattimer, J. K., Mellicow, M. M., and Uson, A. C.: *J. Urol.* 80:401, 1958.
4. Mellicow M. M., Uson, A. C.: *J. Urol.* 81:705, 1959.
5. Deming, C. in Campbell, M.: *Urology.* Saunders, 1954.
6. Gross, R. E., Nenhauser, E. B. D.: *Ped.* 6:843, 1950.
7. Klapproth, H. J.: *J. Urol.* 81:633, 1959.
8. Garrett, R. A., Mertz, H. O.: *J. Urol.* 74:707, 1955.
9. Johnson, S. H. III, Marshall, M. Jr.: *J. Urol.* 74: 707, 1955.
10. Franklin, J. E.: *N.Y. State J. Med.* 53:1659, 1953.
11. Sutow, W. W.: *Am. J. Dis. Child.* 96:299, 1958.
12. Wettenborg, M. H.: *Rad.* 54:679, 1950.
13. Gross, R. E., Farber, S., Martin, L. W.: *Ped.* 23: 1179, 1958.
14. Seaman, W. B. Eagleton, M.D.: *Rad.* 68:1, 1957.
15. Farber, S.: *Am. J. Dis. Child.* 60:749, 1940.
16. Langley, J. J.: *Urol.* 73:417, 1955.
17. Smith, B. A. Jr.: *J. Urol.* 82:101, 1959.
18. Thompson, I. M., Coppridge, A. J.: *J. Urol.* 82:590, 1959.
19. Mellicow, M. M.: *J. Urol.* 73:547, 1955. ◄

Although thyroid cancer is an uncommon tumor in children, an increased incidence of this entity has been reported in recent years. Strong circumstantial evidence exists correlating this increase with previous irradiation to the neck and anterior thorax for "enlarged thymus."

A case of thyroid carcinoma in childhood is presented. Pathology, symptomatology, treatment and prognosis of thyroid cancer are discussed.

Thyroid Cancer in Childhood and Adolescence

*ROBERT K. GIBSON, M.D.**

Indianapolis

CARCINOMA OF THE THYROID gland is relatively rare in childhood and adolescence. However, an increased incidence of thyroid carcinoma has been reported in recent years. Winship[1] has reviewed a series of 334 cases occurring in patients under 15 years of age. This series consisted of 167 published and 167 unpublished cases located by surveys in the United States, Canada and Western Europe. Sixty-five percent of the patients were females. Prior to 1930 there had been only 11 published case reports of thyroid carcinoma in children. Since 1930, 156 cases have been reported in the world literature.

In 1950 Duffy and Fitzgerald[2] recognized an association between thyroid carcinoma and previous x-ray irradiation to the neck area for "enlargement" of the thymus gland. Subsequent reports by Horn and Ravdin,[3] Warren *et al.*,[4] failed to confirm this finding. However, Clark[6] reported on 15 children with carcinoma of the thyroid all of whom had previous irradiation to the head and neck area. The work of Simpson and Hempelmann as quoted by Duffy[5] suggests that there is more than a chance association between thyroid carcinoma in youth and a history of previous x-ray therapy. Eleven cases of thyroid carcinoma developed in 2333 children who had received irradiation to the thymus in infancy. In contrast, no cases of thyroid cancer occurred in 2622 untreated siblings who served as the control group.

Furthermore, the animal experiments of Doniach[7] add to the incriminating evidence against x-ray therapy. Carcinoma of the thyroid gland developed in seven out of 21 rats treated with irradiation to the thyroid area followed by prolonged methylthiouracil administration. In 13 rats treated only with x-ray, carcinoma of the thyroid occurred in one animal. These results would indicate that the prolonged pituitary stimulation, produced by the hypothyroidism of methylthiouracil therapy, potentiates the carcinogenic properties of irradiation. Doniach postulates that irradiation is an initiating factor and the subsequent normal growth and development of the thyroid from infancy to puberty may be a promoting factor in producing carcinoma of the thyroid in children.

Question Radiation Therapy

On the basis of these findings Duffy[5] concludes "there is strong circumstantial evidence that therapeutic x-radiation in infants 'may' be an etiologic factor in the thyroid cancer of childhood and adolescence." Therefore, indiscriminate x-ray therapy to the head, neck and superior thorax for benign conditions in infants or children must be condemned. At present there is no

* Fellow in Pediatrics, Indiana University Medical Center, Indianapolis.

evidence that either x-ray radiation or I_{131} can cause carcinoma in adult human thyroid tissue.

The incidence of thyroid carcinoma in children seen at the Indiana University Medical Center has been extremely low. Among 1409 children with tumors seen at the James Whitcomb Riley Memorial Hospital between November 1924 and June 1951, Lawrence and Donlan[8] found no cases of thyroid carcinoma. Since 1951 one case of thyroid carcinoma in a patient under 16 years has been observed.

Case Report*

A 14-year-old white female was admitted to the Indiana University Medical Center on 7/23/55. Twelve days prior to admission an exploratory operation had been performed elsewhere for excision of an "egg-sized" nodule in the right anterior neck. Further details of the operation were unknown. She was referred to this hospital because a histological diagnosis of carcinoma of thyroid was made on the surgical specimen.

The patient had first noticed a small, nontender nodule in the right anterior neck one year prior to admission. During the ensuing year the mass had increased in size and medical consultation had been obtained. The only symptom attributable to the mass was mild dysphagia for three weeks prior to surgery. Past medical history was non-contributory. Inquiry into the possibility of irradiation of the neck was not made.

Physical examination revealed an adolescent girl who did not appear ill. Her vital signs were normal. The only abnormal physical findings were a healing low transverse scar over the anterior neck with moderate edema and induration of the underlying tissue. No thyroid masses were palpable and the cervical lymph nodes were not enlarged.

Urinalysis was normal. Hemoglobin was 13.3 gm, RBC 4.45 million/mm^3 and WBC 7,050 with a normal differential. Chest x-ray was interpreted as normal.

On 7/25/55 a hemithyroidectomy and unilateral radical neck dissection were performed. Histological diagnosis on the specimen was follicular type carcinoma of the thyroid gland with metastasis in one of 25 cervical lymph nodes. Her post-operative course was uncomplicated. Following surgery the patient received x-ray therapy to the neck in a total dose of 2100 r.

The patient was followed periodically until August 1959 at which time she was lost to follow up study. During this period there was no evidence of local or metastatic recurrence.

Papillary carcinoma is the most frequent type of thyroid cancer in childhood.[1,2,3,4,9] In the accumulated series of Winship,[1] 65% of the tumors contained a papillary element. Papillary carcinoma invades adjacent thyroid tissue and is not encapsulated. It is usually confined to one lobe of the thyroid, but may on occasion, be bilateral. Metastasis to regional lymph nodes is common. Follicular and alveolar carcinoma are next in frequency. Solid cell tumors, Hürthle cell carcinoma and undifferentiated carcinoma are relatively uncommon tumors of the thyroid in childhood.

A high incidence of carcinoma in nodular thyroids has been observed. In the collected series of Winship,[1] 27% of 176 thyroid nodules in children proved to be carcinoma. Cope *et al.*[10] have reported an incidence of malignancy in 19% of single thyroid nodules and goiters localized to one lobe of the thyroid. Enucleation or wedge resection of such nodules is hazardous and should be avoided. Hemithyroidectomy is the procedure of choice in these cases. Goiters comprised of multiple nodules are uncommon in children.

Most Common Symptom

The most common symptom of thyroid cancer is the presence of a mass, either in the lateral cervical area or in the thyroid gland. Occasionally choking sensations, tenderness and cough are present. Hoarseness, dysphagia and pain occur only in advanced disease.

Thyroid carcinoma should be considered in the differential diagnosis of persistent unexplained cervical lymphadenopathy. Fourteen of 22 patients reported by Horn and Ravdin[3] had enlarged cervical nodes as their primary complaint. In six of these patients there had been a time interval of 9-12 years between the onset of symptoms and the diagnosis. Since thyroid carcinoma is generally considered to be a slow growing tumor in childhood, the high incidence of regional metastases is probably attribuable to the lengthy time interval between recognition of a mass and medical consultation. Cope *et al.*[10] have emphasized the importance of Delphian

(* The author is indebted to Dr. J. S. Battersby, Indiana University Medical Center, for permission to use this case.)

lymph node enlargement in patients with thyroid cancer. They found these nodes to be involved in nine out of 13 patients with cancer of the thyroid. The node or nodes lie in the midline of the neck just above the thyroid isthmus and anterior to the middle cricothyroid ligament. Due to the paucity of overlying tissue and the presence of firm thyroid cartilage posterior to the nodes, they are readily palpable. Thyroiditis and hyperthyroidism can also produce enlargement of these nodes.

Pulmonary Metastases Incidence

Pulmonary metastases have been present in a sizeable percentage of patients at the time of diagnosis. Winship[1] reports an incidence of 15% with pulmonary metastases and Crile[9] reports a 22% incidence. These metastatic lesions are usually confined to the basilar segments of the lower lobe and are miliary in distribution, often resembling miliary tuberculosis or histoplasmosis.

Evaluation of treatment is difficult because no one person has treated enough patients or followed patients a sufficient length of time to be certain of the results. There is general agreement that an attempt should be made to eradicate the tumor surgically. This involves excision of the involved lobe and isthmus, and involved groups of lymph nodes.

Thirty percent of the patients in Winship's series[1] had radical neck dissections, either unilateral or bilateral. Crile[9] condemns radical neck dissection on the following grounds: (1) Lymph node metastases are well encapsulated and do not invade the surrounding tissue (2) in his series there was no reappearance of the tumor in muscle or areolar tissue. For these reasons, the sternomastoid muscle and jugular vein are spared if possible, and the compartments of the neck that are not grossly involved are not disturbed. The complications of surgery for carcinoma are the same as for any thyroid surgery, namely recurrent laryngeal nerve palsy, pneumothorax and tetany if the parathyroids are removed. A postoperative course of x-ray therapy to both sides of the neck is usually recommended.

New Adjunct to Treatment

The newest adjunct to the treatment of thyroid carcinoma consists of the administration of large amounts of dessicated thyroid postoperatively. Removal of a major portion of the thyroid gland results in a diminution of circulating thyroid hormone, thereby increasing the production of thyroid-stimulating hormone (TSH) by the pituitary gland. TSH stimulates thyroid tissue to grow, and presumably will affect abnormal as well as normal glandular tissue. Daily thyroid administration will ensure normal circulating thyroid hormone levels and consequently will suppress the formation of TSH. Three grains of dessicated thyroid daily is tolerated well by most patients and is the recommended dosage. Four patients with metastases have been treated in this manner by Crile[9] and all are living and well 18 months to 10 years after surgery. The metastatic lesions have either regressed or failed to grow in these patients.

Radioactive iodine has been used in occasional patients who have extensive metastases. It would seem logical to reserve radioactive iodine therapy for those patients with metastatic lesions that fail to respond to the therapeutic regimen described above. Furthermore, since only 15% of thyroid cancers will take up therapeutic amount of I_{131}[1] this form of therapy can be of limited value at best.

The prognosis in thyroid carcinoma is difficult to evaluate because of the slow growth of this tumor and the long survival rates reported. In Winship's series,[1] there was a mortality rate of 17% with death occuring from the immediate postoperative period to 23 years after diagnosis. Ninety-four percent of Crile's[9] patients are living with an average survival of more than five years. Thyroid carcinoma would appear to be one of the least malignant of carcinomas in the young age group. Follow up periods must be extended for many years, for recurrences after long periods of quiescence are not unusual.

REFERENCES

1. Winship, T.: Carcinoma of the Thyroid in Childhood. *Pediatrics* 18:459, 1956.
2. Duffy, B. J. Jr., Fitzgerald, P. S.: Thyroid Cancer in Childhood and Adolescence. *Cancer* 3:1018, 1950.
3. Horn, R. C., Jr., Ravdin, I. S.: Carcinoma of the Thyroid Gland in Youth. *J. Clin. Endocrin.* 11:1166, 1951.
4. Warren, S., Alvizouri, M., Colcock, B. P.: Carcinoma of the Thyroid in Childhood and Adolescence. *Cancer* 6:1139, 1953.
5. Duffy, B. J. Jr.: Can Radiation Cause Thyroid Cancer? *Tr. Am. Goiter A.* 17:1384, 1957.
6. Clark, D. E.: Association of Irradiation with Cancer of the Thyroid in Childhood and Adolescence. *J.A.M.A.* 159:1007, 1955.

7. Doniach, I.: Comparison of the Carcinogenic Effect of X-radiation with Radioactive Iodine on the Rat's Thyroid. *Brit. J. Cancer* 11:67, 1957.
8. Lawrence, E. A., Donlan, E. J.: Neoplastic Diseases in Infants and Children. *Cancer Research,* 12:900, 1952.
9. Crile, G. Jr.: Carcinoma of the Thyroid in Children. *Ann. Surg.* 150:959, 1959.
10. Cope, O., Dobyns, B. M., Hamlin, E. Jr., Hopkirk, Jr.: What Thyroid Nodules are to be Feared. *J. Clin. Endocrin.* 9:1012, 1949. ◄

MEMO TO: ISMA Members

The JOURNAL is interested in full-length scientific papers and case reports for early publication. This is an open invitation to you to submit such work. Each paper is given careful consideration.

A few regulations regarding publication of papers are printed on the Contents page.

This announcement is made following a decision to increase the number of scientific papers published if sufficient material is available.



Thyroid Malignancy

Nodular goiters may harbor malignancy — Proper surgical excision is usually curative.

*GOETHE LINK, M.D.**

Indianapolis

DOCTORS OFTEN ASK about my experience with thyroid malignancy. Their questions usually suggest a latent skepticism about the importance and frequency of thyroid cancer. I will discuss the frequency of thyroid malignancy and its relation to goiter.

I am unable to present a statistical report of the many malignancies I have encountered because until recently the pathologists could not make a reliable diagnosis of malignancy in thyroid disease. Malignancy, when present, often was not found, and follow-up of a patient, like as not, proved a diagnosis of cancer to have been wrong. If there was doubt about a pathologic diagnosis, submitting the tissue to other pathologists only added to the confusion.

The American Goiter Association attempted to remedy this by establishing a central bureau for the study of thyroid tissue. I have several reports about specimens that I sent to this committee which contained the opinions of the most distinguished pathologists in the country. They could not agree on a diagnosis; in fact, they could not agree as to whether malignancy was present or not. One report, as an example, received from the committee in January 1950 and signed by Allen Graham, chairman of the committee, gives the following diagnoses, each by a different pathologist: "small cell carcinoma," "reticulum cell sarcoma" and "struma lymphomatosa."

In 500 thyroidectomies which I performed between 1944 and 1952 there were only three malignancies found and reported by the pathologists. In 500 cases operated since 1952, 21 malignancies have been found. From this we can only conclude that statistical appraisal of the frequency of cancer of the thyroid based upon work done before 1950 is of doubtful value. Though recent pathologic reports more nearly represent the true incidence of cancer in goiters, it is probable that malignancies may still be overlooked due to the pathologic polymorphism in many goiters and difficulty in finding small malignant foci.

Discover Malignancy in 13-Year-Old

On June 17, 1959, I did a thyroidectomy on a 13-year-old girl. She had a large diffuse goiter, had been very toxic and had been on treatment for a year to prepare her for surgery. The two lobes after removal weighed 122 gm. Malignancy had not been considered, as it is least frequent in this type of goiter. Several days later the pathologist called, rather excitedly, to tell me he had found carcinoma in one lobe. When I arrived at the laboratory I found that he had serially sectioned both lobes. There were two malignant foci, each about 8 mm in diameter, not far apart, near the center of the left lobe. I am sure that a few years ago this malignancy would not have been discovered.

This case as well as the others here presented reflect upon the fallacy of needle diagnosis of thyroid carcinoma as well as the mistaken idea of watchful waiting over a pathologic condition of which the danger can not be appraised.

Malignancy of the thyroid covers a spectrum at one end of which are the anaplastic small round cell and giant cell tumors, so malignant that, as Lahey[1] said, operation is almost a waste

* From the Thyroid Clinic of St. Vincents Hospital, Indianapolis. Read before the Annual Regents Meeting, International College of Surgeons, Indianapolis, May 6, 1959.

of time. At the other end are the papillary and follicular types which are curable with surgery.

Fortunately, the greatest number of thyroid malignancies belong to the papillary group. These are among the most curable of any human cancers and should be attacked surgically regardless of how extensive and advanced they may be as is shown by the following case.

A white female, age 29, was operated Oct. 25, 1940 for nodular goiter. Both lobes and isthmus were resected in three masses as follows, 5 x 3 x 2 cm, 4 x 2.5 x 3 cm and 4 x 2.5 x 1 cm. In addition a metastatic tumor was removed from the superior carotid triangle measuring 4.3 x 1.5 x 1.3 cm. Another metastatic mass was removed from the anterior mediastinum measuring 4.5 x 4.5 x 3.5 cm. Diagnosis: adeno-carcinoma, papillary and follicular type. The patient is living and in good state of health today, except she must take thyroid extract.

Early Writers Warn of Thyroid Cancer

A few earlier writers warned us that thyroid cancer was not rare and told us that it was found as a complication of nodular goiters. In 1902 Erhardt,[2] a German surgeon, called attention to the relation between nodular goiter and carcinomas. Bloodgood[3] in 1905-6 wrote: "Malignant tumors of the thyroid must be seen and removed in the early stage, a period in the growth when they cannot be differentiated from the benign cysts and adenomas. For this reason, every asymmetrical enlargement of the thyroid gland in individuals over 30-years of age should be subjected to operative removal."

It was not, however, until 1945 that the real importance of thyroid malignancy and especially its tendency to originate in the common nodular goiter was shown by Warren Cole[4] in a work so well done that it was generally accepted. Since his publication of "Potential Dangers of Non Toxic Nodular Goiter," in 1945, much has been added to our knowledge of carcinoma of the thyroid.

Shortly before his death and published posthumously, Dr. Frank Lahey[1] wrote, "We have found it extremely difficult to convince internists and family doctors that a discrete adenoma of the thyroid is really the origin of cancer of the thyroid . . . the incidence of malignant disease in discrete adenomas is so high that they should all be removed." Lahey and Hare[5] further stated, "Prophylactic removal of all discrete adenomas would do much to lower, if not abolish, the occurence of cancer of the thyroid."

Dr. Cole[4] showed a 17% malignancy in all nodular goiters. He warned us to be careful in handling nodular masses while doing thyroidectomy for fear that unrecognized cancer might be present and thus be scattered in the wound.

Theodore Winship[6] presented a study of 275 cases of childhood thyroid carcinomas. He gave the incidence of carcinoma in nodular goiters in children as 29%. McClintock, at the pathologic seminar held at Indianapolis Veterans Hospital May 22, 1955, gave 40% as the incidence of carcinoma in nodular goiter in children 15 years or younger (personal communication).

In August of 1949 there came out of Texas *The Cancer Bulletin*,[7] published by the Medical Arts Publishing Foundation, the Texas Cancer Coordinating Council and the National Cancer Institute. This bulletin was remarkable for its wealth of scientific information and in the courageous presentation of very up to date advice. Credit is due to our own Indiana State Board of Health for putting this bulletin into the hands of the physicians of Indiana. I wish to quote from the leading article in this bulletin which is entitled, "Goiter and Cancer of the Thyroid Gland." In quoting freely from this work which appeared 10 years ago I put upon it my stamp of approval after 10 years of test and at the same time show the valuable results obtained from this educational effort.

Hoosier Medics Heed Bulletin

That the doctors of Indiana read and are on their toes became evident very soon after circulation of the bulletin. Patients with smaller nodular goiters began coming in and they were anxious and ready to get rid of them. I did not waste time sticking a Silverman needle into their goiter trying to find malignancy. I removed their nodular goiters and shall tell you of only a few which will illustrate the result of this practice.

I was asked one day by one of our best informed medical men what my attitude was toward nodular goiters, saying that he had a patient with a nodule in her thyroid gland. In reply I quoted from the *Cancer Bulletin*, "All single non-toxic nodules of the thyroid gland should be viewed with the same degree of suspicion as are nodules in the breast." The doctor was debating as to whether or not he should watch it a while, I firmly advised against that

course. After operation, the pathologist found a small focus of adeno-carcinoma in the specimen. Let me say here that our pathologists are now alert to the frequency of thyroid malignancy and their work in this field is as reliable as in other fields.

In one case operated in October 1953, where I had done a block removal of a mass of glands, internal jugular vein and adjacent tissue together with the entire right lobe and part of the left lobe of the thyroid gland for papillary adeno-carcinoma, the pathologist hunted two weeks for the primary focus, which when found was only four or five mm in diameter.

Let me now quote the summary from the *Cancer Bulletin.*[7] "The vast majority of all malignant neoplasms of the thyroid arise in pre-existing goiter. There are no pathognomonic signs of early malignancy. Nodular goiters offer an ever-present threat of malignancy, for 2.6 to 17% of these goiters have been found to harbor malignant cells. This danger, together with the risk of possible hyperthyroidism, tracheal or esophogeal compression and cosmetic disfigurement, constitute adequate reason for surgical removal of these goiters.

"Single nodules in the thyroid and nodular goiter in men and in children are even stronger indications for surgical intervention. So called lateral aberrant thyroid nodules are carcinomas. A patient should never be told to wait until it bothers him. Except for the relatively infrequent highly malignant forms of thyroid cancer, the chances for cure are excellent if proper treatment is carried out."

Most of this information has been given to the patient; he understands the implications well. Therefore, I ask the pathologist to add at the end of his diagnostic report, if malignancy is not present, one short sentence for those fortunate ones: "No evidence of malignancy found." This removes from the patient's mind the fear of cancer hanging over him like the sword of Damocles which our duty has compelled us to implant there.

Current Aids Further Reduce Mortality

The aids that we now have in thyroid surgery, better knowledge of pathology, better antithyroid drugs and antibiotics have helped further to reduce an already small mortality. I am able to report a continuing unbroken series of 1949 thyroidectomies without a death. The mortality risk is so small that it is no longer a deterrent in accepting thyroidectomy.

The incidence of malignancy in multinodular goiters given by different authors varies. Some of the reports are astounding. From the Mayo Clinic[8] for example: "During the period 1950 through 1955, however, carcinoma was present in 70% of the children with nodular goiter."

Dr. Arnold Jackson,[9] after quoting from L. W. Sloan of Columbia who "believes any nodular goiter in a child must be considered malignant until proved otherwise, and the same is true of a clinically solitary adenoma," sums up by saying: "I believe that if it was theoretically possible to remove all adenomatous goiters when observed, carcinoma of the thyroid would become nearly extinct."

Conclusions

1. Thyroid malignancy is not rare.
2. Adenomatous or nodular goiters have an important malignancy incidence.
3. Any nodule or lump in the thyroid gland should be viewed with the same apprehension given to a lump in the female breast.
4. The risk of thyroidectomy is so small now that it is not a reason against our saying that all nodular goiters should be removed.
5. I agree heartily with the position taken by the Indiana State Board of Health as set forth in the *Cancer Bulletin,* July-August, 1949 and presented to the physicians of Indiana.

REFERENCES

1. Lahey, Frank H.: The Origin and Management of Cancer of the Colon and Rectum. *The American Journal of Surgery,* 86:490-492, November 1953.
2. Erhardt, O.: Zur Anatomie und Klinik der Struma maligna. *Beitr. z Klin. Chir.* 35:343-464, 1902.
3. Bloodgood, J. C.: Adenoma of the Thyroid Gland, A Clinical and Pathological Study. *Surgery, Gynecology and Obstetrics,* 2:121-144, February 1906.
4. Cole, W. H., Slaughter, C. P., Rossiter, L. J.: Potential Dangers of Nontoxic Nodular Goiters. *J.A.M.A.,* 127:883-888, April 7, 1945.
5. Lahey, F. H., Hare, H. F.: Malignancy in Adenomas of Thyroid. *J.A.M.A.,* 145:689-695, March 10, 1951.
6. Winship, T., Chase, W. W.: Thyroid Carcinoma in Children. *Surgery, Gynecology, and Obstetrics,* 101: 217, 1955.
7. Goiter and Cancer of Thyroid Gland. *The Cancer Bulletin,* 1, iii:50, July-Aug. 1949.
8. Hayles, Alvin B., Kennedy, Roger L. J., Woolner, Louis B., Black, B. Marden: Nodular Lesions of the Thyroid Gland in Children. *Transactions American Goiter Association,* pp. 397-421, 1956.
9. Jackson, Arnold, M.D.: *The Jackson Clinic Bulletin.* 16, iii:72, Aug. 1954. ◄

A Case of Seven Primary Malignancies

And a report of 30 cases of multiple malignancies

*EDWARD W. GRAHAM, M.D.**
*EDWARD B. SMITH, M.D.***
Indianapolis

THE PURPOSES of this paper are to report the study of a patient with seven primary malignant neoplasms and to record the incidence of multiple primary malignant neoplasms observed at autopsy at Indiana University School of Medicine.

The criteria used to identify primary malignant tumors are those of Warren and Gates[15] who stated that:

1. Each tumor must be malignant.
2. Each tumor must be adequately separated from its neighbor.
3. Neither must be a metastasis.

These criteria are more liberal than those proposed in 1879 by Billroth[3] who required that: (1) each tumor must be histologically different, (2) each tumor must arise from a different area, and (3) each tumor must produce metastasis similar to its primary growth.

Billroth[3] in 1879 was the first to report the occurrence of different primary malignant tumors in the same patient and was the first to give his concept as to what constitutes multiple malignancies.

Warren and Gates,[15] in a series of 1,078 autopsies in which malignant neoplasms were found, encountered 40 instances of multiple malignancy (3.7%). Among these was one case of triple malignancy. Of the 40 patients, 25 were females and 15 were males with the average age for males being 67.7 years and for females 58.2 years. It was concluded that multiple malignant tumors occur more frequently than can be explained on the basis of chance.

Warren and Gates[15] stated that this may be explained by a predisposition or susceptibility to cancer in certain persons, or by the action of some factor favoring the development of cancer. The nature of this predisposition is as yet unknown. On the basis of widely inclusive studies, the frequency of multiple malignancy is 1.8% of cancer cases.

Attribute Some Malignancies to 'Susceptibility'

Warren and Ehrenreich,[14] in a series of 2,829 autopsies of cancer patients, found 194 cases of multiple malignant neoplasms. Combined with the series previously reported, there were 3,907 autopsies with an incidence of 6.0% multiple cancers. Of the 194 patients with malignant neoplasms, 131 were males and 63 females. The average age of the males was 65.2 years and of the females 56.9 years. Warren and Ehrenreich[14] concluded that multiple malignancies may be attributed to susceptibility or predisposition to cancer in some persons or groups of persons.

Moertel and Hagedorn[10] reported 120 cases of leukemia or lymphoma with coexistent primary malignant neoplasm diagnosed in the 10 years from 1944 through 1953. A total of 194 similar cases were found reported in the literature by these writers. They comment that the physician

* Department of Pathology, Veterans Administration Hospital, Indianapolis.
** Chairman, Department of Pathology, Indiana University Medical Center, Indianapolis.

must be constantly aware of the possibility of another malignant neoplasm coexistent with leukemia or lymphoma, this being especially true of the patients in whom the leukemia or lymphoma tends to run a relatively benign course. Any signs or symptoms suggestive of a focal malignant lesion in a patient with leukemia or lymphoma should be regarded as representing the primary lesion of a cancer until pathologically proved otherwise.

Albrecht[1] studied 31,630 autopsy cases in which 6,188 were cancer cases. There were 203 cases with multiple primary malignant tumors over a period of 30 years. That is, the multiplicity involved 3.28% of all cancer patients. There were more males than females, about 2:1. Albrecht[1] found that bronchial carcinoma is more uncommon and that carcinoma of the prostate and bladder are more frequent than statistically expected.

Multiple Primary Malignances

McGregor and Bacon[9] reported that of 1,788 patients with cancer admitted to the proctology service at Temple University Medical Center between September, 1940, and May, 1958, 162 or 9.1% had multiple primary malignancies of which 90 were men and 72 were women. Ninety-four of these 162 patients had multiple primary lesions of the large intestine alone, an incidence of 58.1% among the patients with multiple primary malignancies and an incidence of 5.3% among the total number of patients with cancer of the colon and rectum.

The remaining 68 patients (41.9%) had involvement of the large intestine and of organs or systems other than the colon. Of the 94 patients with multiple primary lesions of the large intestine alone, 60 were men and 34 were women. In addition to these 60 men, there were nine men with second or third primary cancer in the upper gastrointestinal tract. Twenty-nine (40%) of the 72 female patients had cancer of the large intestine and in addition a primary malignant neoplasm of the genitalia or of the breast.

Cannot Establish Common Stem

Cohen, Rubin and Eisemann[5] studied a woman who died at 29 years of age because of a number of malignant neoplasms which developed over a span of 3½ years. These included Hodgkin's disease, carcinoma of the breast with Paget's disease, pleomorphic sarcoma in the mastectomy scar, superficial malignant melanoma of the skin, leukemia and atypical glandular proliferation of the endometrium.

About one month after her death, her father developed Hodgkin's disease and died 13 months later at the age of 62 years. Though the possibility is suggested that the complex and varied mesenchymal neoplasms, Hodgkin's disease, sarcoma in the mastectomy scar and leukemia, are related cytogenically, proof of a common stem cell producing these three neoplasms has not been established.

Tenney *et al.*[12] reported the case of a 63-year-old white male who presented a triple malignancy consisting of a poorly differentiated adenocarcinoma occurring in a sessile polyp with invasion of the muscularis mucosae in the colon, bronchogenic carcinoma of the squamous cell type being primary in the left lower lobe bronchus, and a melanoblastoma involving the retina of the right eye. These writers point out that a patient with a previous history of cancer deserves those investigative procedures necessary to rule out a second or even a third primary lesion.

Karger,[7] after reviewing the literature concerning 8,202 autopsied cases in which 1,400 malignancies were found over a 10-year period, found one case that had three tumors and 13 cases that had two tumors for a percentage of one. Double tumors were more frequent in females than males. However, the average age was no higher for patients with multiple than those with single tumors. The average age of women with multiple malignancies was 71.5 years. Karger[7] states that multiple cancer is no more frequent than what is expected on the basis of chance. No predisposition to an organ or a pair of organs was found.

Multiple Cancer Incidence

Watson,[16] in writing on the incidence of multiple cancer in which 538 patients with multiple malignancies were observed clinically, noted that 134 of these patients had two or more lesions *when first seen.* The remaining 404 developed the second lesion after an interval. He concluded that the incidence of true multiple cancers (that is, two or more primary malignant tumors in different organs or systems) does not differ from the ordinary incidence rate of cancer in a normal population. No evidence was found either of a constitutional tendency to develop a second cancer or of the development of an immunity following a first cancer.

Goldberg *et al.*[6] state the probability of developing cancer is greater among females than males, and that one in four females and more than one of every five males may be expected to develop some form of cancer during their lifetime. It was noted that 50% of the total cancer among males occurs as primary tumors of the skin, prostate, lung, stomach and intestines while 50% of the total cancer among females occurs as primary tumors of the breast, intestines, skin and cervix of the uterus. Cancer of the breast alone accounts for more than one-fifth of the total cancer among females.

Wallace[13] states that between January, 1946 and December, 1950, 3,006 patients having 3,096 primary neoplasms were studied at University College Hospital, London, England. Of these 3,006 patients, 71 developed two primary neoplasms between 1946 and 1950, 35 developed one neoplasm between 1946 and 1950, and had another primary neoplasm within five years before or after the first. In these 106 patients 240 primary neoplasms occurred.

Twenty-eight additional patients developed one primary neoplasm in the 1946-50 period and a second more than five years before or after it (recorded up to December, 1954). Three of these patients developed three primary neoplasms in all; 59 primary neoplasms occurred in these 28 patients. Altogether, 112 patients each developed two primary neoplasms; 16 developed three; three developed four; and three developed five primary neoplasms. Forty patients developed all their primary malignant tumors after the age of 70. Summarizing, he states that if 20 patients attend the hospital with a malignant tumor, one will develop later another primary malignant tumor.

Gastrointestinal Proportion High

Almost all studies of multiple primary malignant neoplasms show a high proportion of multiple cancers of the gastrointestinal tract. These are chiefly of the large bowel and may be related to polyposis in which malignant change is so common.

Marrangoni and McKenna[8] observed 618 patients with carcinoma of the female genitalia in a 10-year period. There were 15 instances in which there were one or more separate primary malignant tumors of the female genitalia—an incidence of 2.4%. Each of two patients had three primary cancers. Three cases of carcinoma of the ovary were associated with carcinoma of the uterus; six cases of carcinoma of the colon were associated with carcinoma of the ovary and uterus; three cases of carcinoma of the breast were associated with carcinoma of the ovary and uterus; and one case of carcinoma of the kidney was associated with carcinoma of the cervix.

The two triple malignancies involved breast, sigmoid colon and cervix; and colon, ovary and uterus. The ages in this series varied from 32 to 69 years, with the average age being 49.8 years. The youngest patient had an adenocarcinoma of the rectum and a papillary carcinoma of the right ovary. The oldest patient had an adenocarcinoma of the colon and an adenocarcinoma of the endometrium. These authors stress the value of diagnostic curettage and exfoliative cytology, particularly in the diagnosis of cancer of the uterus.

Study Age, Time Interval

Barrett, Miller and Fessenmeyer,[2] in a survey of 36 cases of multiple primary malignant neoplasms based on records obtained from surgical records, revealed an average age incidence of 52 years for the appearance of the initial primary tumor, and an average time interval between primary tumors of 3.22 years. There were 32 females and four males in this series, a ratio of eight to one. Calculation of the incidence rate in systems and organs reveals that 17 patients, or 47%, had a primary lesion in the gastrointestinal tract; 15 patients, or 41%, had involvement of a breast; and nine patients, or 25%, had a primary lesion in one ovary. The time interval between the discovery of multiple primary cancers was greatest in those confined to the gastrointestinal system and was shortest in those involving the ovaries and gastrointestinal system. In this series there was a family history of cancer in 26% of the cases in which reliable histories were available.

Cahan[4] noted that in 2,502 cases of cancer of the lung observed over a period of 28 years (up to 1954), there had been 81 instances in which the lung tumor was one of two or more separate primary malignant growths—an incidence of 3.2%. Each of two patients had three primary cancers. The sites of the separate malignant growths in Cahan's series included 18 of the oral cavity, 19 of the larynx, five of the colon and rectum, and three each of the bladder, kidney and skin (squamous carcinoma), one of the breast, and two of the testicle. Two patients had Hodg-

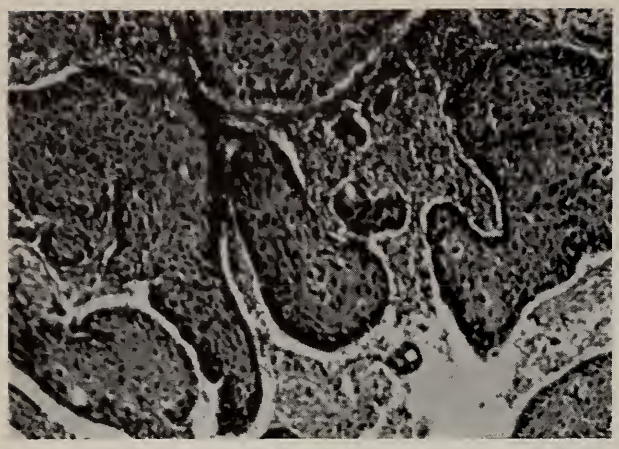


FIGURE 1

EPIDERMOID CARCINOMA of the skin of the cheek. Magnification x100.

kin's disease and two had lymphocytic leukemia. There was one each with cancer of the prostate, breast, cervix, common bile duct and branchiogenic cyst, as well as one with soft part sarcoma.

The cases with triple primary neoplasms included one patient who had cancer of the lung, breast and sigmoid colon and another who had cancer of the lung, tongue and larynx. In the 64 cases in this series, excluding the basal cell carcinomas, cancer of the lung was synchronous with another malignant tumor in 24 instances, and in 40 instances it was metachronous.

Cahan[4] concludes that the relatively frequent association in his series between carcinomas arising in the head and neck and separate primary cancer of the lung should stimulate alertness for this possibility. The resectability rate of 75% in this series of patients and the survival of eight patients for five years or more should encourage aggressive action in the treatment of multiple primary cancers.

Case Report

A 79-year-old retired merchant was admitted to the Robert W. Long Hospital of the Indiana University Medical Center in 1953 with a chief complaint of lesions on the cheek and nose that had failed to heal. A small, crusted lesion was present on the tip of the nose and a similar lesion was on the left cheek. The spleen was palpated two finger breadths below the costal margin. A rountine hemogram revealed a hemoglobin of 10.3 gm, a red cell count of 3,400,000 cells per cu. mm, a white cell count of 231,000 cells per cu. mm, of which 99% were lymphocytes. The platelet count was 548,190 per cu mm.

The lesions on the cheek and nose were excised and microscopic examination revealed them to be epidermoid carcinomas. A diagnosis of chronic lymphocytic leukemia was made by study of the peripheral blood and bone marrow. The patient was treated for chronic lymphocytic leukemia and discharged. The patient was treated periodically for his leukemia and remissions of the disease resulted.

The patient was admitted for the last time on Sept. 11, 1958 complaining of weakness, weight loss, anorexia and chills. Laboratory reports revealed a total white cell count of 12,750 white blood cells per cu. mm, a red cell count of 2,500,000 cells per cu. mm, hemoglobin of 8.8 gm per 100 milliliters, 135,000 platelets per cu. mm, with a differential leukocyte count of 57 neutrophils, 42 lymphocytes and 1 monocyte. A month later the total white blood cell count was 33,700 cells per cu. mm, with 3,700,000 red blood cells per cu. mm, and 11.5 gm of hemoglobin per 100 milliliters. The differential leukocyte count was unchanged. A bronchoscope was passed and tumor tissue removed from the right main stem bronchus proved to be epidermoid carcinoma. The patient died Oct. 15, 1958.

Findings at Autopsy

At autopsy the lining of the right main stem bronchus was replaced in part by a firm, gray neoplasm which extended to surround the bron-

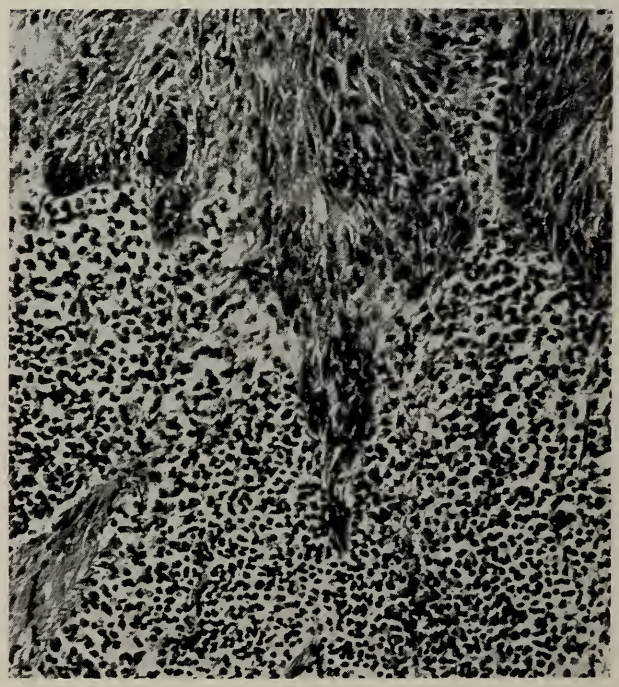


FIGURE 2

EPIDERMOID CARCINOMA of the skin of the nose. Magnification x100.

chus (Fig. 4). Microscopically, the neoplasm was found to be an epidermoid carcinoma with metastases to bronchial lymph nodes, the parietal pleura, diaphragm and liver.

In the transverse and descending colon were three polyps, the largest measuring 3 x 1 x 1 cm. Microscopic examination revealed locally invasive, well-differentiated adenocarcinoma in the largest polyp (Fig. 7).

In the wall of the ascending colon was a firm, tan neoplasm involving an area 3.5 x 2.5 cm, appearing as a plateau-like elevation 8 mm thicker than the surrounding normal mucosa, and extending into and replacing the inner circular layer of muscle of the colon (Fig. 6).

The prostate gland was slightly enlarged, moderately firm, slightly nodular and bulging on the cut surface. Examination of the microscopic sections revealed a small adenocarcinoma which had spread to involve the perineural lymphatics in the capsule of the prostate gland (Fig. 5).

The bone marrow presented no gross abnormalities. No evidence of leukemia remained in the sections of bone marrow studied microscopically. Re-examination of microscopic sections of material removed by sternal puncture during life confirmed the diagnosis of lymphocytic leukemia made at that time (Fig. 3).

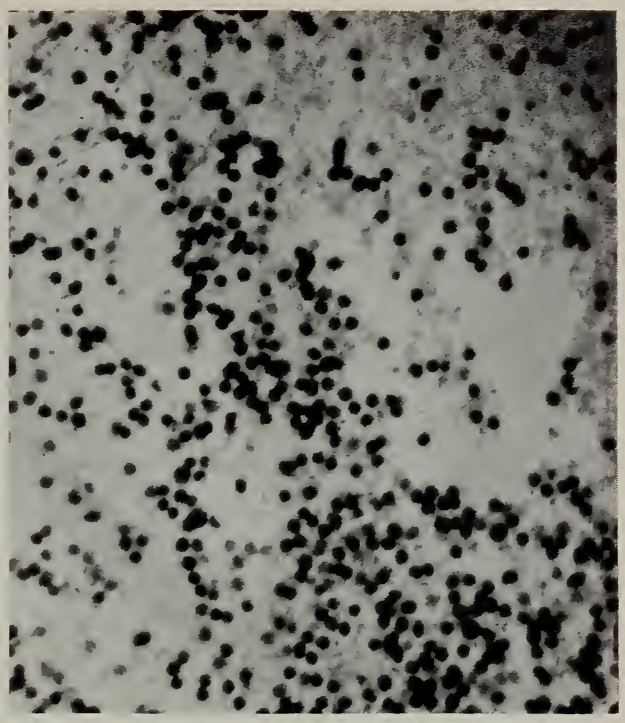


FIGURE 3

MICROSCOPIC SECTION of the sediment of material removed by sternal puncture. The diagnosis of lymphocytic leukemia was made because of the preponderance of small leukemic cells of the lymphocytic series.

Final Anatomical Diagnosis

1. History of epidermoid carcinoma of the skin of the left cheek (1953).
2. History of epidermoid carcinoma of the skin of the nose (1953).
3. History of chronic lymphocytic leukemia (1953) (No evidence of leukemia found at the post mortem examination).
4. Bronchogenic carcinoma (epidermoid) of the lower lobe of the right lung with metastases



FIGURE 4

EPIDERMOID CARCINOMA of the bronchus. Magnification x100.

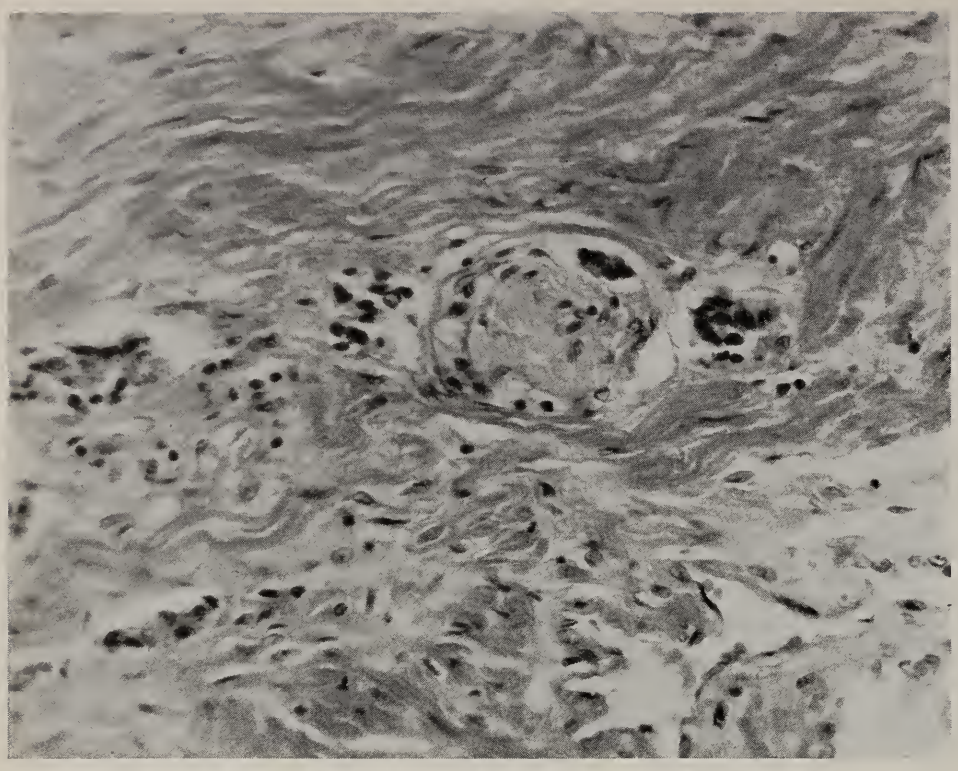


FIGURE 5
ADENOCARCINOMA of the prostate showing neoplastic cells in the perineural lymphatics. Magnification x60.

to bronchial lymph nodes, to the liver, parietal pleura and the diaphragm (1958).

5. Adenocarcinoma of the prostate.
6. Adenocarcinoma of the ascending colon.
7. Polyps (3) of the transverse and descending colon, the largest of which contained locally invasive adenocarcinoma.

Discussion

In a review of 9,145 autopsy cases at the Indiana University Medical Center, Indianapolis, from 1914 to 1959, there was a total of 1,501 patients (16.4%) who had cancer examined at autopsy. Of the 1,501 patients with cancer, 30 patients or 2% had two or more malignant neoplasms. Table I gives the age, sex, organ and lesions in these 30 patients with multiple malignant neoplasms. Of the 1,501 patients with cancer, 888 were males and represent 59.2% of the total. There were 613 females with cancer, representing 40.8%. The average age of females with cancer was 46 years while the average age for males was 49.5 years. In this series of patients with a single malignant neoplasm the oldest male was 96 years of age. He had a basal cell carcinoma of the skin. The oldest female was 99 years of age. She had an epidermoid carcinoma of the bronchus.

The 30 cases of multiple primary malignancies represent 16 males and 14 females. The average age of females with multiple primary malignancies was 57.2 years. The youngest female patient was 12 years of age with astrocytoma of the brain and an adenocarcinoma of the colon. The next youngest was a woman 30 years old with myelogenous leukemia and epidermoid carcinoma of the cervix. The oldest female patient with multiple cancers was 88 years of age with epidermoid carcinoma of the skin and an epidermoid carcinoma of the cervix.

The oldest male with a multiple primary cancer was 86 years of age with a basal cell carcinoma of the skin and an epidermoid carcinoma of the lip. The youngest male was 48 years of age with undifferentiated carcinoma of the bronchus and Hodgkin's disease. The average age of men with multiple malignancies was 70.9 years. The largest number of multiple primary malignant neoplasms in one case was seven shown in case number 29 of Table I. This patient had an epidermoid carcinoma of the cheek, an epidermoid carcinoma of the nose, chronic lymphocytic leukemia, epidermoid carcinoma of the bronchus, adenocarcinoma of the prostate, adenocarcinoma of the ascending colon, and a locally invasive adenocarcinoma in a polyp of descending colon.

In Table I it is seen that there are eight patients with a malignant lymphoma who had a second malignancy. This is consistent with the

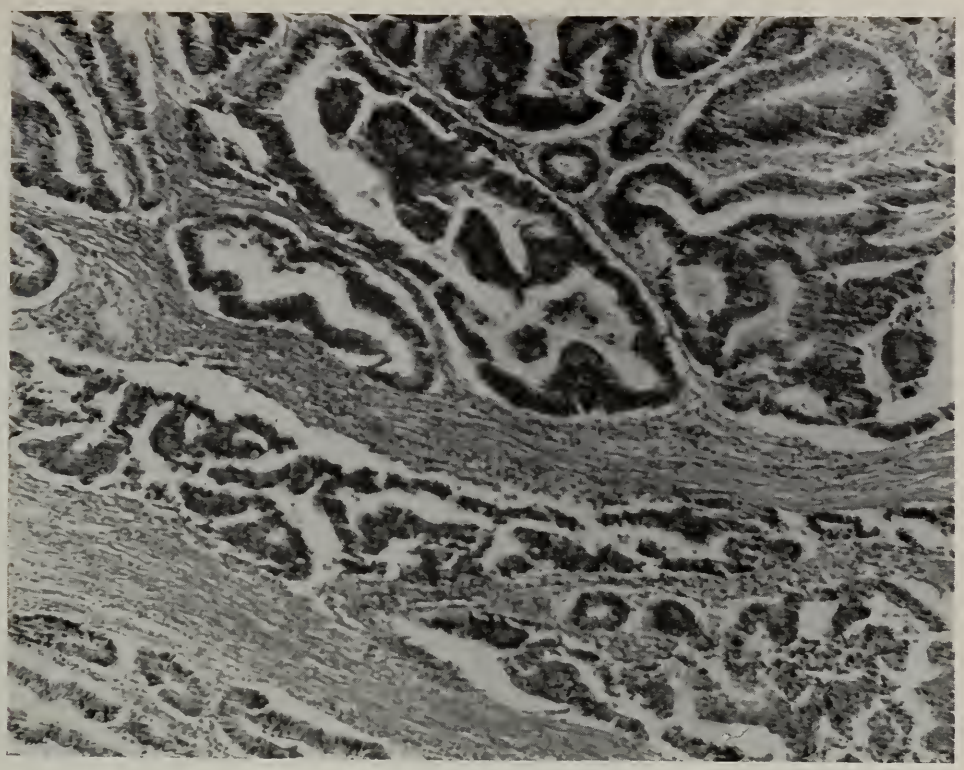


FIGURE 6
ADENOCARCINOMA of the ascending colon. Magnification x100.

findings of Moertel and Hagedorn[10] who found 120 cases of leukemia or lymphoma with a coexistent malignant neoplasm. These authors state further that the physican must be constantly aware of the possibility of a coexistent malignant disease, especially in patients in whom the leukemia or lymphoma tends to run a chronic course. In the case of our patient with seven primary malignancies all the criteria for diagnosing chronic lymphocytic leukemia were met yet no signs were seen at autopsy. Reich[11] reports an apparent recovery from chronic lymphocytic leukemia that has persisted for five years; this is similar to the remission found in our case.

The fact that women have multiple primary malignant neoplasms at an earlier age than men in our study is probably related to the susceptibility of the female sex organs to carcinoma. Of the 14 women with multiple malignant tumors, nine had malignant tumors of the cervix and breast, five of the cervix of the uterus, and four of the breast.

Summary

1. Nine thousand one hundred and forty-five (9,145) autopsy cases were reviewed and 1,501 of these included one or more malignant neoplasms.

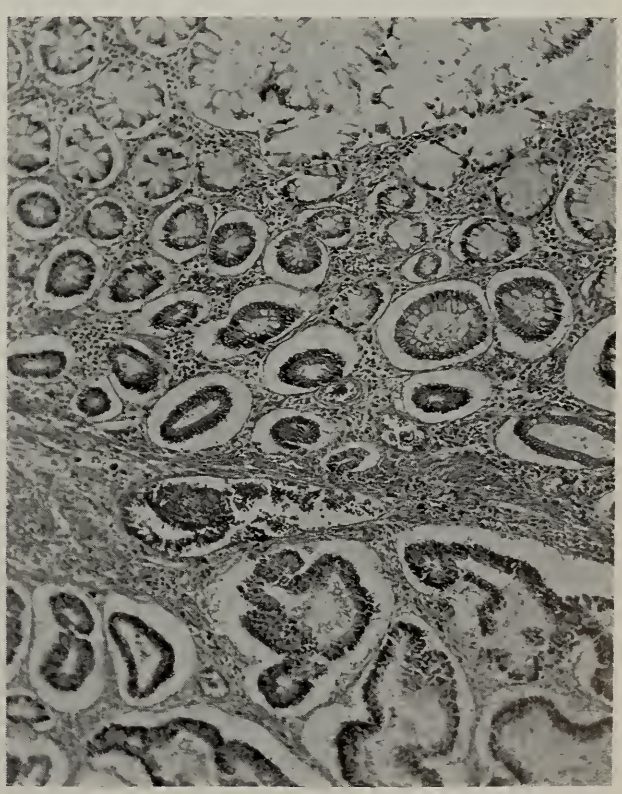


FIGURE 7
SUBMUCOSAL INVASION by adenocarcinoma in the tip of the largest polyp found in the descending colon. Magnification x100.

SERIES OF MULTIPLE MALIGNANCIES
ORGANS AND LESIONS

CASE	AGE	SEX		
(1)	72	M	Colon, adenocarcinoma	Esophagus, epidermoid carcinoma
(2)	56	F	Breast, adenocarcinoma	Stomach, adenocarcinoma
(3)	69	M	Tympanic antrum, epidermoid carcinoma	Urinary bladder, papillary carcinoma
(4)	56	F	Brain, ependymoma	Stomach, adenocarcinoma
(5)	55	F	Pancreas, adenocarcinoma	Cervix, epidermoid carcinoma
(6)	30	F	Cervix, epidermoid carcinoma	Hematopoietic system, myelogenous leukemia
(7)	72	F	Cervix, epidermoid carcinoma	Stomach, adenocarcinoma
(8)	65	M	Tongue, epidermoid carcinoma	Pancreas, adenocarcinoma
(9)	57	M	Bile duct, carcinoma	Urinary bladder, non-papillary carcinoma
(10)	62	F	Breast, carcinoma	Colon, adenocarcinoma
(11)	69	F	Breast, carcinoma	Reticuloendothelial system, Hodgkin's disease
(12)	72	M	Bile duct, carcinoma	Prostate, adenocarcinoma
(13)	66	F	Bronchus, adenocarcinoma	Reticuloendothelial system, Hodgkin's disease
(14)	88	F	Skin, epidermoid carcinoma	Cervic, epidermoid carcinoma
(15)	68	M	Skin, epidermoid carcinoma	Bronchus, undifferentiated carcinoma
(16)	55	F	Cervix, epidermoid carcinoma	Uterus, adenocarcinoma
(17)	12	F	Brain, astrocytoma	Colon, adenocarcinoma
(18)	54	M	Skin of the heel, malignant melanoma	Hematopoietic system, chronic lymphocytic leukemia
(19)	79	M	Prostate, adenocarcinoma	Colon, adenocarcinoma
(20)	73	M	Skin, basal cell carcinoma	Bronchus, epidermoid carcinoma
(21)	86	M	Skin, basal cell carcinoma	Lip, epidermoid carcinoma
(22)	77	F	Kidney, carcinoma	Cervix, epidermoid carcinoma
(23)	70	M	Pancreas, adenocarcinoma	Colon, adenocarcinoma
(24)	47	F	Breast, carcinoma	Cervix, epidermoid carcinoma
(25)	74	M	Pancreas, adenocarcinoma	Colon, adenocarcinoma
(26)	48	M	Bronchus, undifferentiated carcinoma	Reticuloendothelial system, Hodgkin's disease
(27)	85	M	Lip, epidermoid carcinoma	Reticuloendothelial system, reticulum cell sarcoma
(28)	84	M	Bronchus, undifferentiated carcinoma	Reticuloendothelial system, lymphosarcoma
(29)	79	M	Skin of the cheek, epidermoid carcinoma; skin of the nose, epidermoid carcinoma; reticuloendothelial system, chronic lymphocytic leukemia; bronchus, epidermoid carcinoma; prostate, adenocarcinoma; ascending colon, adenocarcinoma; and descending colon, adenocarcinoma	
(30)	56	F	Bone, plasma cell myeloma	Cervix, epidermoid carcinoma

TABLE I

2. Among the 1,501 autopsy cases with malignant neoplasms, 30 patients or 2% had two or more primary malignant neoplasms.

3. A case was presented in which a patient had seven primary malignant neoplasms involving five different organ systems: an epidermoid carcinoma of the cheek, an epidermoid carcinoma of the nose, chronic lymphocytic leukemia, an epidermoid carcinoma of the bronchus, adenocarcinoma of the prostate, adenocarcinoma of the ascending colon, and locally invasive adenocarcinoma of a polyp in the descending colon.

4. Lymphoma or leukemia coexistent with a second primary milignant neoplasm was present in eight cases.

5. Thirty cases of multiple primary malignant neoplasms in this series represented 16 men and 14 women with the average age of the women being 57.2 years. The average age of the men with multiple malignant tumors was 70.9 years.

6. Women have multiple malignant neoplasms at an earlier age than men possibly because of the susceptibility of their sex organs to carcinoma.

ACKNOWLEDGMENTS

The authors wish to thank Dr. Frank Vellios of Indiana University School of Medicine for reviewing the slides and Dr. David Rosenbaum of the Veterans Administration Hospital, Indianapolis, for helpful suggestions. The photographs were prepared in the Departments of Illustration of the Indiana University School of Medicine and the Veterans Administration Hospital, Indianapolis. To Miss Donna King we owe thanks for help in typing our paper.

REFERENCES

1. Albrecht, Peter: Uber die Multiplizitat primarer maligner Geschwulste. *Oncologia,* 5:12-42, 1952.
2. Barrett, W. D., Miller, K. T., Fessenmeyer C. R.: Multiple primary cancer. *Surg. Gynec., and Obst.,* 89:767-774, 1949.
3. Billroth, T., Chirurgische Klinik; Wien 1871-6;

nebst einem Gesammt-Bericht uber die chirurgischen Kliniken in Zurich und Wien wahrend der Jahre 1860-76; *Erfahrungen auf dem Gebiete der praktischen Chirurgie.* Berlin, A. Hirschwald. 1879; p. 258.
4. Cahan, W. G.: Lung cancer associated with cancer primary in other sites. *Am. J. Surg.,* 89:494-514, 1955.
5. Cohen, H., Rubin, S., Eisemann, G.: Hodgkin's disease (familial) associated with multiple malignant neoplasms. *Cancer,* 11:1247-1254, 1958.
6. Goldberg, I. D., Levin, M. L., Gerhardt, P. R., Handy, V. H., Cashman, R. E.: The probability of developing cancer. *J. Nat. Cancer Inst.,* 17:155-173, 1956.
7. Karger, J. Von: Statistics of multiple malignant primary tumors. *Arch. Geschwulstforsch.,* 11:211-228, 1957.
8. Marrangoni, A. G., McKenna, R.: Multiple cancer, primary in the female genitals and other sites. *Am. J. Obst. and Gynec.,* 63:660-663, 1952.
9. McGregor, R. A., Bacon, H. E.: Multiple cancers in colon surgery. *Surgery,* 44:828-833, 1958.
10. Moertel, C. G., Hagedorn, A. B.: Leukemia or lymphoma and coexistent primary malignant lesions: A review of the literature and a study of 120 cases. *Blood,* 12:788-803, 1957.
11. Reich, Carl: Apparent cure in chronic lymphocytic leukemia. *J. A. M. A.,* 170:169-171, 1959.
12. Tenney, Lloyd E., Benedict, R. Walske, Kisner, Paul: Triple primary cancer. *Am. J. Surg.,* 97: 241-243, 1959.
13. Wallace, A. F.: Multiple malignant primary neoplasms. *Brit J. Surg.,* 45:165-169, 1957.
14. Warren, S., Ehrenreich, T.: Multiple primary malignant tumors and susceptibility to cancer. *Cancer Res.,* 4:554-570, 1944.
15. Warren, S., Gates, O.: Multiple primary malignant tumors; a survey of the literature and a statistical study. *Am. J. Cancer,* 16:1358-1414, 1932.
16. Watson, T. A.: Incidence of multiple cancer. *Cancer,* 6:365-371, 1953. ◄

From 13 to 200

Since its beginning in 1950, the National Science Fair—International has grown from 13 to more than 200 contributing regional fairs. This year, 10 foreign countries may also be represented. The average finalist represents 1,875 other young exhibitors. On May 12, from 9 a.m. to 10 p.m., at Butler Fieldhouse, Indianapolis, the public may view the work and ideas of America's top young scientists. Their greatest gain will not be in the many prizes awarded to winners but in the inspiration, knowledge and experience which will help them plan their futures.



The Case of the Luetic Couple

*ARNOLD LIEBERMAN, M.D.**
New York, New York

MR. ARTHUR, an elderly veteran of the First World War, worked as a laborer until early in the Second World War; he developed vague symptoms and was treated for various things; one day he went into a rather violent spell of being disoriented and so had to be taken to Bellevue for observation. The neurological findings were very suggestive of central nervous system syphilis; a spinal puncture gave fluid under pressure with elevated albumen and cell count; the VDRL was four plus and the colloidal gold curve was typically paretic.

He was given the usual course of treatment standard for the pre-penicillin days; he received bismuth by muscle and neo-arsphenamine by vein; a course of malaria therapy was instituted in addition to the usual supportive and symptomatic measures. In spite of it all, he deteriorated rapidly and had to be transferred to the Veterans Administration facility where he sank quickly to the soilers' ward. Several years later energetic penicillin therapy failed to do much.

In 1953, we were in the process of experimenting with a new procedure for mental disease. Later, we were to report our work in *Geriatrics* magazine for 1954 (Vol. 9, No. 3, and again No. 8—March and August). In selecting our patients, we decided that Mr. Arthur would be a particularly suitable subject for this bit of research; as he was mentally incompetent, pemission had to be obtained from his wife who was his legal guardian.

. . . the Obvious Scrub-woman

That is how I first met Mrs. Arthur. This first sight of her was startling. Here was a Slavic Tug-boat Annie waddling into my office under the escort of the secretary. The clothing did not

---

* The third of an intermittent series of case reports. Dr. Lieberman formerly practiced in Lake County, Ind. Art by Miki Wilson, Hawaii.

appear to be even respectable rags, but it was mended and kept neat. She was shapelessly dumpy with immense, muscular shoulders and ham-like hands terminating in stubby fingers gnarled by typical Heberden nodes of osteo-arthritis and eroded by oceans of sudsy water. She was the obvious scrub-woman whose life had been spent sloshing down endless miles of dirty floors and washing mountains of someone else's laundry. She moved with elephantine awkwardness and with visible pain. Her huge, completely flat feet were encased in men's shoes that had been cut to permit room for enormous bunions, mis-shapen toes and assorted corns.

The sleazy coat would not have brought 50¢ at a rummage sale. It was mid-winter and she was purple-blue from the chill of the hard northeaster blowing outside. The straggly, nondescript hair was gathered in pig-tails by a bright colored, mis-matched pair of ribbons. Almost as a cartoon, the large, washed-out blue eyes sat on each side of an upturned nose that had been broken badly and never re-set. No prize fighter ever had a nasal passage disarrayed so brutally. A discarded man's felt hat completed the picture.

Anything to Help Her Johnny

In her hand was clutched a note from the ward nurse. In a broad, Lithuanian accent, Mrs. Arthur stated her mission. Yes, she would be glad to sign the permit—anything to help her Johnny. Her voice was flat and submissive and yet somehow pleasant. Looming over the desk at which she was seated, she almost smothered the permit as she leaned her ample bosom (devoid of any encasing bra) forward and scrawled laboriously *Olga Stanislaukas Arthur*. Still grasping the pen like a dangerous spear, she said almost shyly, "Johnny showed me how." Then, so as not to give the wrong impression, she added hastily, "I cannot write anything else." The apologetic smile revealed broken stumps of teeth innocent of any care whatever.

Arthur's wife was forgotten as the experiments proceeded. We were incredibly lucky with him; by the end of the summer, Mr. Arthur could be removed from the hopeless ward. He was able to communicate his wants and he recognized attendants and other people talking to him. Twice a month, his wife visited him; just a week before Thanksgiving, she hobbled into my office. A large shopping bag was under her arm; and from it she extracted a large afghan. "I knit it special for you; it is to thank you for what you done for Johnny; he talked real nice today. I hope you like it," she added anxiously—dismayed at the sudden thought that I might be displeased. She must have toiled endless hours crocheting the huge, gaudy thing; besides, the money spent on the yarn alone must have been a real sacrifice for her. It was both embarrassing and deeply touching.

Lap-Dog Loyal Eyes . . .

She grasped both of my hands and started raising them to her mouth in order to kiss them. Her lap-dog loyal eyes began to fill with tears as I, most gently, seated her, disengaged my hands, and explained to her that in our free America such demonstrations of devotion just were not done. Little by little, much of her personal story came out.



"I knit it special for you . . . for what you done for Johnny . . ."

The little Lithuanian village in which she was born had been in the path of the invading armies of the Kaiser in the First World War. The women of her hamlet had been ravished repeatedly by the see-saw of the criss-crossing armies, so she did not know her father. All she could remember of her childhood was work, more work, and then extra work. Before she entered her teens, the girls of her town had been kidnapped by some soldiers of a company stationed nearby. This had left her infected and barred permanently from motherhood.

Towards sex she had no feeling. "One must bear the men," she remarked as a fact of life. "What can one do?" The village priest took pity on her; he secured her a job as a chambermaid on a boat plying out of Memel. For many years she traveled around Northern Europe seeing nothing but the beds she made, water closets she cleaned and the corridors that always seemed to need sloshing down.

As the next World War came along, the boat fled to England. Geography and politics were completely beyond her ken, but she did know that the ship began making round trips to Brooklyn. Once, while on shore leave, she got to do some shopping and sightseeing; twice she got to Coney Island. "Such wonderful places there," she half sighed with the wistful recollection, "And such wonderful things in the windows. In my village not even the landlord had things like they show here—and all you need is money!"

On one such shore leave, the contents of her purse were spotted as she bought some yarn. "A very nicely dressed man" picked her up and took her to a den; she was mickey finned, attacked and rolled. All she remembers was waking up and trying to get back to her vessel; it had set sail without her. She had no passport but the police did not doubt her story: it was obvious that she was transparently incapable of fabulizing. Pending the next trip of her ship, she was given a temporary job as a chambermaid in a little hotel for men only.

Her boat never did return, as it was torpedoed and sunk on the very trip which Olga had missed. So the temporary job became a steady one; she was allowed to stay here and obtain treatment for the very unpleasant disease she had acquired when robbed and abused. It was just before the penicillin era and so she had to submit to the then usual course of intramuscular bismuth and intravenous arsenic.

She accepted stoically the pain and discomfort of the injections; she was resigned even to the severe secondary eruption she was not prevented from developing; she murmured somewhat at the horrible gluteal abscess that resulted from a careless superficial injection—eventually that had to be incised and drained. Olga did sigh reproachfully, "*Very* expensive doctors in this country . . ."

American Name is Hers

In the hotel where she worked, one of the boarders took a particular liking to her. He enjoyed the way she darned his socks and took care of his laundry; he appreciated the fact that she never talked back to him when he would ramble about his experiences in the American expeditionary force led by General Pershing; he realized how useful she was to him when she would help him to bed when he was the worse for liquor. When he was sick with pneumonia, Olga tended Mr. Arthur and actually nursed him back on his feet. It was when he had recovered from his illness that Mr. Arthur decided to marry her; she did not protest. Without any pretense of courtship, he took her to the city hall to have the ceremony performed. Thus she acquired legal status as an American citizen; also, the bonus of an American name was hers.

For Olga, marriage meant only additional work in caring for her man; the union could never be consummated physically, as he was too old and too ill. Having been a slavey and a drudger all her life, her comment was quite different, "Johnny was always good to me; he never beat me even once."

Very soon after the ceremony, Mr. Arthur began to be more confused and irrational than usual. With the aid of the hotel owner, arrangements were made for hospitalization. As his wife, Olga obtained her legal share of his pension; also, her job continued to pay room and board plus $40.00 a month. She had continued giving Mr. Arthur the same loyalty with which a dog clings to its master and so she was genuinely happy when he had recovered to the point of recognizing her. The visits to the hospital were to her a duty like going to Mass: an unquestioned part of the pre-ordained nature of things.

More than One Diagnosis

Another year rolled around; our luck with Mr. Arthur held. It seemed to us that the mental deterioration had been more on an arteriosclerotic basis than from the proven general paresis. We were experimenting with a treatment for senile arteriosclerotics; Mr. Arthur fitted into that category; his response seemed proof that more than one diagnosis could be correct. The medical minutiae are available in the two 1954 issues of *Geriatrics* already alluded to; the titles of the articles were "Subconvulsive Intravenous Metrazol Therapy . . ." and "Evaluation of Intravenous and Oral Use of Metrazol Therapy in Hospitalized Arteriosclerotic Psychiatric Patients."

At any rate, we did not see Olga again until that Christmas when she drifted in with another shopping bag under her arm. Out of it cascaded a truly magnificent shawl for my wife and a dozen monogrammed handkerchiefs for me. It was deeply moving and it also put me in a quandary. "What can I do for *you,* Mrs. Arthur?" Well, more of her story came out. She was still getting "shots" for her "blood"; "special to her," they still cost $3.00 per week. Besides the drain on her meager income, they seemed to be doing no visible good whatever; she was in constant pain and she was getting so stiff that she was in danger of losing her job. Her real grief, however, was that she could kneel no longer at Mass!!

Unremitting toil and disaster had been her constant companions; she was inured to their presence and accepted her lot as being normal; it did truly distress her to think that the priest would consider her remiss in proper respect for God while she remained standing during the course of her devotions. . . .

Her profound sincerity was tremendously moving; I did not feel that I would be censured unduly for breaking regulations in giving Mrs. Arthur an unauthorized examination. I had gotten her personal story before and was well aware of the venereal diseases she had had; even a casual examination revealed arthritic changes which seemed to be a mixture of trauma over the years, the old gonorrheal infection and just plain osteoarthritis.

The Heberden nodes were huge and the bunions terribly deforming; movements at the joints were exquisitely painful, out of proportion for all the arthridides just listed. There simply was nothing to suggest the deforming lesions of rheumatoid arthritis; I looked for tophi in vain; there was not even a hint of Parkinsonism, scleroderma or calcinosis. But the horrible, gnawing pain was there indubitably and—given the patient—a diagnosis of "psychosomatic" or what have you would have been ridiculous, to say the least. The heart and lungs were perfectly normal; pelvic exam showed only an old, completely burned out pelvic peritonitis; neurological testing turned up nothing bearing on the problem.

Broke a Few Regulations . . .

Syphilis did not appear to be the likely culprit, but we decided on a course of intensive penicillin therapy while embarking on a series of some simple tests plus observation of masterful inactivity. Rather surreptitiously but with a clear conscience we broke quite a few hospital regulations. A routine blood count was done in addition to the usual urinanalysis; blood studies were requested which included the usual VDRL, sugar, uric acid, urea nitrogen, cephalin flocculation, cholesterol; a spinal tap was done and the normal looking fluid was also sent for a battery of tests; x-rays of all extremities and the lower spine and pelvis to say nothing of the skull were ordered and done.

Penicillin seemed to help from the start; of course, a tremendous quantity of old-fashioned aspirin was aiding, too. The blood did not show syphilis but the spinal fluid had some lymphocytosis and also some increase in globulin. The spinal fluid Wasserman was two plus only but the colloidal gold had a faint but unmistakable mid-zone reaction. We were almost ready to diagnose the "pins and needles" in her feet as very early tabetic crises. In conjunction with the suggestive lightning-like pains and the history of inadequate treatment, the diagnosis appeared more and more certain. The blood studies were otherwise unremarkable except for a rather high uric acid; still, the reading of 5.8 mg could be accepted as high normal.

The x-rays were gone over in a conference with our chief of radiology; the films certainly showed an abundance of osteoarthritis, there was something that looked like a luetic peri-

osteitis along the shin bones: the case seemed all buttoned up as lues and its various ramifications. Just as I was going to ask some questions as to the unusual severity of the pains, the radiologist pointed at some punched-out areas of rarefaction below both knees and scattered around the metatarsal joints. "These things are absoutely typical of *gout,* doctor!"

A Single, Unifying Etiological Agent

Just as with Mrs. Arthur's husband, more by luck than by design, we had stumbled on the hidden culprit in the case. Since junior medical student days, we had been drilled to always look for a single, unifying etiological agent; the knowledge of the presence of the venereal diseases and the obvious osteoarthritis had dulled our diagnostic acumen and lulled us into a false sense of attainment; we had seen no necessity for further studies. The next day, Mrs. Arthur was seen with a vicious flare-up of all her agonizing pains; a blood uric acid was repeated and this time gave us a reading of an even 9 mg — indubitable confirmation of the diagnosis of gout.

Olga was placed on intensive anti-gout medication. Colchicine in full dosages wrought an almost miraculous relief of the agonizing pains — thus confounding any lingering skepticism we might have had of the radiological diagnosis.

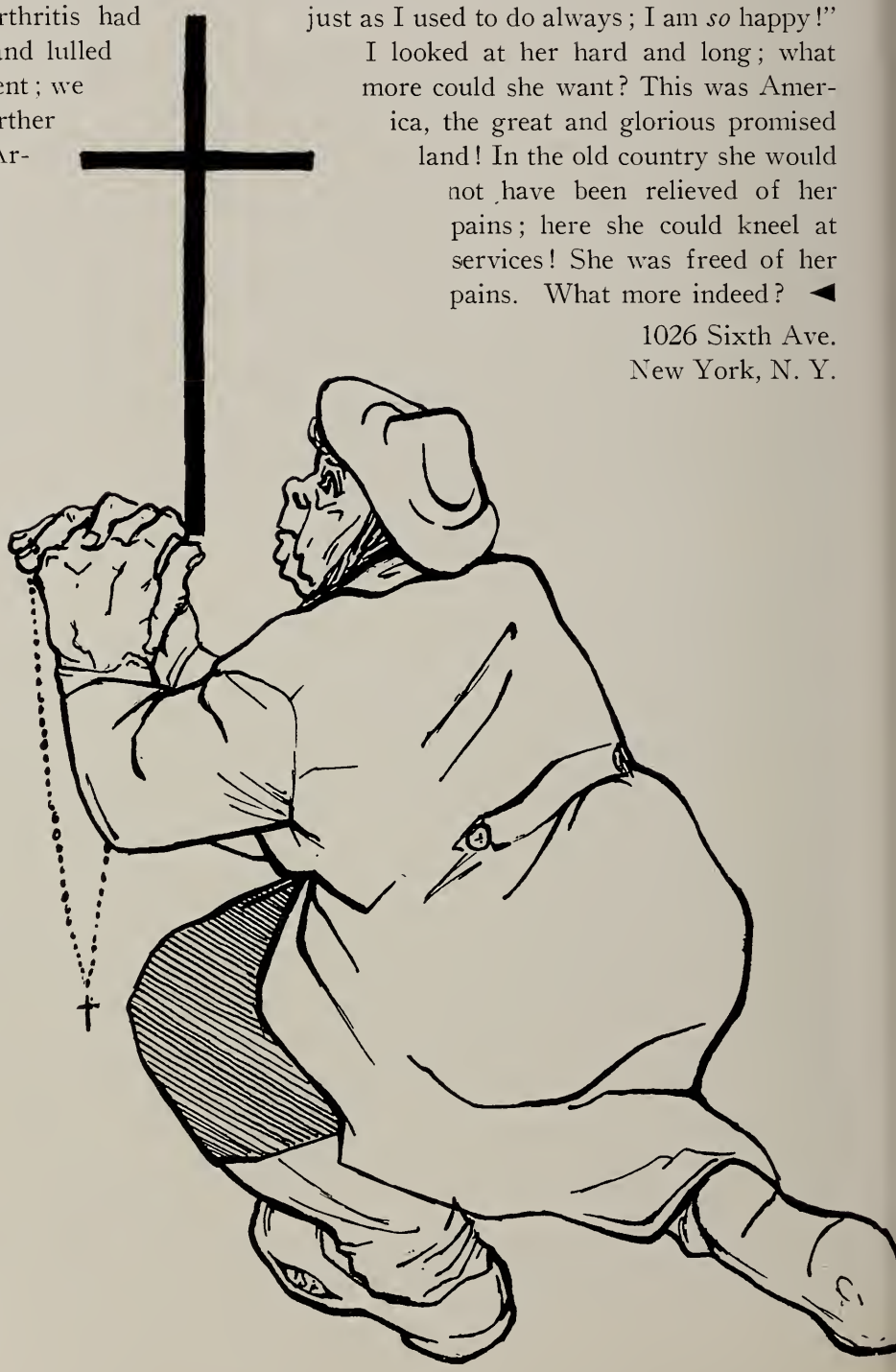
The penicillin course was completed and she was placed on very small doses of steroids; aspirin was continued in diminishing doses for the lingering aches and pains. I heard indirectly from the resident that Olga had blossomed out into robust vigor; I did not see her personally until she came into my office at Easter time.

Again Her Shopping Bag Was Filled

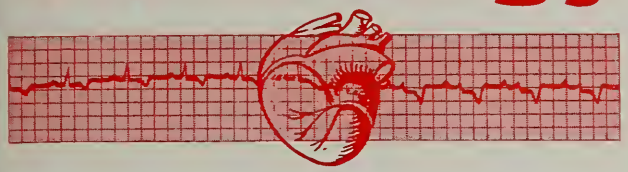
She rolled in almost jubilantly; again her shopping bag was filled with presents; her joyous, "Your medicine has made me so much better" was a pleasure to hear. And then she became very earnest and solemn, "I have wonderful news, my doctor: I went to services this morning and I could *kneel* all the way through: just as I used to do always; I am *so* happy!"

I looked at her hard and long; what more could she want? This was America, the great and glorious promised land! In the old country she would not have been relieved of her pains; here she could kneel at services! She was freed of her pains. What more indeed? ◄

1026 Sixth Ave.
New York, N. Y.



Condensed Cardiology



Presented as a regular feature of The JOURNAL, Condensed Cardiology is a series of short talks on cardio-vascular diagnosis and treatment, edited by the staff of the Robert M. Moore Heart Clinic of the Marion County General Hospital, Indianapolis.

Second Heart Sound

CHARLES FISCH, M.D.
Indianapolis

AUSCULTATION OF THE HEART has advanced rapidly in the past 15 to 20 years largely through the application to this field of cardiology of new, more sensitive and easier to handle recording devices with a high degree of selectivity of sound spectra and good reproducibility. As a result, the various auscultatory phenomena have assumed a new significance, for it has been possible to interpret them not only in terms of anatomical but also pathophysiological alterations.

A physician familiar with modern auscultation cannot only make a reasonably accurate anatomical diagnosis but also make some intelligent estimate of the severity of the pathological changes and the physiological alteration. Evaluation of the second heart sound in terms of intensity, quality, distribution and splitting may give clues as to the severity of valvular lesions; presence of delayed ventricular activation, relative increase of right ventricular output and pulmonary hypertension.

The second heart sound (S-2) is due to vibrations set up by closure of the aortic (A-2) and pulmonic (P-2) valves. Ordinarily, the major contribution to the intensity of the S-2 is made by the closure of the aortic valve. Because of its intensity, the latter is widely distributed and alone accounts for the S-2 at the apex. P-2 is softer than A-2 and is, as a rule, restricted to the pulmonic area. Failure in the past to appreciate the fact that S-2 at the apex represents A-2 has led to an erroneous notion that A-2 is often absent in aortic stenosis.

As a rule, in a normal adult the closure of the two valves is audible as a single sound. Splitting (separation) of the two components (A-2-P-2) of the second sound (S-2) with a delay of the P-2 is due to delayed and/or prolonged emptying of the right ventricle. This phenomenon, when transient and accompanying respiration, is a physiological finding due to increased flow of blood through the right ventricle during inspiration. Delay of activation of the right ventricle, such as occurs in the presence of right bundle branch block, may postpone the closure of the pulmonic valve with a resultant fixed split of S-2. Persistent splitting, however, is of much more value in the diagnosis of lesions associated with a significant, selective increase of right ventricular blood flow. In such states, the splitting is fixed and the degree of separation of the components is as a rule proportional to the magnitude of the shunt, this relationship being disturbed, however, by raising pulmonary pressure.

Classical examples of selective increase in right ventricular flow with fixed splitting of S-2 are atrial septal defects and anomalous pulmonary drainage. Another situation in which there exists a prolongation of right ventricular ejection is obstruction to the outflow, e.g., pulmonary stenosis. If the degree of valvular deformity is mild and P-2 not obliterated, the degree of split-

From the Robert M. Moore Heart Clinic, Marion County General Hospital, Indianapolis.

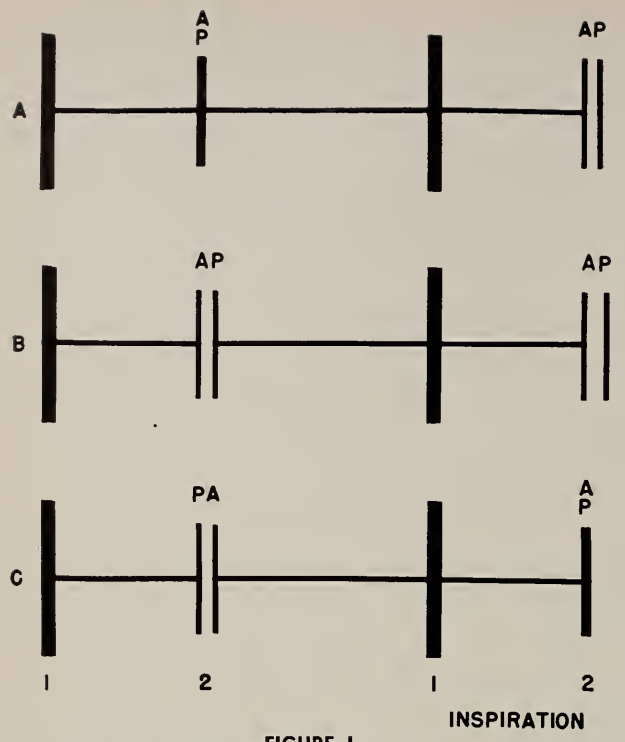


FIGURE 1

THIS DEMONSTRATES the behavior of the second heart sound during normal inspiration (A), selective overloading of right ventricle (B) and selective overloading of left ventricle paradoxical splitting (C).

A—the second sound is caused by closure of aortic and pulmonic (A, P) valves. On inspiration the sound is split with delay of pulmonic component.

B—during isolated right ventricular overload (e.g., atrial septal defect, anomalous pulmonary drainage), the second sound is split both on expiration and inspiration with the splitting becoming wider during the latter phase.

C—during selective overload or delay of left ventricular emptying (e.g., aortic stenosis, patent ductus arteriosus) there is a normally split second sound with delay of the aortic component (PA). On inspiration, and with physiological delay of P-2, the second sound may again become single.

ting bears a definite relation to the intraventricular pressure. Rarely will early closure of the aortic valve result in a split S-2 with delayed P-2.

"Paradoxical" splitting is defined as splitting of S-2 in which the separation is most obvious during expiration and becomes less pronounced or disappears completely with inspiration. Situations that give rise to this phenomenon are associated with delayed emptying of the left ventricle and displacement of A-2, e.g., aortic stenosis, left bundle branch block and patent ductus arteriosus. On inspiration, the P-2 "closes in" and narrows or eliminates the gap. The latter behavior is paradoxical.

In an adult without any cardiovascular disturbance, A-2 is louder than P-2, and if transmission of A-2 into the pulmonic area can be ruled out, an accentuated P-2 is usually indication of pulmonary hypertension. Such an interpretation is more secure if the accentuated P-2 is associated with closely split S-2. In some cases, an accentuated P-2 may be the sole finding of pulmonary hypertension. Diminution, but rarely absence of A-2 or P-2, may characterize an aortic or pulmonary stenosis respectively. In contrast to an accentuated P-2, the former changes are of secondary importance because of an associated systolic ejection murmur of a stenosis. ◄

The World's Largest

In 10 years, the National Science Fair—International has grown to be the world's largest assembly of top-level senior high school science projects in the world. The 1960 fair, to be held in Indianapolis at Butler Fieldhouse, will be open to the public from 9 a.m. to 10 p.m. on May 12. Over 90% of these 14 to 19-year-old finalists actually go on to make science or engineering their careers. It's an important time for the youngsters . . . many will be seeking a much clearer picture of their futures. Interest in them provides a type of inspiration not available in the many prizes which participants will receive.

'Changing Concepts Concerning Cancer' Theme of Fourth National Conference

Physicians interested in any phase of cancer control are invited to attend the Fourth National Cancer Conference in Minneapolis, Sept. 13-15.

"Changing Concepts Concerning Cancer" will be the theme of the meeting, arranged every four years under the auspices of the American Cancer Society, Inc., and the National Cancer Institute. Physicians from throughout the world are expected to attend.

The tentative schedule for the 3-day program is as follows:

Tuesday, September 13

9:00 a.m.
Greetings

9:15-9:50 a.m.
Address on Theme (General Session)
Speaker: Dr. Michael B. Shimkin

10:00 a.m.-12:30 p.m.
Cancer Etiology Panel (General Session)
Chairman: Dr. Howard B. Andervont

1:30-5:00 p.m.
Symposia on:
Cancer of the Breast
Chairman: Dr. Edward F. Lewison
Summary Session Participant: Dr. Alfred M. Popma
Cancer of the Lung
Chairman: Dr. Alton B. Ochsner
Summary Session Participant: Dr. Arthur J. Vorwald
Cancer of the Female Genital Tract
Chairman: Dr. Joe V. Meigs
Summary Session Participant: Dr. John L. McKelvey

Wednesday, September 14

9:00-9:50 a.m.
Address: Frontiers in Biology and Cancer Research (General Session)
Speaker: Dr. George W. Beadle

10:00 a.m.-12:30 p.m.
Cancer Pathogenesis and Spread Panel (General Session)
Chairman: Dr. Warren H. Cole

1:30-5:00 p.m.
Symposia on:
Cancer of the Gastrointestinal Tract
Chairman: Dr. I. S. Ravdin
Summary Session Participant: Dr. Joel W. Baker
Cancer of the Male Genitourinary Tract
Chairman: Dr. Reed M. Nesbit
Summary Session Participant: Dr. Herbert Bredler
Leukemias and Lymphomas
Chairman: Dr. Sidney Farber
Summary Session Participant: Dr. Alfred Gellhorn

Thursday, September 15

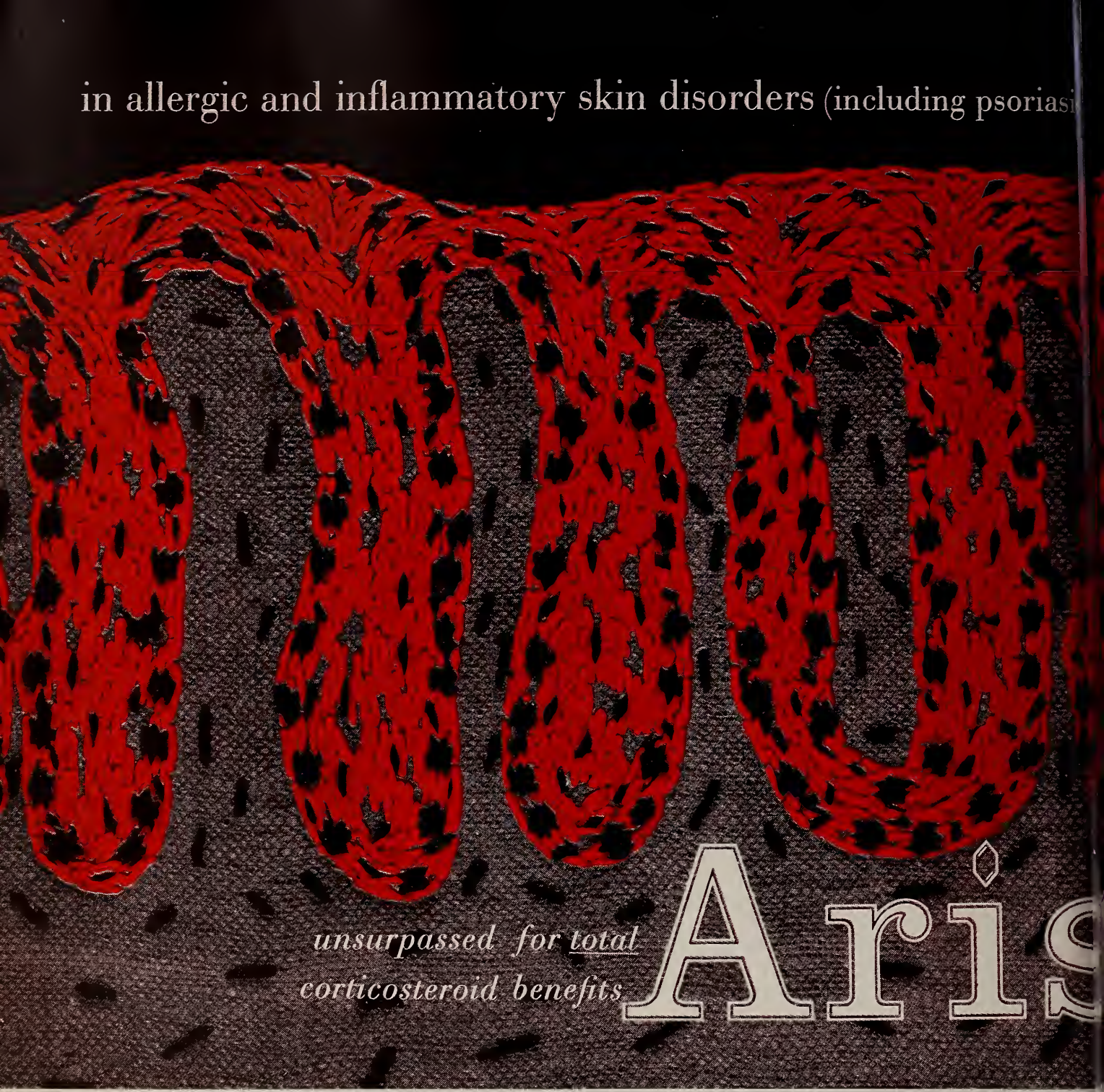
9:00-9:50 a.m.
Address: Care of the Advanced Cancer Patient (General Session)
Speaker: Dr. Herman E. Hilleboe

10:00 a.m.-12:00 Noon
Cancer Therapy Panel (General Session)
Chairman: Dr. Owen H. Wangensteen

1:00-3:00 p.m.
Symposia on:
Cancer of the Skin
Chairman: Dr. Thomas B. Fitzpatrick
Summary Session Participant: Dr. Eugene VanScott
Cancer of the Head and Neck
Chairman: Dr. William S. MacComb
Summary Session Participant: Dr. Edgar Frazell
Cancer Control
Chairman: Dr. John R. Heller
Summary Session Participant: Dr. David A. Wood

3:00-5:00 p.m.
Summary Session (General Session)
Chairman: Dr. Eugene P. Pendergrass ◄

in allergic and inflammatory skin disorders (including psoriasi

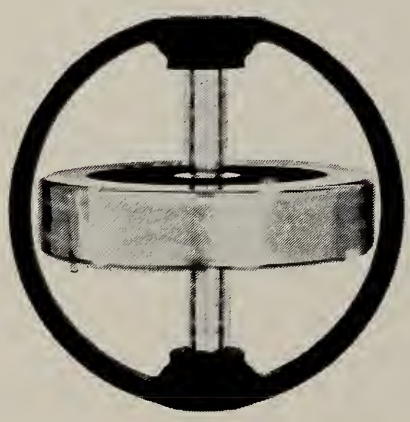


unsurpassed for total corticosteroid benefits

Aris

Substantiated by published reports of leading clinicians

- **effective control** of allergic and inflammatory symptoms[1-3,7,8,12-15,17,18]



- **minimal disturbance** of the patient's chemical and psychic balance[1,4-18]



At the recommended antiallergic and anti-inflammatory dosage levels, ARISTOCORT means:

- **freedom from salt and water retention**
- **virtual freedom from potassium depletion**
- **negligible calcium depletion**
- **euphoria and depression rare**
- **no voracious appetite — no excessive weight gain**
- **low incidence of peptic ulcer**
- **low incidence of osteoporosis with compression fracture**

Precautions: With ARISTOCORT all traditional precautions to corticosteroid therapy should be observed. Dosage should always be carefully adjusted to the smallest amount which will suppress symptoms.

After patients have been on steroids for prolonged periods, discontinuance must be carried out gradually over a period of as much as several weeks.

Supplied: 1 mg. scored tablets (yellow); 2 mg. scored tablets (pink); 4 mg. scored tablets (white); 16 mg. scored tablets (white).

Diacetate Parenteral (for intra-articular and intrasynovial injection). Vials of 5 cc. (25 mg./cc.).

References: 1. Feinberg, S. M.; Feinberg, A. R., and Fisherman, E. W.: *J.A.M.A.* 167:58 (May 3) 1958. 2. Epstein, J. I., and Sherwood, H.: *Conn. Med.* 22:822 (Dec.) 1958. 3. Friedlaender, S., and Friedlaender, A. S.: *Antibiotic Med. & Clin. Ther.* 5:315 (May) 1958. 4. Segal, M. S., and Duvenci, J.: *Bull. Tufts N.E. Medical Center* 4:71 (April-June) 1958. 5. Segal, M. S.: Report to the A.M.A. Council on Drugs, *J.A.M.A.* 169:1063 (March 7) 1958. 6. Hartung, E. F.: *J. Florida Acad. Gen. Practice* 8:18, 1957. 7. Rein, C. R.; Fleischwager, R., and Rosenthal, A. L.: *J.A.M.A.* 165: 1821 (Dec. 7) 1957. 8. McGavack, T. H.: *Clin. Med.* (June) 1959. 9. Freyberg, R. H.; Berntsen, C. A., and Hellman, L.: *Arthritis & Rheumatism* 1:215 (June) 1958. 10. Hartung, E. F.: *J.A.M.A.* 167:973 (June 21) 1958. 11. Zuckner, J.; Ramsey, R. H.; Caciolo, C., and Gantner, G. E.: *Ann. Rheumat. Dis.* 17:398 (Dec.) 1958. 12. Appel, B.; Tye, M. J., and Leibsohn, E.: *Antibiotic Med. & Clin. Ther.* 5:716 (Dec.) 1958. 13. Kalz, F.: *Canad. M.A.J.* 79:400 (Sept.) 1958. 14. Mullins, J. F., and Wilson, C. J.: *Texas J. Med.* 54:648 (Sept.) 1958. 15. Shelley, W. B.; Harun, J. S., and Pillsbury, D. M.: *J.A.M.A.* 167:959 (June 21) 1958. 16. DuBois, E. L.: *J.A.M.A.* 167:1590 (July 26) 1958. 17. McGavack, T. H.; Kao, K. T.; Leake, D. A.; Bauer, H. G., and Berger, H. E.: *Am. J. M. Sc.* 236:720 (Dec.) 1958. 18. Council on Drugs: *J.A.M.A.* 169:257 (January) 1959.

Lederle LEDERLE LABORATORIES, A Division of AMERICAN CYANAMID COMPANY, Pearl River, N. Y.

The Journal

of the INDIANA STATE MEDICAL ASSOCIATION

Devoted to the interests of the medical profession of Indiana

Editor: Frank B. Ramsey, M.D., 1802 North Illinois Street, Indianapolis 2, Indiana

Associate Editors: A. W. Cavins, M.D., 221 South Sixth Street, Terre Haute, Indiana; Lall G. Montgomery, M.D., Ball Memorial Hospital, Muncie, Indiana; David A. Bickel, M.D., 515 Odd Fellows Building, South Bend, Indiana; Stephen L. Johnson, M.D., 521 Sycamore Street, Evansville, Indiana.

Editorial Board: Term Expires

George M. Johnson, M.D., Richmond . . Dec. 31, 1960
Irvin W. Wilkens, M.D., Indianapolis . Dec. 31, 1960
Harold D. Lynch, M.D., Evansville . . Dec. 31, 1961
Jene R. Bennett, South Bend . . . . Dec. 31, 1961
Samuel R. Mercer M.D., Fort Wayne . Dec. 31, 1962
Franklin F. Premuda, M.D., Hammond . Dec. 31, 1962

Necrologist: James B. Maple, M.D., 117 West Washington Street, Sullivan, Indiana.

Assistant Editor: Corki Wilson

Editorial Assistant: Sara M. Snyder

Business Manager: James A. Waggener

1019 Hume Mansur Building, Indianapolis 4, Indiana

A.M.E.F. Dollars and Donors Rise

AS WAS PREDICTED last fall, the American Medical Education Foundation finished 1959 with a solid increase in contributions as compared with the two previous years.

The '59 books were closed with a total of $1,195,824.79. Disregarding cash gifts from the AMA, which are made in some years and not in others, this handsome sum represents a 17.2% increase over that of 1958 and 36.7% increase over 1957.

And almost as important as the increase in the money is the increase in number of contributors. They swelled in numbers like the dollars: 49,729 in 1958—55,399 in 1959.

Indiana is reported progressing in the same fashion, from 4054 contributors to 4,126. And in dollars from $50,259.97 to $51,661.58.

All of the expenses of the foundation, administrative and otherwise, are paid by the AMA. This channels the entire $1,195,824.79 down to the last penny direct to the medical schools of the nation. Each school is free to spend A.M.E.F. grants as it sees fit; there are no strings on the money.

No better cause was ever devised for philanthropic dollars. Here's to more increase in 1960.

Practical Politics — Better Government

THE CHAMBERS of commerce of the United States are conducting training courses in practical politics. This is a part of their crusade for better government. The business men think that the way to get better government is to learn how to elect qualified citizens to political office.

The doctors as a group are among their best customers. Individual physicians and some county medical societies *in toto* have enrolled in the practical politics courses all over the country.

The courses are conducted by local chambers of commerce or by similar community organiza-

tions. General coordination is by the national organization, the Chamber of Commerce of the United States and the state organizations such as the Indiana State Chamber of Commerce.

During the last few months courses have been conducted in dozens of Indiana towns and cities. Hundreds of interested citizens have benefited. Doctors who are interested should contact their local chamber of commerce or business men's club or write the State Chamber of Commerce in Indianapolis.

From Texas:

Cancer of the Colon: Detection or Prevention

THERE IS NO QUESTION but that cancer detection clinics over the country have made great contributions to the prevention and cure of cancer. Were the name changed to "Cancer Prevention Clinic," it is probable that more patients with vague symptoms might seek help before it is too late. The average patient lives in fear of cancer and is certainly more interested in prevention than he is in detection of cancer, no matter how early the latter is found. It has been stated many times that each doctor's office should be a cancer detection clinic. Here again, the term "cancer prevention" might be employed.

It generally is agreed that cancer of the colon and rectum develops in benign lesions such as adenomas and papillomas that have been present for an undetermined length of time. How much better to locate and destroy such lesions early before they become malignant? To this end there are two simple methods available to the physician —the proctoscope in his office and referral to his colleague, the roentgenologist.

There is nothing mysterious or difficult about the proctoscope or sigmoidoscope. It is one of the simplest of the "scopes." The busy physician might say that he does not have the time or equipment. Certainly, he is busy, but with a little practice the examination can be accomplished easily in 60 seconds. He can surely afford that much time when the patient's life might be at stake. Certainly he does not have a trick "upside-down" examining table that some, but not all, of the specialists use. The knee-chest position on any examining table or bed is just as good and may be better in some cases. Knee-chest means just that (not knees and elbows) with the thighs perpendicular to the table and the back "swayed in" as much as possible. Previous cleansing enemas facilitate the examination.

Digital examination always, without fail, should precede a proctoscopic examination. After passing the anorectal muscular ring (easily felt), the obturator is withdrawn and the instrument advanced under direct vision. Location and destruction by fulguration of a small polyp should give one a keen sense of personal satisfaction that he has probably prevented a cancer and that the patient has received a fair "shake" for his time and trouble.

Many the patient who has made the fatal mistake of assuming that blood or other symptoms were due to hemorrhoids when cancer was present. Large hemorrhoids may be present and obvious to the physician, but the proctoscope can prevent the physician from making the same mistake as the patient. The busy practitioner might have a rule about whom to examine by proctoscope: (1) new adult patients as part of a routine physical, (2) adults who have had a polyp or those without symptoms every one or two years, and (3) patients of any age with rectal bleeding or other rectal complaints.

Roentgen examination of the colon is necessary for the location of lesions above the reach of the proctoscope. The roentgenologist thus becomes an invaluable member of the cancer prevention team. He locates small lesions that can be excised before they become malignant. Air contrast studies are considered necessary in the identification of small polyps and always should be requested.

The busy physician might have a rule to request colon roentgenograms for all patients with one of the following: (1) a history of blood mixed with or smeared on the stool, no matter the anorectal lesions present, (2) even one small rectal polyp, (3) blood smeared on the rectal wall, (4) blood on bits of stool in the rectum, and (5) cancer of the rectum (multiple lesions

may be present). A personal study of the roentgenograms at a conference with the roentgenologist will prove invaluable.

Thus, the family physician has the leading role in cancer preventioin. The average patient wants to be examined and appreciates a thorough examination. Hearing a complaint and dismissing a patient with a prescription should not be sufficient. Only by more and better examinations will we be able to accomplish much towards cancer prevention and detection.

Harry B. Burr, M.D., Houston.

Reprinted from *The Texas State Journal of Medicine*, February 1959.

From Hawaii

Kaiser Plan in Honolulu

HENRY J. KAISER established his Kaiser Foundation Health Plan in Honolulu on May 21, 1958. Its $4,000,000, 150-bed hospital, which is to be finished by the end of the year, is to be—at the beginning, at least—an open staff institution. The plan itself is a closed panel, of course. As we go to press, it consists of five doctors: Richard S. Dodge, Richard C. Durant, Walter B. Herter, Homer M. Izumi and Samuel L. Yee.

The press release announcing the establishment of the plan described the arrangements in part as follows:

> 1. Local doctors, practicing teamwork medical care as a group, will direct and provide all the professional medical service for Health Plan members. A group of Mainland physicians will *not* be brought to Hawaii . . . but to the contrary, the local group of physicians will manage professional services on a fully independent, autonomous basis.

The independence and autonomy apparently are intended to describe the relationship of the Honolulu group to the Kaiser Foundation, rather than the relationship of the member doctors to one another. Additional doctors are invited to participate in the plan on either a part-time or full-time basis. There is room for 50 in all.

The founding partners "emphasized" ("claimed" might have been more apt) that the Honolulu program "incorporates 'free choice' principles and practices." The basis for this assertion appears to be the fact that

> The prospective subscriber . . . first has the right to choose between the Kaiser Plan and at least one other health service or insurance plan which would allow him to receive care *by other physicians* [italics added].

This freedom to reject the plan (which of course is not limited to "prospective" subscribers) applies to individual members of groups signing up for the plan. The implication that such recalcitrants must subscribe to some other plan may have been unintentional: public relations-ese is not the most effective medium for the communication of ideas.

"Freedom of choice" is further explained in the next paragraph:

> Members of the Kaiser Health Plan select their own personal or family physicians *from among the doctors servicing the plan* [italics added].

This is followed by two new interpretations of the phrase:

> The Honolulu program likewise offers a free choice to local physicians, including the opportunity for all qualified physicians to use the hospital . . . and the choice by local physicians serving Health Plan members as to how much time they wish to devote to caring for Health Plan members.

Closed panel medicine with severely restricted choice of physician is no novelty in Hawaii; our plantation medical care system has relied on it for decades, and still does. It is not even wholly novel in Honolulu, having been applied to group medical care for at least two local firms during the thirties, and to one of them still.

On this scale, however, and with the addition of prepaid hospitalization, it is a new experiment for urban Honolulu. As such, it will be watched with great interest—and, we trust, detachment—during the months to come. Only time will tell whether its integration with orthodox medical practice can be accomplished successfully—or, indeed, at all.

Reprinted from the *Hawaii Medical Journal*, July-August, 1958.

President's Page



Recently I heard of a method of food merchandising in the southern part of our country which seemed to be a novel type procedure. This is in the nature of a grocery store called "Seven-Eleven." The name stems from the hours the store is open—seven in the morning until eleven at night. The number of employees needed to operate this establishment is small and there is not a large investment in the building; consequently the overhead is not great. The merchandising is done without duplication of items and good qualtiy standard brands of food are merchandised.

The reason this particular type endeavor is going over is the simplicity with which it operates. It seems that the super-markets are growing so big and providing so many items for sale that the average housewife is confronted with a parking problem, a long trip past several shelves and a wait at the checkout counter. This other manner of purchasing food is much more simple and direct. This, of course, is a swing back to a method that in the past was used generally.

One wonders if it wouldn't be well to contemplate giving the same consideration to medicine. Throughout past years there has been a tendency to bypass the general practitioner and seek help directly from a specialist. This has led to the development of clinic and hospital services to supply the demand for medical attention. Are our present hospitals and clinics reaching the same point in service distribution that the supermarkets are reaching? One wonders if again the general practitioner, situated conveniently for people, is not still the answer. If this trend in merchandising of groceries continues to prove itself, perhaps this should indicate to us that a similar trend back to the general practitioner should be anticipated.

One cannot create an organization without encountering problems in management and the functioning of the organization. Simplicity is lost in such an effort and regimentation enters in. A general practitioner is in a much better position to render many of the services required in medicine than are organizd groups of ponderous size. Perhaps 75% of the procedures now being done in hospitals, that formerly were done in doctors' offices, could be returned there and the patient would be just as well off. Think of the time that would be saved and the reduction in duplication of effort, curtailing somewhat the general expense, if we could come up with such a practice again.

All in all it gives one a feeling of comfort to realize that the American people will accept that which is best for them. We may make all sorts of plans for the practice of medicine but we must realize that in the final analysis public acceptance determines what is to be done. This certainly is healthy. It remains for the doctors of this country to provide the best medical care in the world and a major portion of our problems are solved by this effort alone.

Earle W Bennett M.D.

The Women's Auxiliary

REPORTS TO I.S.M.A.

Civil Defense Committee

Trying to interest County Women's Auxiliaries in Civil Defense has made me more cognizant of the responsibility I have personally to my family and to my community "if the bomb should fall" or if a natural disaster—fire, flood or earthquake—should happen in our area.

The more I read and distributed publications describing how to build a family shelter and stock it with food and water, blankets, flashlight, portable radio, first aid equipment, amusements and sanitation needs, the more I realized that doctors' wives have the peculiar responsibility of showing the community the advantages of being prepared for any emergency, and the satisfaction of knowing that in an emergency we act as we have been trained to act. Simple games at home can teach the children what each one can do if the game suddenly should be "for real."



Mrs. Schneider

Last September when I spoke to the women's auxiliary at Muncie about preparation for civil defense, I told them I did not expect them to do all the things I outlined as necessary for survival, but I'll hazard a guess that many of them checked their flashlight batteries and marked the CONELRAD wavelengths on their radios. Two more programs on civil defense are planned for county auxiliary meetings—one for Bartholomew-Brown county auxiliary and one for Vanderburgh county when Delores Johnson, assistant state director, will speak at Evansville.

When our auxiliaries keep members informed on changing needs for civil defense, offer classes in home nursing and first aid and put up exhibits showing first aid kits, emergency food supplies and inexpensive home shelters, we are helping ourselves as much as others in our communities, for civil defense is, first and most important, acutely personal. Individuals may have to depend upon their own knowledge and resourcefulness for days or weeks after a major attack.

Dr. Carroll P. Hungate, chairman of the Committee on Disaster Medical Care, emphasized women's important roles in civil defense in a speech at the Chicago Regional meeting in January when he said, "As with many civic programs, if the women want a good civil defense program, we would have it."

Continued

NEW FROM

SEARLE

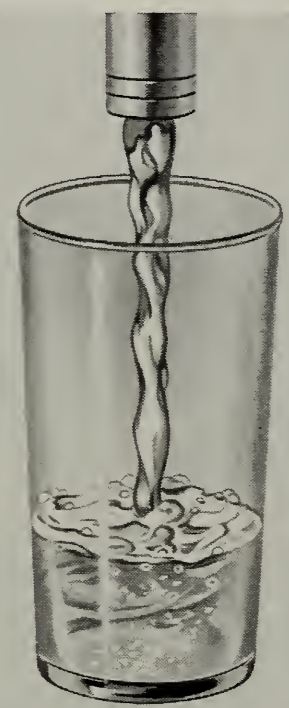
INSTANT MIX METAMUCIL®

Psyllium hydrophilic mucilloid with citric acid and sodium bicarbonate



just pour powder from one packet

- **each packet is equivalent to one rounded teaspoonful of Metamucil powder**



add cool water slowly... it's instantly mixed

all the advantages of smoothage therapy in the relief and correction of constipation

- **stimulates normal peristalsis**
- **induces natural elimination**
- **promotes regularity**
- **keeps stools soft and easy to pass**
- **avoids harsh laxatives or purgatives**



and it's EFFERVESCENT!

- **convenient, premeasured-dose packets**
- **delightful mild lemon flavor**

INSTANT MIX METAMUCIL
16 Packets

G. D. SEARLE & CO. • Chicago 80, Illinois

Women constitute a majority in 15 occupations; almost one-third of the total civilian labor force are women. Therefore, women must accept special responsibilities for emergency functions within the nation's labor force. Moreover, women are traditionally mainly responsible for family welfare. So, it follows, that women will shoulder responsibility for civil defense as well as for other emergencies.

Since we constantly compare and contrast our efforts to those of the Russians, it is interesting to note that in 1958 every Soviet citizen was required to take a 22-hour civil defense training course. Since that time the Russian Voluntary Society for Assistance to the Army, Air Force and Navy has been instructing the civilian population in anti-aircraft, anti-atomical, anti-chemical and anti-biological defense. Civil defense units have been established in every factory, collective farm, school, university and other institutions in Russia.

Even knowing the "facts" and what the Russians are doing—both as to space warfare and civilian defense—Americans in general and mid-Westerners in particular are hard to scare into action. Preparing for civil defense is a problem—but it is one that we can solve by using our American ingenuity, our knowledge of careful preparations needed and our woman's will to protect our homes and families from disaster.

Sylvia Schneider
Chairman

Character Melting Pot

A man's character and personality rub off on those who brush against him in the crowd. If they do so often and long it becomes perceptible, and if the bond between them grows strong it becomes determining. Each of us is in part a composite of the people we have known and been influenced by. We are constantly receiving from others, even as we are constantly imparting portions of ourselves to others. Each of us is a steward of life values and is alive in thousands of places at once.

Clarence Edwin Flynn
"The Bond Between Us"
Partners, Oct. 1959

"What Are Doctors Going To Do?"

'Are We Caring For The Old Folks?'

Emmett B. Lamb, M.D., Chairman
Commission on Public Health

"Care of the Aged" is a term that is appearing with ever increasing frequency. It seems to be the subject of discussion for many groups, and often is approached with alarm. The pattern seems to be that of emphasis upon the increasing life span with a tremendous increase in the number of citizens of 65 years or older, and that these citizens are for the most part in great need of care which cannot, or will not, be supplied by themselves, their families or the local committee. The next assumption that often follows is that this person is old and sick and medical care is the need and the point of neglect.

When the discussions are analyzed, it is evident that this is only in a very small part, medical care, but the great part is food, housing, clothing, entertainment and personal effects. Nevertheless, the medical profession is brought into the critical focus, and we repeatedly are asked, "What are the doctors going to do about it?"

Why the Sudden Alarm?

When we think of this situation, we next ask ourselves what are we doing for the aged people, and before we answer that, we ask why this sudden great alarm from so many quarters for them. Is it because there is a belief that there is widespread want and suffering among our older people? Is it the fear that we will soon be a nation all past 65 years of age? Is there some other motive for personal or political reasons?

There is probably no one simple, universal answer for all inquiries, but we, as doctors, can certainly say we have in our practice attempted to care for people, both old and young. We are still doing that.

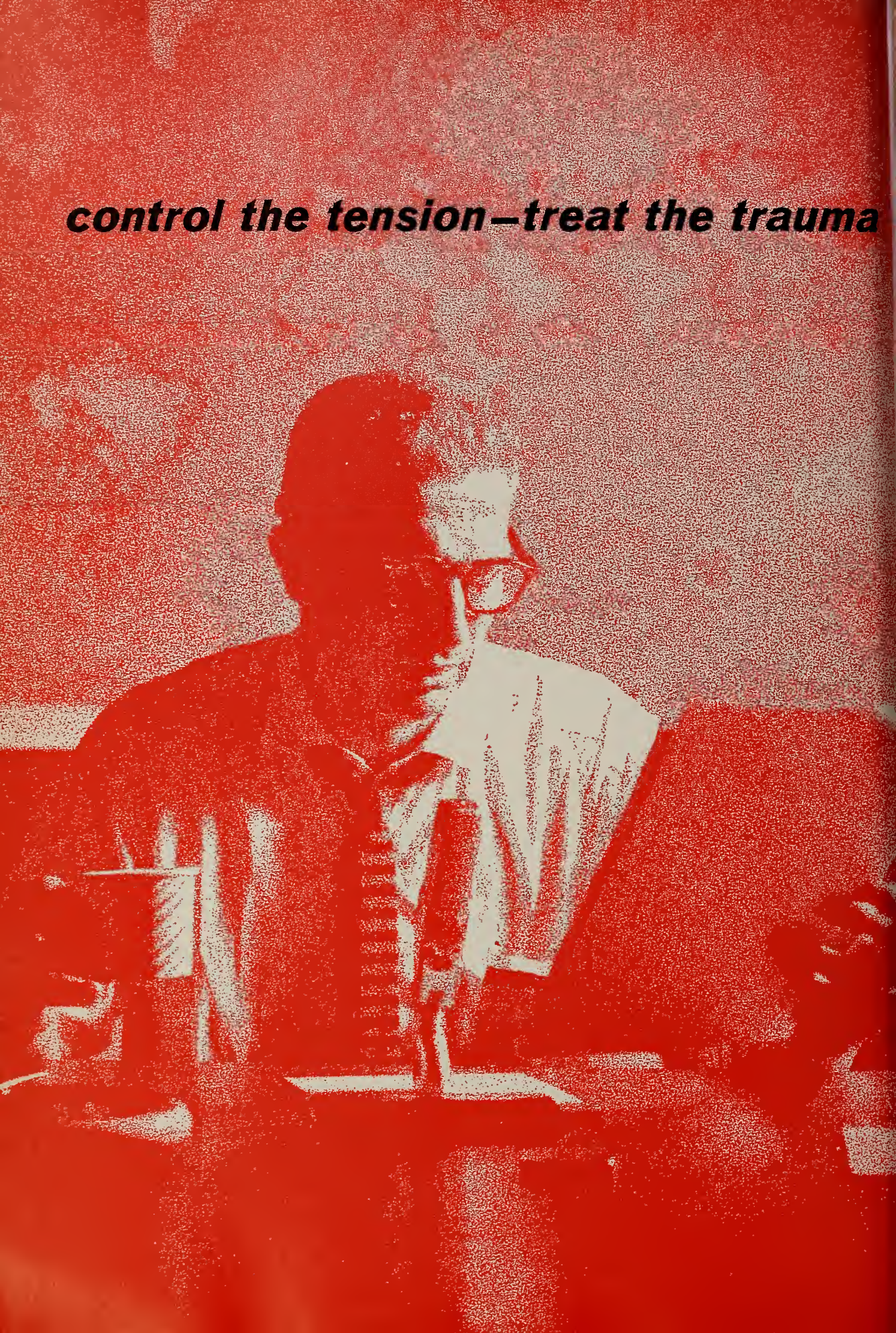
Many of these fears can be allayed in that carefully and actuarially composed statistics by various agencies, and, particularly, our life insurance companies, indicate that a little more than 9% of our total population are now past the age of 65. These same, careful actuary studies made by our life insurance companies, whose business it is to know, indicate that by 1980 the population will have increased in all areas; however, there will still be, even with the increasing life span, only slightly above 10% of the people 65 years or older. These facts should certainly allay, at least in part, one of these great alarms.

Great Progress

Organized medicine has recognized these questions and these alarms and has attempted to answer these at our state and county level. Each county medical society has been solicited to be aware of the situation, and in several counties, special committees have been formed to act as liaison with persons or groups interested in these questions.

Great progress has been made and it would seem we should continue to advise our public that we have been and will continue to care for our aged people in an efficient, realistic and sympathetic manner. ◄

control the tension–treat the trauma



Rosemary is the beloved herb of the Middle Ages and of the cooks of today. It is an herb of story and legend, closely connected, in some countries, with elves and baby fairies. However, the most charming story of this spiky, fragrant herb is that the Virgin Mary threw her cloak over a Rosemary bush and lay down to rest. From then onward the delicate little flowers took on the heavenly blue of her cloak.

The uses of it have varied over the centuries from binding scholars' brows at exam time to use in funeral wreaths, bridal bouquets, to help baldness and always 'for remembrance.'

This adorable herb has been used as a cure for almost everything, particularly associated with the alleviation of melancholy—a malady seemingly more understood in the Middle Ages. One could bind it against the right arm in a linen cloth and . . . "it shall make thee light and merry . . ." or put it under the bed to ward off "evyll dreames," or yet make a box with it, smell it from time to time and it will "preserve thy youthe."

In Angle Saxon leechcraft there is a recipe for giddiness, fever or spasm which includes Rosemary with some 24 other herbs, pepper and gum mastic, to be taken after fasting. Hippocrates used it in his simples. Much later, in the 15th Century, Paré, famous for his treatment of gun-shot wounds (greatly usurping the place of Melancholy as primary ailment) compounded the following potion: sage, Rosemary, thyme, lavander, camomile, rose petals, all boiled in white wine with added oak ashes and applied to the wound.

Rosemary is of benefit to many creatures. It is planted near bee hives as food for them as well as keeping them in good health. It also makes a superlative honey. Little newly hatched chickens should be lightly perfumed with Rosemary to keep them from the pip.

It is very efficatious against plague. By sprinkling the house with the fresh herb, the air is kept light and free from the plague. It is excellent for whomever "hath the weake sight" and should be eaten, flower and leaves, with bread and salt every morning.

In the 17th Century when the apothecaries of England received their charter and, as a separate society, broke with the Grocers' Guild to their great advantage, Rosemary was still a medicinal herb, although it was gradually assuming a place of great importance in the culinary world.

Its essential oil was used then as now in numerous aromatic essences and mouth washs and today in many tooth pastes. It is the basic ingredient in the preparation of the famous Queen of Hungary water. The oil of Rosemary combined with alcohol, as in Hungary water, seems to have a similar effect to tincture of Arnica, although much milder, in the treatment of contusions and as a friction or compress in rhumatic pains.

It is used today in an infusion as a calmant and against spasms. However it is more important for use, in an infusion, in the treatment of jaundice and liver congestion. It is interesting to note that the basis of the infusion can be a good white wine or, according to taste, be replaced by Malaga or Marsala. But, as a calmant, antispasmodic and digestive, the former is strongly advised.

Today, as in the past, it is wedded to beef. In stews, potroasts, and with the heavier fleshed birds, its pungent flavor pleases the palate and its aroma regales the mind proving that its oldest use is still in effect, for who can sit before a good roast with Melancholy as companion?

And what more can be asked of an herb than it succor the pains and aches of the body, administer to the spirit and be a boon to the cook?

There is an old saying which should not be dismissed lightly in connection with the fragrant Rosemary. It is that "where the bush flourishes, the Mistress rules." ◄

The Forand Bill

PAUL D. CRIMM, M.D.
Evansville

THE CONFLICT between the socialistic and the free enterprise methods of conducting our existence is still on the march Therefore, as a citizen interested in free enterprise, I am obligated to call your attention to the threatening increase in your taxes contained in the Forand Bill, which is now before the House Ways and Means Committee of Congress.

Last November, Norman Thomas, the former perennial nominee of the Socialist party for the Presidency of the United States, said in an unrigged television broadcast on NBC that he had accomplished the aims and purports of the Socialist party because most of his platform had been appropriated by both the Democrat and Republican parties. And so, we have been losing the battle of free enterprise, because like the *Battle of Sexes,* there has been too much fraternizing.

Defeat Beggars and Thieves

Not many years ago, the medical profession aroused doctors, lawyers, merchants and chiefs of industry to defeat the beggars and thieves who promoted the Murray-Wagner-Dingell Bill; in other words, socialized medicine. Republican Congressmen of the North, co-operating with Democrats of the South, and vice versa, killed that measure, brimful of "cradle to the grave" medicine. But the social planners in our United States are as industrious as beavers, for they have been endeavoring constantly to bring forth compulsory health insurance and hospitalization through various back doors.

Again in 1960, the Congress will be faced with a compulsory health insurance bill (HR 4700) which is designed to amend the Social Security Act. Under this bill, some sixteen million persons eligible for Social Security benefits, most of those over 65, would be entitled to receive hospital, nursing home and surgical treatment under a government-run program. Again, we must cross party lines to defeat it. Especially so, since it does not include four million men over 65 and women over 62 who are neither covered by nor eligible for Social Security.

Hold Everything!

Under the Forand Bill, the government would contract to pay hospitals, nursing homes, physicians and dentists for the service they would provide. And the government could change the program at its pleasure, after the fashion of a certain cannibal chief in Africa. One morning his warriors were preparing to put a beautiful blonde into the boiling pot. Suddenly the chief's messenger ran out of the royal hut in a panic and shouted, "Hold everything! The chief wants his breakfast in bed this morning."

What would this bill cost if it became law? The benefits provided for in the bill would be financed by an increase in the Social Security tax rate on the present wage base of $4,800.00, up to Jan. 1, 1969. By 1969, if the tax increases remain as scheduled and are not lifted, the tax will be $216.00 for the worker and $216.00 for the employer for a total of $432.00. In 10 years time the combined total will be more than double the average federal income tax today for a married man with two children.

For six consective election years, Congress has changed the Social Security Act. The size of the benefit checks was raised in 1950, 1952, 1954 and 1958. All have resulted in sharp increases in Social Security taxes. The tax rate increased automatically to 3% last January. It will hit 3½% in 1963, 4% in 1964, and 4½% in 1969. The rate for self-employed persons is

Like spraying alcohol on tomatoes to make "stewed tomatoes," Forand Bill is threat to our economy and individualism, yet fails hopelessly to meet problems of the aged.

50% higher than that on employees. The Department of Health, Education and Welfare estimates that in the first years the cost of the Forand Bill would be 1 billion, 121 million dollars. The American Medical Association estimates that the first year's cost would be between two billion and two billion, 387 million dollars. Already, Social Security taxes are scheduled to reach 9% of the payroll of those making up to $4,800.00 in the years ahead. This is in addition to your income taxes and other taxes.

Taxes Keep on Growing

Social Security taxes, like income taxes, keep on growing. Our first income tax was in 1913. The normal tax was 1% and the surtax up to 6%. Now it goes as high as 91%. The first Social Security law was a modest one which was designed to help the aged and unfortunate widows and children. It was not meant to do the whole job. But each election year it has been used by Congress for its vote-getting appeal—to do something for the people. They do not tell you about the cost or what it is doing to the people.

Consider the salary range and the number of people in the Vanderburgh County, Ind., area, which includes Henderson. There are 41.1% who make between $4,000 and $7,000 a year. In the city of Evansville 43.1% make between $4,000 and $7,000 a year. In the Vanderburgh County area, including Henderson, 20.2% make between $2,500 and $4,000, in Evansville 19.2%. These are the people that Social Security taxes hit the hardest. And if similar hospitalization bills are passed for everybody, within a few years all these people might as well be on the government payroll.

Smaller Paychecks!

Now, if you add the billions it will take to operate the Forand Bill to this aforementioned 9%, it will mean smaller paychecks for everyone under Social Security. Those who are self-employed likewise will feel the pinch of this proposal. Even then, what the social planners reckon that it will cost always falls short of reality. This, plus the progressive increase in our population, makes it improbable that the Forand Bill's calculations would prove an exception to the rule. In the meantime, the world is worrying about over-population, due to careless bedroom calisthenics.

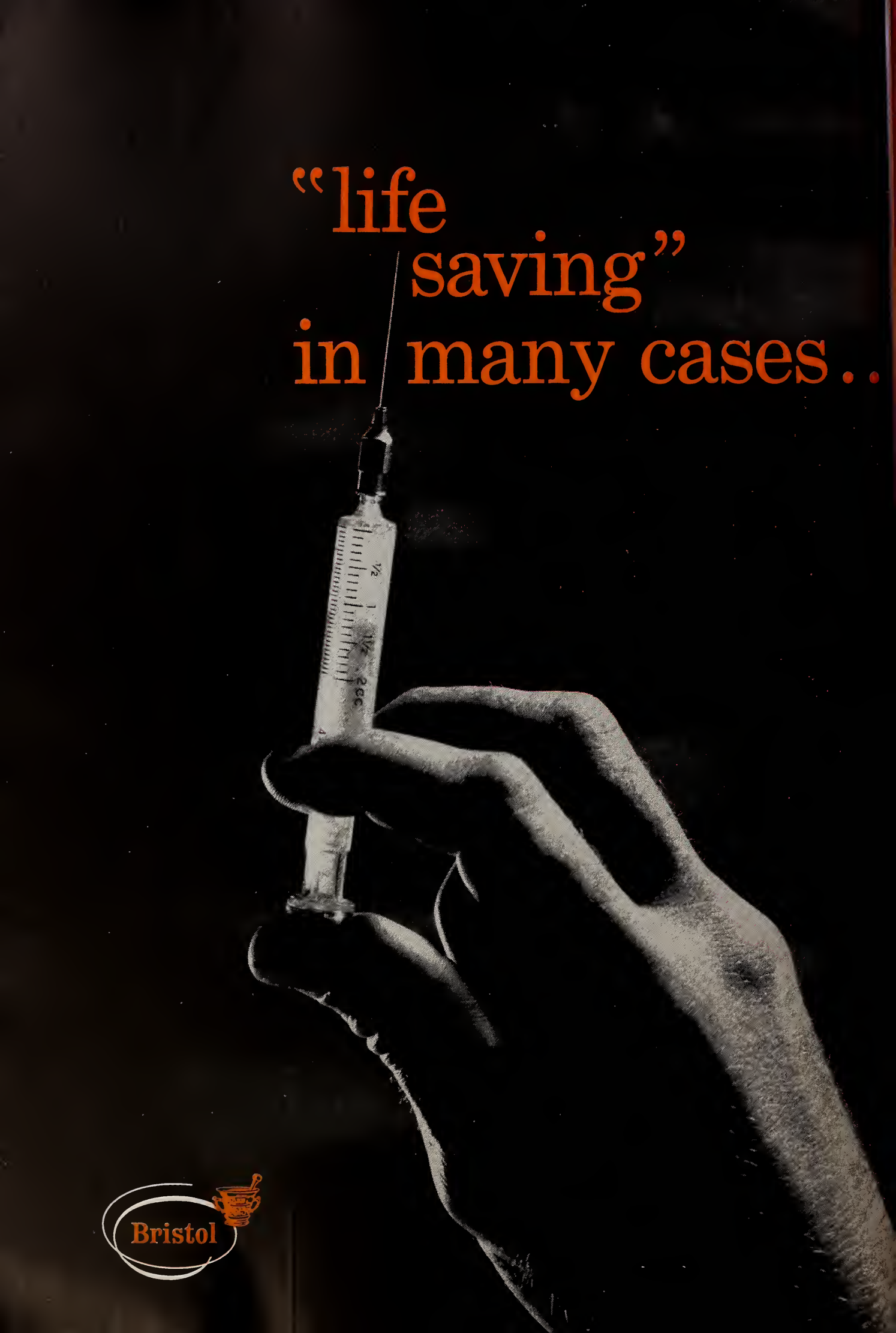
In 1947, Saskatchewan, Canada, established its first hospital insurance plan. After one year of operation, Saskatchewan found that the costs were nearly half again as great as the original estimate. The latest figure is 23% of the net general expenditure of the province, more than for education, or needed highways.

In 1949, the province of British Columbia adopted a hospital insurance plan. Since then, its costs have more than tripled and are still going up. To meet this problem, the province boosted its sales tax and increased its general revenue tax. Reports on all accepting government hospital insurance shows that costs do not drop, they either double or triple. The cost of the Forand Bill should frighten every American taxpayer, including even the members of the legal profession who have never been too excited about socialized medicine.

Seven Frightening Faults

Besides being so expensive, the basic faults of the Forand Bill are: (1) The Forand Bill does not cover those who need medical help, but only those over 65 now covered by OASI. (2) Those

Continued on page 718


"life
saving"
in many cases..
Bristol

KANTREX®

INJECTION

Kanamycin Sulfate Injection

...a highly potent, bactericidal antibiotic for combating staph and gram negative infections

...well tolerated when used on a properly individualized dosage schedule which does not induce excessive blood levels

"In many instances its effect has been dramatic and life saving . . ."[1]

"Six of the patients who survived were considered to be terminally ill at the time kanamycin was started but showed dramatic improvement and eventual complete recovery."[2]

"...indeed, the results [with kanamycin] are the most remarkable ever achieved with otherwise fatal staphylococcal infections that we have ever seen."[3]

"There appears to be no doubt that kanamycin has been lifesaving in those instances in which organismal resistance precludes the use of other antimicrobials."[4]

Information on dosage, administration and precautions contained in package insert or available on request.

SUPPLY: KANTREX Injection, 0.5 Gm. kanamycin (as sulfate) in vial containing 2 ml. volume. KANTREX Injection, 1.0 Gm. kanamycin (as sulfate) in vial containing 3 ml. volume.

REFERENCES: 1. Yow, E. M.: Practitioner 182:759, 1959. 2. Yow, M. D., and Womack, G. K.: Ann. N. Y. Acad. Sci. 76:363, 1958. 3. Bunn, P. A., Baltch, A., and Krajnyak, O.: Ibid. 76:109, 1958. 4. Council on Drugs, J.A.M.A. 172:699, 1960.

BRISTOL LABORATORIES, SYRACUSE, NEW YORK

Forand Bill

Continued

now over 65 immediately will receive medical care free without any contribution; the cost charged to wage earners of the future. (3) Since no "needs" test is included, those not desiring this federal insurance will be forced to accept it and pay for it. Health problems for the aged are varied, while this plan will provide but for a few of them. (4) Alleged free choice of physicians in the Forand Bill is a misnomer, since there is no choice whether you want this compulsory health insurance or whether you pay, and there is no freedom of selection of doctors, hospital and nursing facilities; only a choice of those presented to you. (5) Medical and hospital care is now available to those who need it and cannot afford to pay. (6) Diagnostic services, internal medicine and other forms of medical aid are not covered by the Forand Bill, thereby creating an inequity. (7) Where health facilities and services are provided free of cost, there is always a tendency of excessive utilization, resulting in overcrowded facilities, malingering and indigency.

As you know, there are many people over 65 who require constant hospitalization. The Forand Bill provided a compiled total of only 120 days of hospital and nursing home care each year, with only a maximum of 60 days in a hospital. Who will take care of them the other 225 days? The health services of the local community must care for them, so the community might as well care for them 365 days. We are caring for them now without the Forand Bill.

Voluntary Insurance Gain

With these faults evident, another wolf in sheep's clothing is that it would undermine voluntary health insurance and gradually replace it, because few people would be able to carry both government and private insurance. During the last 10 years, the health insurance industry has been proving its ability to handle the extensive needs of our growing population. Twenty years ago, almost no health insurance coverage existed for those over 65. In 1952, 26% of those 65 or older had health insurance. This growth in voluntary insurance would be expected as long as our senior citizens are free to choose the sort of health coverage which is best suited to their individual needs. According to the Health Insurance Association of America, 75% of the people over 65 will be covered by voluntary insurance in 1965.

What else can we do for the elder group? There are 14,000 individuals on Social Security in Vanderburgh County and only 7,000 of these are over 65 years of age. The Vanderburgh County Welfare Department has about 1,100 people who receive Social Security and public assistance or one or the other. These people, when ill, require hospitalization. They now receive the care they need through private, fraternal and religious organizations, township trustees and the welfare programs, which are paid for by the taxpayers, through the federal, state and local governments, and as previously stated, there are many citizens over 65 who do not need assistance, yet passage of such a bill includes the haves and the have nots.

Making Stewed Tomatoes

At the present time, the American Medical Association is in the process of studying the health problems of the aged. They find that the available statistics are neither conclusive nor complete. Yet, the Forand Bill proposes far-reaching legislation aimed at solving the problems of the aged without knowing very much about the problem. To pass any kind of legislation, if it were advisable, is not practical or is it sound planning for another 10 years. It is like prescribing medicine without making a diagnosis, or spraying alcohol on tomatoes in order to make stewed tomatoes.

Walter Reuther of C.I.O. and Eveline M. Burns, a professor at Columbia and former president of the National Conference on Social Welfare, both advocate the passage of the Forand Bill. It is satisfactory with them to provide tax-subsidized hospital, nursing and surgical care for an estimated 12 to 13 million people, to be paid for by a compulsory tax on 73 million people.

Mr. Reuther says: "It is perfectly obvious that this is a program for government, and I am sure that it is a job for the Federal government. Obviously, the Forand Bill will not solve all of the problems that I have enumerated which now face its potential beneficiaries. No initial piece of legislation of this type was ever perfect at its inception."

Continued



for the acute asthmatic attack elixir synophylate®

(Theophylline Sodium Glycinate)

RAPID ORAL CONTROL WITHOUT G.I. IRRITATION

ELIXIR SYNOPHYLATE relieves wheezing and dyspnea in 5 to 10 minutes after a single dose. Significant blood levels are achieved in 15 minutes, persisting for at least 4 hours.

Because of its built-in buffer, theophylline sodium glycinate [SYNOPHYLATE] is "tolerated in larger doses than are possible with other theophylline preparations,"[1] including aminophylline.[1-3]

the most potent theophylline elixir available . . . may avoid need for I.V. injection

1. A.M.A. Council on Drugs: New and Nonofficial Drugs 1959, Philadelphia, Lippincott, 1959, p. 389. 2. United States Dispensatory (Osol-Farrar), ed. 25, Philadelphia, Lippincott, 1955, p. 1412. 3. Grollman, A.: Pharmacology and Therapeutics, ed. 3, Philadelphia, Lea & Febiger, 1958, p. 208.

Each tablespoonful (15 ml.) contains 0.33 Gm. (5 gr.) equivalent to 0.16 Gm. (2½ gr.) Theophylline U.S.P. Supplied: Bottles of 1 pint and 1 gallon.

Literature on request.

. . . particularly useful for children

Products Born of Continuous Research

THE CENTRAL PHARMACAL COMPANY Seymour, Indiana

Forand Bill

Continued

"... public payment ..."

Dr. Burns says: "Little progress has been made in the last 10 or 15 years on social security. The country should move ahead on improvement of existing programs and establishment of programs for risk areas now uncovered. A medical care program will be one of the major areas of legislative activity in the future. Shall we move into the public payment for or provision of medical care on a wholly opportunistic basis by taking what we can get when we can get it? If so, extension of Old Age and Survivors' Insurance to include hospitalization costs of beneficiaries will have the best chance of early action. Nothing short of national health service can meet the total problem."

On Dec. 4, Dr. Burns again stated that 25 years from now we will find the government deeply involved in organizing and financing medical care. Certainly these statements remove the medical profession from being diplomatic about discussing the Forand Bill, even though diplomacy is the art of saying "nice doggy" until you have time to pick up a rock.

Constructively speaking, what can be done to defeat this financial monstrosity and medical catastrophe? There are now many plans, some now in effect, which are more sensible and practical in providing medical care. A co-operative attack is being planned on the problem by the medical and nursing professions, sane social workers, insurance companies and business, industrial and community leaders.

Gimmick to Corral Votes

The insurance companies have done much to keep health insurance in private hands. The Health Insurance Association of America adopted a program in December of 1958. These companies write more than 80% of the health insurance in the United States. Their program encourages non-cancellable coverage, coverage for persons over 65, and group insurance that covers the right to convert if the employee leaves the firm. The response of member companies has been enthusiastic. Coverage and the quality of coverage has improved. Many additional companies are now offering to senior citizens policies that are guaranteed renewable for life. At least half of the new group insurance makes some provision for continuation of coverage to employees who retire. Several insurers are offering policies that are paid up at age 65. Additional companies are removing the cancellable features or modifying their cancellation practices. The steadily rising membership in voluntary health insurance plans suggests that the Forand Bill opposes free enterprise and is a gimmick to corral votes in the old-age group.

Robert R. Neal, general manager of the Health Association of America, says, "The agent holds the key to the whole situation. To keep the government out of the insurance business, he needs to vigorously push the sale of health insurance. He should write more hospital and surgical coverage on elderly people. The need is urgent. He should see that employee groups—both large and small—have the most modern coverages, including major medical and an income when employees are sick or injured. He has the products; the needs are waiting to be filled. He owes it to himself to see as many people as fast as is humanly possible. This is his and our year of crisis, for we have just one year to demonstrate that private industry can do the job and that there is no need for federal intervention."

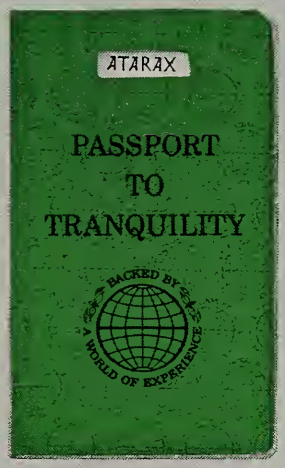
Chronological old age is the yardstick by which we measure old age; and according to this yardstick, the United States has more elderly persons than ever before. Not only has the older group been made to live longer, but the middle-age group is healthier than ever before. Our life expectancy has increased by more than 20 years during the last 50 years.

"... whistle and brush teeth ..."

After all, old age should not be thought of solely on the basis of chronological age, for, as someone once said: "We are as young as our success, as old as our fear; as young as our desire, as old as our despair." To us good health involves the state of physical, mental and social well-being. If we detract from well-being, it determines the person's total health. To guarantee the total health for all those over 65 demands the co-operation of everyone of the medical profession, co-operation of the patient's family, his friends, his church and the community. If all these parts function, it gives the elderly an intangible quality called "the will to live." And it

A GUIDE TO

THE REALMS OF THERAPY BEST ATTAINED WITH



ATARAX®

(brand of hydroxyzine)

World-wide record of effectiveness—over 200 laboratory and clinical papers from 14 countries.
Widest latitude of safety and flexibility—no serious adverse clinical reaction ever documented.
Chemically distinct among tranquilizers—not a phenothiazine or a meprobamate.
Added frontiers of usefulness—antihistaminic; mildly antiarrhythmic; does not stimulate gastric secretion.

Special Advantages	Supportive Clinical Observation	...and for additional evidence
IN CHILDREN unusually safe; tasty syrup, 10 mg. tablet	"... Atarax appeared to reduce anxiety and restlessness, improve sleep patterns and make the child more amenable to the development of new patterns of behavior...." Freedman, A. M.: Pediat. Clin. North America **5**:573 (Aug.) 1958.	Bayart, J.: Acta paediat. belg. **10**:164, 1956. Ayd, F. J., Jr.: California Med. **87**:75 (Aug.) 1957. Nathan, L. A., and Andelman, M. B.: Illinois M. J. **112**:171 (Oct.) 1957.
IN ELDERLY PATIENTS well tolerated by debilitated patients	"... seems to be the agent of choice in patients suffering from removal disorientation, confusion, conversion hysteria and other psychoneurotic conditions occurring in old age." Smigel, J. O., et al.: J. Am. Geriatrics Soc. **7**:61 (Jan.) 1959.	Settel, E.: Am. Pract. & Digest Treat. **8**:1584 (Oct.) 1957. Negri, F.: Minerva med. **48**:607 (Feb. 21) 1957. Shalowitz, M.: Geriatrics **11**:312 (July) 1956.
IN ALLERGIC PATIENTS useful adjunctive therapy for asthma and dermatosis; particularly effective in urticaria	"All [asthmatic] patients reported greater calmness and were able to rest and sleep better ... and led a more normal life.... In chronic and acute urticaria, however, hydroxyzine was effective as the sole medicament." Santos, I. M., and Unger, L.: Presented at 14th Annual Congress, American College of Allergists, Atlantic City, New Jersey, April 23-25, 1958.	Eisenberg, B. C.: J.A.M.A. **169**:14 (Jan. 3) 1959. Coirault, R., et al.: Presse méd. **64**:2239 (Dec. 26) 1956. Robinson, H. M., Jr., et al.: South. M. J. **50**:1282 (Oct.) 1957.
IN HYPEREMOTIVE ADULTS does not impair mental acuity	"... especially well-suited for ambulatory neurotics who must work, drive a car, or operate machinery." Ayd, F. J., Jr.: New York J. Med. **57**:1742 (May 15) 1957.	Garber, R. C., Jr.: J. Florida M. A. **45**:549 (Nov.) 1958. Menger, H. C.: New York J. Med. **58**:1684 (May 15) 1958. Farah, L.: Internat. Rec. Med. **169**:379 (June) 1956.

SUPPLIED: Tablets, 10 mg., 25 mg., 100 mg.; bottles of 100. Syrup (10 mg. per tsp.), pint bottles. Parenteral Solution: 25 mg./cc. in 10 cc. multiple-dose vials; 50 mg./cc. in 2 cc. ampules.

ROERIG Rx

New York 17, N. Y.
Division, Chas. Pfizer & Co., Inc.
Science for the World's Well-Being

Forand Bill

Continued

is advantageous to get old because ofttimes you can do two things at once—you can whistle and brush your teeth at the same time.

The passage of the Forand Bill would do away with the free medical care which physicians give regularly to the general public. *Medical Economics* magazine reports that doctors devote at least 10% of their working hours to direct charity service. They give another 10% of their time to non-charity patients who never pay their bills. For example, a survey in Louisiana shows that the average physician gives $3,531 per year free medical care. South Dakota gives $2,365 and California gives $6,000.

In Vanderburgh County, Ind., the average is about $2,500 per year per doctor. Included in the estimated $500,000 worth of charity medical care given by physicians in our county, there is about $175,000 worth of service given to the township and welfare patients who are hospitalized. For this service the Vanderburgh County Medical Society receives a token payment of $19,170 a year. All this money goes to help operate the Medical Society's office and program. Our arrangments with the township trustees and the welfare department is one of the best bargains the taxpayers ever had. It represents a savings of 7 to 8% per $100 of the tax rate.

Positive Thinking

A good example of positive thinking about medical care for the aged is the program developed in Santa Cruz County, Calif., during the last three years. The co-operation of all of their health agencies has gone far to solve the senior age problem at much less cost to the county. In addition, they are doing much in the field of preventive medicine.

About eight years ago, the Vanderburgh County Medical Society and the Board of Managers at Boehne Hospital in Evansville, Ind. approved a positive plan for the care of the indigent and the aged which included a two-million-dollar building at Boehne Hospital. This entire plan, which would have solved the old age and the indigent care problem in Vanderburgh County, was defeated by just one vote. This vote represented a group of people who would rather spend the taxpayers' money for patronage instead of pink pills for the sick. However, during the past two years, part of this project has been carried on at Boehne Hospital. Other examples of positive community thinking in Vanderburgh County are exemplified by Regina Pacis Nursing Home and the projected Good Samaritan Home.

Money No Cure-All

The Forand Bill would allow the government to pick up the elderly person's hospital bill, even if he had an income of $1,000 a month. At the present time, the state of Illinois picks up the hospital bill of the residents of the state of Illinois if they are ill with tuberculosis, regardless of income. This does not mean that the health of the state of Illinois as far as tuberculosis is concerned is any better than the health of Indiana, which uses the means test—pay according to your income—the system used by free enterprise. Hence, the Forand plan does not give us a health project that would mean any better health for the elder person, since all of the elderly who are indigent will be taken care of by local welfare and township programs. The need for federal government intervention is nil, since money is no cure-all to solve health problems.

In the Dec. 14, 1959 issue of *Newsweek,* Raymond Moley commented on the trends for 1960 and said, quote: "The crazy Federal Social Security and Welfare set-up, in the face of the certain event of bankruptcy, will be rationalized, but one way to keep the Social Security system from going bankrupt is to defeat the Forand Bill."

Nineteen hundred and sixty is both a congressional and Presidential election year. We do not have much time to prove that private organizations and local communities are equipped to handle the health and insurance needs of the nation. The medical profession with all its ramifying organizations cannot defeat the Forand Bill alone. The co-operation of all civic organizations is prerequisite in arousing our citizens from a state of uninformed crassitude.

In recent years, all leaders of organized medicine have planned ahead on the aforegoing health problems, but the rank and file physicans, as well as most public officials, have been dilatory in removing excessive civic plumbum from their *derriere.* This syndrome was recognized first at Valley Forge in 1776.

Continued on page 729

Forand Bill

Continued from page 722

A Ray of Hope

One ray of hope was contained in a press report on Dec. 5, which stated that Chairman Wilber D. Mills of the House Ways and Means Committee sprinkled cold water on the Forand Bill when he cautioned against the proposed changes that would raise Social Security taxes. So, it is up to you fellow physicians to acquaint all citizens with the enormous tax load of such a plan. It is your civic as well as professional obligation to influence other congressmen, not only to throw cold water but ice-cold water on this bill. Congressmen will listen to you, as a member of the electorate, as demonstrated by President Eisenhower when he pleaded with you on television to ask your Congressmen to vote for a strong anti-labor racketeering bill. It passed by a healthy margin.

Everybody should realize that the Forand Bill, if enacted, will be the beginning of the end for voluntary health insurance, the end of a sound financial Social Security system, and the deterioration of excellent medical care. Certainly it will deteriorate the art if not the science of medicine. Science has advanced now to the extent that it now costs about $25 an ounce. On the other hand, the art of medicine has no price tag. It is almost immortal, like the plays of Shakespeare, the marbles of the Greeks and the music of Wagner.

Therefore, fellow practitioners of the healing art, I beseech you to disengage yourselves from your civic lethargy. Talk to or write your Congressman to vote against this poignant political payola, namely the Forand Bill. ◄

———

As lordlier mortals continue to flash
Credit cards to square the amount,
I refuse to feel humble paying cash—
But I cannot help feeling no-account!—Thomas Usk.

———

I asked a mountaineer named Zeke, who was 103 years old, how he passed his time. He told me that in winter he mostly sleeps, in the spring he chases some likely female cousin about the rocks, in the summer he makes moonshine whiskey out of potato peeling and coffee grounds, and in the fall he mostly drinks it.—Alex Atkinson & Ronald Searle, *By Rocking Chair Across America.*

immortals of chinese mythology:



Han Hsiang-tzu

This nature-loving physician achieved immortality by falling out of a tree

TODAY..
this trail-blazing steroid is achieving lasting recognition by its unsurpassed record of accomplishment

METICORTEN

METICORTEN,® brand of prednisone, 5 mg. tablets.
SCHERING CORPORATION • BLOOMFIELD, NEW JERSEY

You will soon receive in your mail a handmade, full-color, three-dimensional figure of this Chinese Immortal, mounted and suitable for framing.

S-348B

Schering

WHAT'S NEW AND SPECIFIC FOR NIGHT CRAMPS



INCREASES AND MAINTAINS BLOOD FLOW FOR 10-12 HOURS

UNUSUALLY GOOD"[1] VASODILATION Roniacol Timespan produced significant or complete relief of night cramps in a majority of patients.[2] Action: specific dilation of peripheral vessels.[2] Result: Roniacol increases blood flow to ischemic extremities.[3-5]

ONE DOSE EFFECTIVE ALL NIGHT New, sustained-release Roniacol Timespan brings convenience and protection to your patients with night cramps—precludes interrupted sleep by providing nightlong prophylaxis with a single evening dose.

NO CONTRAINDICATIONS—NEGLIGIBLE SIDE EFFECTS Unlike sympathetic blocking agents, Roniacol is selective—produces no cardiac stimulation, no hypotension, no gastrointestinal stimulation[6,7]—may be used safely in the presence of gastritis, peptic ulcer or coronary disease. Of 264 patients on Roniacol Timespan, only thirteen experienced side effects—none of them major.[2]

RONIACOL TIMESPAN for intermittent claudication, night cramps, cold hands and feet, in such peripheral vascular conditions as generalized or cerebral arteriosclerosis, Buerger's disease, varicose and decubitus ulcers, Meniere's syndrome[8] and vertigo due to impaired cerebral circulation.

DOSAGE: One or two Roniacol Timespan tablets in the morning and at night.

SUPPLY: Tablets of 150 mg, bottles of 50. When prolonged effects are not desired, prescribe Roniacol Tartrate Tablets, 50 mg, or Roniacol Elixir, 50 mg per teaspoonful (5 cc).

REFERENCES: 1. R. E. Sumner, Personal Communication. 2. Reports on File, Roche Laboratories. 3. E. C. Texter, et al., **Am. J. M. Sc.**, 224:408, 1952. 4. M. M. Fisher and H. E. Tebrock, **New York J. Med.**, 53:65, 1953. 5. I. H. Richter, et al., **New York J. Med.**, 51:1303, 1951. 6. C. M. Castro and L. De Soldati, **Angiology**, 4:165, 1953. 7. R. M. N. Crosby, **Am. J. M. Sc.**, 225:61, 1953. 8. J. Dosdos and G. E. Arnold, **Eye Ear Nose & Throat Month.**, 38:1035, 1959.

Roniacol® —brand of beta-pyridyl carbinol. Timespan®

ROCHE **ROCHE** LABORATORIES • Division of Hoffmann-La Roche Inc • Nutley 10, N. J.

RONIACOL TIMESPAN

TABLETS

SAFE, SPECIFIC PERIPHERAL VASODILATOR IN THE NEW SUSTAINED-RELEASE FORM



Blue Shield: A Growing Membership

This article is one in a series prepared by Blue Cross-Blue Shield

From a beginning membership of 80,568 late in 1946 to 1,363,882 at the end of 1959 is dramatic evidence of the acceptance of Blue Shield by the people of Indiana.

Today, Blue Shield membership continues to grow. During 1959, a net increase of 57,701 persons were added to Blue Shield protection. This is a significant achievement when you consider the fact that almost one-third of the population of the state were members at the beginning of the year. Then too, there has been extremely active competition from commercial insurance companies who have entered the field during the past five years, thereby decreasing the enrollment potential to a marked degree.

Of the total 1,363,882 Blue Shield members, 1,210,106 or 88.7% of the membership now include In-Hospital Medical coverage, an increase of 66,053 over that recorded for the year 1958.

As of December 1959, some 275,664 participants carried Blue Shield's diagnostic program. This program covers x-ray and pathology for diagnostic purposes in the doctor's office as well as in the hospital. This was an increase of 231,174 persons over that of 1958. Already over 20% of all Blue Shield members have this protection and the number is growing rapidly. Blue Shield is not only interested in protecting new members, but in providing the best possible coverage for those that already belong.

Significant membership gains were made in 1959 as a result of the special enrollment campaign held in September. Nearly 30,000 persons were added to Blue Cross-Blue Shield coverage during the 12-day campaign. Particular emphasis had been placed on meeting the health care needs of the senior citizen. In this respect, of the total new participants, 34.9% equaling 10,190 persons were in the over-65 category.

Of the 64% of the state's over-65 population that would be interested in a special health protection program, Blue Cross-Blue Shield now covers nearly half or some 115,000 senior citizens.

Also during the year, special attention has been given to continuing protection of dependents reaching 19 years of age and no longer included under the family certificate. A system of notifying such persons of their right to continue health care coverage in their own name was adopted. Nearly 1,000 chose to do so. Additional individuals in this age group retained Blue Cross-Blue Shield coverage through their place of employment. This notification is now a continuing program and will be carried out in the months ahead.

Blue Shield members are protected by Preferred, Special or Standard coverage. Of the total membership, 68% have Standard, 20% Preferred, with the remaining 12% holding Special. However, when considering those enrolled through accounts, 40% have Preferred or Special, with the remaining 60% holding Standard coverage.

Because the Preferred schedule is doing a good job, Blue Shield will make a maximum effort to push it, along with the new increased in-hospital medical program, during 1960. The Preferred schedule is paying about 84% of the surgeon's total charges with over three-fourths of all claims, distributed about equally by procedure regardless of frequency or cost, paid in full.

Continued



in infectious disease[17,22,30,36]
in arthritis[18,19,20,29]
in hepatic disease[2,3,4,5,38]
in malabsorption syndrome[1,2,6,27]
in degenerative disease[6,7,19,20,40]
in cardiac disease[23,28,29,38,41]
in dermatitis[24,39]
in peptic ulcer[8,21,38]
in neuroses & psychiatric disorders[25,26]
in diabetes mellitus[31,32,33,38]
in alcoholism[9,11,35,37,38]
in ulcerative colitis[10,14,16]
in osteoporosis[13,19,20]
in pancreatitis[15]
in female climacteric[12,34]

Patients with chronic disease deserve the nutritional support provided by

Theragran-M

Squibb Vitamin-Minerals for Therapy

11 vitamins, 8 minerals
clinically-formulated and potency protected to provide
enough nutritional support
to do some good

with vitamins only
Theragran
also available:
Theragran Liquid
Theragran Junior

1-41 a list of the above references will be supplied on request.

SQUIBB

'THERAGRAN'® IS A SQUIBB TRADEMARK

Squibb Quality—the Priceless Ingredient

Indiana State Board of Health

DIVISION OF COMMUNICABLE DISEASE CONTROL

MONTHLY REPORT - February, 1960

Disease	Feb. 1960	Jan. 1960	Dec. 1959	Feb. 1959	Feb. 1958
Animal Bites	224	225	246	189	56
Chickenpox	1068	879	592	752	395
Conjunctivitis	152	82	68	53	26
Diphtheria	2	1	1	0	2
Dysentery, Unspecified	50	67	40	19	39
Impetigo	76	88	97	65	23
Infectious Hepatitis	91	57	38	49	33
Infectious Mononucleosis	19	16	20	21	2
Influenza	11387	2177	1114	1011	1222
Measles (Rubeola-Rubella)	940	578	280	755	2064
Meningitis, Meningococcal	2	1	4	2	8
Meningitis, Other	12	9	49	7	16
Mumps	298	256	178	227	458
Pertussis	39	39	95	137	36
Pneumonia	341	272	259	257	146
Poliomyelitis	0	0	4	0	0
Streptococcal Infections	1048	668	492	1048	555
Tinea Capitis	38	12	16	45	31



"I call it the house that gallstones built!"

Blue Shield

Continued

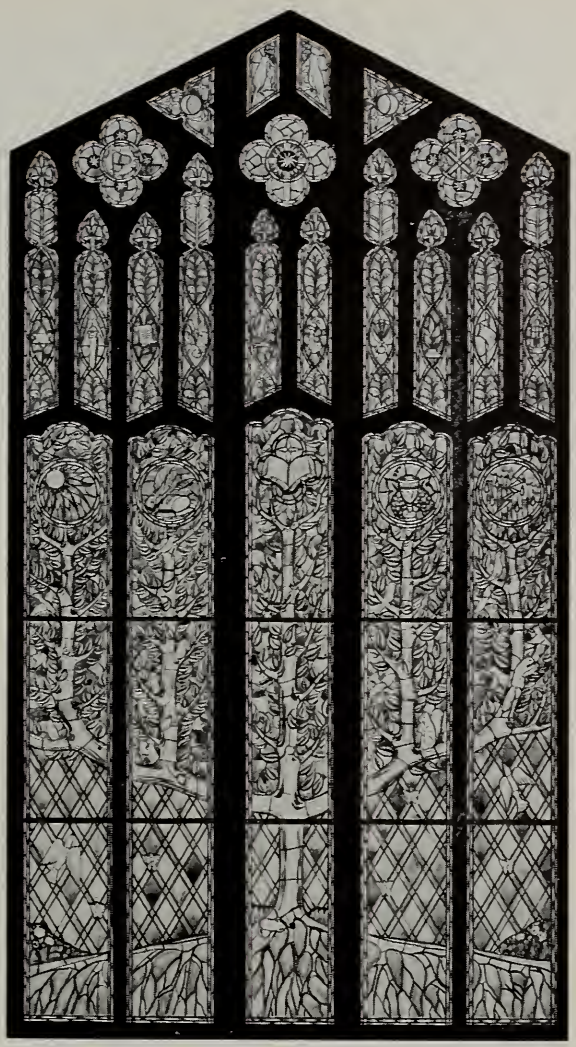
Of the total 427,149 claims processed by Blue Shield in 1959, 94% were paid. The 6% rejected were not paid chiefly for the following reasons: (1) member's benefits had been exhausted; (2) the service was not covered; (3) there was a waiting period in effect; and (4) no surgery done—member does not have medical coverage.

This year, greater efforts through intensfied advertising will be made to enroll more and more of the total population of the state, surpassing the one-third mark now covered. New programs and services will be offered to meet the growing needs of the public. For Blue Shield believes that prepaid medical services is the best solution to the problem of financing medical care, and that our approach is in the best interests of members, doctors and the tax-paying public.

Sanford Schwartz
Public Relations Division ◄

Our Cover Story

Stained Glass Windows



First Christian Church
Bloomington, Indiana

A tree of life window, containing over 7,000 individual pieces of imported hand-made stained glass is typical of artistic expressions of faith which inspire worship in churches throughout the world. The roots bury themselves in the earth while branches, reaching up to the heavens, shelter colorful birds, symbolic of human souls, and squirrels, representing a Christian's forethoughts of eternity. Below the branches emblazoned on a field of vivid blue are two doves, standing for peace, purity, meekness and modesty, and butterflies, symbolizing Christ's Resurrection. A mouse at the base recalls the oft-repeated remark, "Poor as a church mouse."

Above each of the five lancets are medallions showing, left to right, the sun, symbolic of the Father; bread and wheat, standing for the word of God and the Church on earth respectively; the open book, representing the Holy Bible with a Star Etoile indicating Christ's Cross; the wine cup or chalice with grapes, symbol for the Eucharist; and rain and lightning, indicating the impartiality of our Lord and the Vengeance of God.

April's cover photograph is a window designed and installed by Stewart-Carey Glass Company, Inc., Indianapolis, for Redeemer Lutheran Church, Seymour, Ind. All art, pictures and explanations were made available to the *Journal* through the courtesy of Stewart-Carey and their stained glass studio, Willard E. Lamm, designer. Photos are by Bass.



Artist Will Lamm creates color sketch of the window as it will appear when completed. A graduate of John Herron Art Institute, he traveled extensively in Europe studying church art.

From artistic skills, exacting hands



From the colored sketch, a full-size line drawing. Heavy lines represent lead that separates glass pieces.



A line cut is made by tracing the drawing onto pattern paper, assigning each division a color number, then cutting the pattern along the lines. Each pattern piece is then the exact size and shape and numbered for color.



Proper glasses having been selected, paper pattern shapes are sorted for color and each piece cut to shape.



Glass is assembled on a horizontal plate of glass which the artist tilts vertically in order to paint additional design or change color tone.

the ageless expression of religious faith

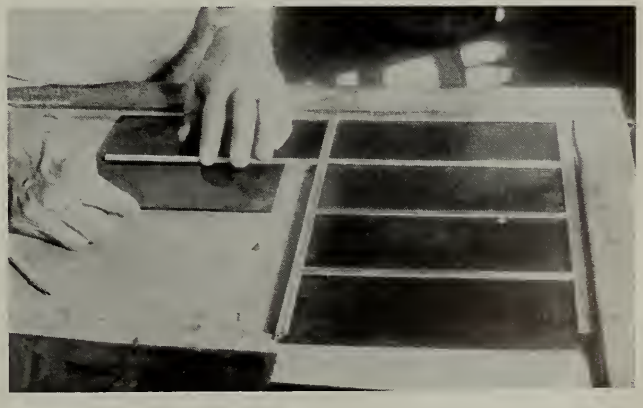
From the customer's suggestions, the artist prepares original colored sketches of inspiring design or figures.

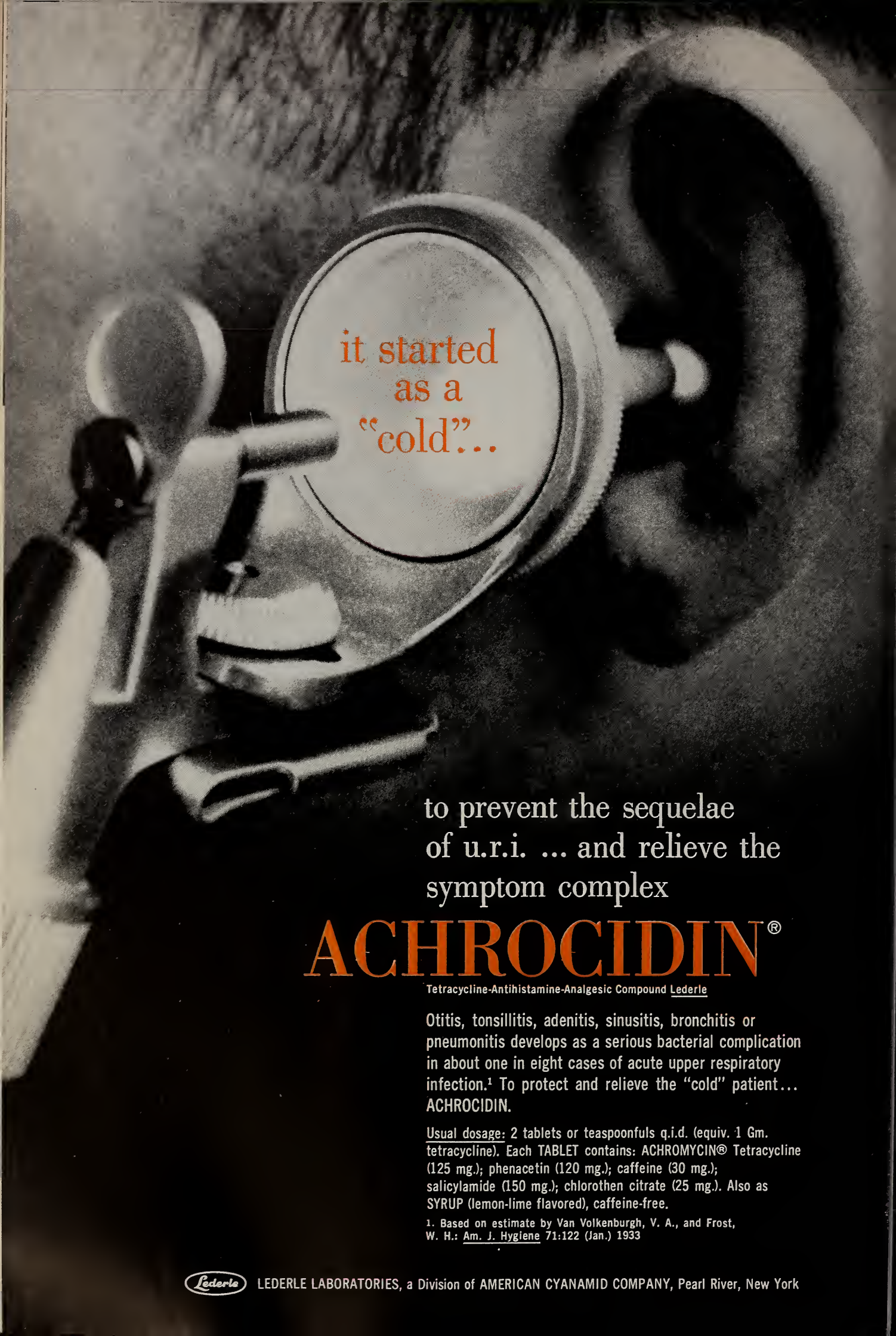
A foremost consideration is the architectural setting of the building. After the pieces of glass are selected for color, texture and pattern, and cut and assembled for the first time, the artist further creates individuality by adding design detail and/or changing the color tone to control amounts of light transmitted through the glass.



Taken off of the plate glass, painted pieces are placed in a furnace to fix the artist's work.

The glass is assembled in a frame, each piece separated by soldered lead. A special type of cement, forced between the lead and the glass, makes the window waterproof and holds the glass firmly in place so that it may be installed in the opening.





to prevent the sequelae of u.r.i. ... and relieve the symptom complex

ACHROCIDIN®

Tetracycline-Antihistamine-Analgesic Compound Lederle

Otitis, tonsillitis, adenitis, sinusitis, bronchitis or pneumonitis develops as a serious bacterial complication in about one in eight cases of acute upper respiratory infection.[1] To protect and relieve the "cold" patient... ACHROCIDIN.

Usual dosage: 2 tablets or teaspoonfuls q.i.d. (equiv. 1 Gm. tetracycline). Each TABLET contains: ACHROMYCIN® Tetracycline (125 mg.); phenacetin (120 mg.); caffeine (30 mg.); salicylamide (150 mg.); chlorothen citrate (25 mg.). Also as SYRUP (lemon-lime flavored), caffeine-free.

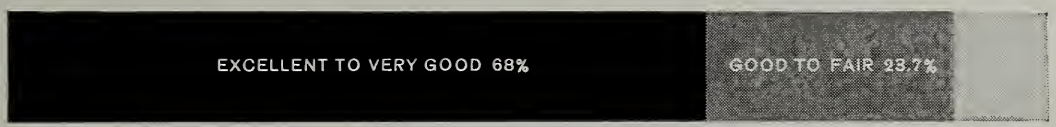
1. Based on estimate by Van Volkenburgh, V. A., and Frost, W. H.: Am. J. Hygiene 71:122 (Jan.) 1933

Lederle LEDERLE LABORATORIES, a Division of AMERICAN CYANAMID COMPANY, Pearl River, New York

relieves both stiffness and pain with safety... sustained effect

In 100 consecutive patients with the low back syndrome, Kestler[1] reported that particularly gratifying was the ability of SOMA "to relax muscular spasm, relieve pain, and restore normal movement, thus speeding recovery in a large majority of the patients."

RESULTS WITH SOMA IN THE LOW BACK SYNDROME*



*Investigators' reports to the Medical Department, Wallace Laboratories. (Total of 278 cases)

NOTABLE SAFETY—extremely low toxicity; no known contraindications; side effects are rare; drowsiness may occur, usually at higher dosage

RAPID ACTION—starts to act quickly **SUSTAINED EFFECT**—relief lasts up to 6 hours

EASY TO USE—usual adult dosage is one 350 mg. tablet 3 times daily and at bedtime

SUPPLIED—as white, coated, 350 mg. tablets, bottles of 50; also available for pediatric use: 250 mg., orange capsules, bottles of 50

1. Kestler, O.: In The Pharmacology and Clinical Usefulness of Carisoprodol, Wayne State University Press, Detroit, 1959. 2. Berger, F. M.; Kletzkin, M.; Ludwig, B. J.; Margolin, S., and Powell, L. S.: J. Pharm. Exp. Ther. *127*:66 (Sept.) 1959. 3. Spears, C. E. and Phelps, W. M.: Arch. Pediat. *76*:287 (July) 1959. 4. Phelps, W. M.: Arch. Pediat. *76*:243 (June) 1959. 5. Friedman, A. P.; Frankel, K., and Fransway, R. L.: Papers presented at Scientific Meeting, New York State Society of Industrial Medicine, Inc., New York, Sept. 30, 1959. 6. Kuge, T.: Unpublished reports. 7. Ostrowski, J. P.: Orthopedics *2*:7 (Jan.) 1960.

Literature and samples on request

Also available on request: The Pharmacology and Clinical Usefulness of Carisoprodol, Wayne State University Press, Detroit, 1959. (185 pages)

SOMA™

(carisoprodol Wallace)

WALLACE LABORATORIES, New Brunswick, New Jersey

ABSTRACTS

BOOK REVIEWS

CANCER

Edited by John B. Field, M.D., Ph.D. Assistant Clinical Professor of Medicine, University of California School of Medicine, Los Angeles. 28 contributors. 812 pp., 271 illustrations. Price $18.50. Little, Brown and Company, 34 Beacon Street, Boston 6, Mass. 1959.

The diagnosis and treatment of cancer is organized by involved systems and includes a chapter devoted to cancer in children as well as chapters on the topic of radiotherapy and chemotherapy. The descriptions and classifications are brief, apparently designed to aid the less experienced and student observer in recognizing and making a proper evaluation of the lesion in any involved system.

Metastatic routes, modes of therapy and prognostic aspects of the different types of cancer (using the broad term) in the various systems are covered in orderly readable arrangement. Only general references are made to the technics of surgery, chemotherapy and radiotherapy. There are some photographs, diagrams and charts for illustration as well as a few brief case reports.

Contributors are recognized as authorities in their respective fields. This is a publication worthy of any practicing physician's or surgeon's bookshelf.

George M. Johnson, M.D.
Richmond

PATIENT CARE AND SPECIAL PROCEDURES IN X-RAY TECHNOLOGY

Carol Hocking Vennes, R.N., B.S.; John C. Watson, R.T., Minneapolis, 1959. C. V. Mosby Company. Price $5.75.

This is the first book published on patient care especially adapted for x-ray technicians by two very capable authors. It's content and thoroughness is such that it will undoubtedly be selected as an accepted textbook by the American Society of X-Ray Technicians to be placed in the Teachers' Syllabus.

Both authors deal with the subject as though only one was writing, showing the close working together that each has enjoyed. The illustrations are photographs which are excellent and are of the type that you wish your students to copy. These pictures follow closely the first reference to them and they fit well into the text on the page.

Emphasis is placed on the care of the patient and the methods described are comparable to that of a clinical situation. The material presented is current and the terminology is challenging to the student. References at the conclusion of each chapter are excellent.

The appearance and readability of the book is excellent with material well arranged.

Lall G. Montgomery, M.D.
Muncie

PREMENSTRUAL TENSION SYNDROME AND PRIMARY DYSMENORRHEA

Eichen Eduard, West Virginia Medical Journal Vol. 50, No. 1, Jan. 1960.

This article comprehensively reviews the up-to-date concepts of the enigmatic endocrine and psychosomatic disturbances associated with the menstrual cycle. The author divides this symptom complex into two components, premenstrual tension and dysmenorrhea.

Reported here is a questionnaire study of 350 student nurses. Only 10% of these young women thought their symptoms serious enough to seek treatment.

The various theories of the cause of the symptoms complex are reviewed and the author recognizes that there is little agreement as to the cause or causes of either premenstrual tension or primary dysmenorrhea.

The observation is made that premenstrual tension may occur without ovulation and even beyond the climacteric. Inharmonious personal relations are common accompaniments, and even tragedies have been known to be associated with premenstrual tension. This syndrome deserves attention because of social and industrial implications, such as absence from work and family discord.

Since the etiology of this symptom complex has not been discovered, the literature is replete with suggested therapeutic agents and because of the complexity of the symptoms, a variety of responses are reported; diuretics, analgesics, tranquilizers and sex hormones have all been used with reported success. The author assesses the use of every medication from Lydia Pinkham's compound to the latest tranquilizers; all have their proponents and all fail to be routinely effective. The oldest remedy for dysmenorrhea, whiskey, is still quite effective, but dangerous from the standpoint of habit formation. The chlorthiazide preparations appear to be quite effective in the management of the congestive phenomenon of sodium retention and overhydration, but these agents are not without the usual side effects.

Despite the important physic component in dysmenorrhea, psychological suggestions have not been very effective in bringing about a cure.

Natural or synthetic estrogens are recommended to relieve dysmenorrhea by inhibiting ovulation. Stilbestrol is the most effective medication for the cost. Patients are started on the fourth of the cycle on 1 mg. daily, this dose is increased 1 mg. daily on the 9th, 14th, and 19th days and discontinued on the 24th day. The newer progestins will also inhibit ovulation when taken from the 5th to the 25th day of the cycle (they will also cause nausea and vomiting).

Reassurance of the patient is an important supporting factor in any treatment regimen; physician-patient rapport is stressed.

The author condemns all major surgical procedures, such as presacral neurectomy, resection of ovaries and uterine suspension for primary dysmenorrhea. Therapy in general is still multidimensional.

This is a comprehensive consideration of the subject by an experienced gynecologist and worth reading by any physician who treats women.

David A. Bickel, M.D.
South Bend

Continued

Tofrānil®

brand of imipramine HCl

in depression

lights the road to recovery in 80 per cent of cases

In the treatment of depression Tofrānil has established the remarkable record of producing remission or improvement in approximately 80 per cent of cases.[1-7]

Tofrānil is well tolerated in usage—is adaptable to either office or hospital practice—is administrable by either oral or intramuscular routes.

Tofrānil
a potent thymoleptic . . .
not a MAO inhibitor.

Does act effectively in *all* types of depression regardless of severity or chronicity.

Does not inhibit monoamine oxidase in brain or liver; produce CNS stimulation; or potentiate other drugs such as barbiturates and alcohol.

Detailed Literature Available on Request.

Tofrānil® brand of imipramine HCl: tablets of 25 mg., bottles of 100. Ampuls for intramuscular administration only, each containing 25 mg. in 2 cc. of solution, cartons of 10 and 50.

References: 1. Ayd, F. J., Jr.: Bull. School Med., Univ. Maryland *44*:29, 1959. 2. Azima, H., and Vispo, R. H.: A.M.A. Arch. Neurol. & Psychiat. *81*:658, 1959. 3. Lehmann, H. E.; Cahn, C. H., and de Verteuil, R. L.: Canad. Psychiat. A. J. *3*:155, 1958. 4. Mann, A. M. and MacPherson, A. S.: Canad. Psychiat. A. J. *4*:38, 1959. 5. Sloane, R. B.; Habib, A., and Batt, U. E.: Canad. M.A.J. *80*:540, 1959. 6. Straker, M.: Canad. M.A.J. *80*:546, 1959. 7. Strauss, H.: New York J. Med. *59*:2906, 1959.

Geigy, Ardsley, New York



Geigy

TO4-60

Abstracts, Reviews

Continued

ANESTHESIA FOR INFANTS AND CHILDREN

Robert M. Smith, M.D., p. 409. Price $12.00. The C. V. Mosby Co., St. Louis, Mo., 1959.

With increasing surgical procedures in infancy and childhood the surgeon and anesthesiologist are faced with the need for special attention to the anesthetic technics employed. The author has in 31 chapters certainly covered the field in a simple and easily understandable manner. The chapters on "Preparing Children for Operation" and "Pre-operation Medications" are quite valuable. Each chapter is headed by an outline, making for quick reference.

Any physician who makes anesthesiology a part or all of his practice will find useful information in this volume.

Walter L. Portteus, M.D.
Franklin

TEXTBOOK OF SURGERY

3rd Edition. Edited by H. Fred Mosby M.A., D.M., Assistant Professor of Surgery, McGill University, Montreal, Canada. 41 contributors. 738 text illustrations. 108 color plates. C. V. Mosby Co., St. Louis, Missouri. Price $17.00. 1959.

This textbook was first published in 1952. The contributors were associated with McGill University and the material was meant to acquaint students at that school with the principles of surgery. This third edition contains additional material with some rewritten sections dealing with the more rapidly advancing fields. The material is sound, well organized and profusely illustrated. Color plates from *Ciba Collection of Medical Illustrations* are reproduced.

George M. Johnson, M.D.
Richmond ◄



"All I know is that when it rains, my leg acts up."

Approved

PROFESSIONAL LIABILITY INDIVIDUAL INSURANCE

by

The No. 1 Malpractice Insurer

Unparalleled Experience ● Specialized Service ● Saving in Cost

THE
MEDICAL PROTECTIVE COMPANY
FORT WAYNE, INDIANA

Professional Protection Exclusively since 1899

INDIANAPOLIS OFFICE: Kenneth W. Moeller, Rep.
5950 Indianola Avenue Tel. CLifford 5-6525

Chicken, grilled with homemade Wesson barbecue sauce, is low in saturated fat—and delicious eating. It gives longer lasting satisfaction.



FREE *Wesson recipes, available in quantity for your patients, show how to prepare meats, seafoods, vegetables, salads and desserts with poly-unsaturated vegetable oil. Request quantity needed from The Wesson People, Dept. N., 210 Baronne St., New Orleans 12, La.*

Wesson's Important Constituents

Wesson is 100% cottonseed oil . . . winterized and of selected quality

Linoleic acid glycerides (poly-unsaturated)	50-55%
Oleic acid glycerides (mono-unsaturated)	16-20%
Total unsaturated	70-75%
Palmitic, stearic and myristic glycerides (saturated)	25-30%
Phytosterol (predominantly beta sitosterol)	0.3-0.5%
Total tocopherols	0.09-0.12%

Never hydrogenated—completely salt free

Each pint of Wesson contains 437-524 Int. Units of Vitamin E



Board of Health Announces Duties of New Commission

The appointment of Charles E. Henley, Greenwood, as field representative in the newly established Rehabilitation Division, was announced recently by A. C. Offutt, M.D., commissioner, Indiana State Board of Health.

A Commission for the Handicapped and a Division of Rehabilitation were established within the framework of the Indiana State Board of Health by action of the 1959 session of the Indiana General Assembly. A director for the division has not yet been appointed, Dr. Offutt asserted, "however, we hope to be able to make this appointment and have the division in full scale operation by July."

As established by the Legislature, the commission, and its administrative arm, the Division of Rehabilitation, were given the following responsibilities:

1. Maintain a central register of the handicapped of the state and keep such register current.
2. Discover and identify, within the state, rehabilitation services and opportunities for the handicapped.
3. Promote the training and recruitment of rehabilitation personnel.
4. Conduct a public relations program dealing with the problems of rehabilitation for the handicapped.
5. Offer assistance to local communities in the development of programs designed to meet the needs of the handicapped.
6. Coordinate the efforts of various official and voluntary agencies providing services for the rehabilitation of the handicapped within the state.

While many official and voluntary agencies have rehabilitation or some phase of rehabilitation as a function, there is no single agency or group presently familiar with all of these services. Dr. Offutt said that "rehabilitation specialists, physicians, nurses and other professional personnel have for some time recognized the need for a central registry of the various services offered, in order that prompt and proper referrals of handicapped persons might be made."

There are cases on record which show that a handicapped person might have to visit two or three agencies—or more—before finding the agency which could render the service needed.

One of Mr. Henley's first responsibilities is that of conferring with representatives of the agencies offering some rehabilitation service and completing a statewide directory of rehabilitation services and facilities.

Formerly with the State Department of Public Instruction as director of the Division of Special Education, Mr. Henley received a bachelor's degree from DePauw University and a master's degree from Indiana State Teachers College at Terre Haute. Prior to his work in the State Department of Public Instruction, Mr. Henley taught in public schools for six years and was a speech and hearing therapist in public schools for two years.

Dr. Offutt declared that no direct services will be rendered by the division, such as diagnosis or treatment of handicapped persons. Rather, the division personnel will work on a consultant basis with local communities in an effort to assist communities meet the needs of their handicapped citizens.

Class of 1910 to Meet May 11

Dr. A. M. Hetherington, Indianapolis, has announced that members of the I. U. School of Medicine Class of 1910 will meet for their golden anniversary reunion during the I. U. Medical Center reunion, May 11. Dinner will be served on the campus.

Physicians Mail Journals To Fight Cold War

CHICAGO (AMA Release)—Dr. Charles B. Daugherty of Jeannette, Pa., is doing his bit to fight the cold war.

Under his direction, American physicians have begun sending their old medical journals to physicians in foreign lands instead of letting them go to waste.

The semi-retired otolaryngologist feels this will help deter the spread of communism.

"Doctors in some of these situations are the only literate persons in their communities and have great influence," he said. "If we can get an individual doctor to say 'America is good,' the whole community will say 'America is good.' "

Physicians in many parts of the world lack current medical literature, and since English has largely replaced German as the medical language of the world, American physicians with their vast amount of such literature are in a position to make a contribution to foreign medicine for the cost of re-mailing old journals, according to an article in the Medicine at Work section of the current (Feb. 27) *Journal of the American Medical Association.*

After nine months, 65 American physicians are mailing journals to 83 of their counterparts overseas. Dr. Daugherty has access to the addresses of 250,000 foreign physicians and hopes to expand the program, called "Colleagues Everywhere." At present, he personally is handling requests for the addresses of foreign physicians.

Authorities to Establish Guides for Community Health Facility Planning

The appointment of a 15-member *ad hoc* committee to develop principles for community-wide health facility planning was announced recently by the Public Health Service and the American Hospital Association.

The committee, composed of authorities in the hospital and health facility field, will be headed by Mr. George Bugbee, president of the Health Information Foundation, New York City.

According to the co-sponsoring organizations, one of the principal functions of the committee will be to establish authoritative guidelines for area planning groups in developing plans for improved hospital services and facilities, especially in metropolitan areas.

Dr. Edwin L. Crosby, director of the American Hospital Association, noted that in recent years hospital authorities have recognized an increasing need for coordinated health facility planning. As a result, he explained, there are now a few metropolitan areas with effective planning groups. In addition, a number of communities have taken steps toward the formation of such bodies.

"Nevertheless," he added, "most areas of the nation do not have such groups. We hope that this situation will soon be remedied and that the guidelines to be developed by the *ad hoc* committee will serve as an impetus toward the establishment of additional planning bodies in all areas now without them."

Other major objectives set for the committee are the development of principles to be followed in the organization and composition of area planning groups and steps which should be taken to assure the acceptance of a planning organization as the authoritative central hospital planning agency of the community.

Continued

for therapy of overweight patients

• **d-amphetamine**
depresses appetite and elevates mood

• **meprobamate**
eases tensions of dieting
(yet without overstimulation, insomnia or barbiturate hangover)

BAMADEX®
MEPROBAMATE WITH D-AMPHETAMINE SULFATE LEDERLE

is a logical combination in appetite control

Each coated tablet (pink) contains: meprobamate, 400 mg.; d-amphetamine sulfate, 5 mg.
Dosage: One tablet one-half to one hour before each meal.

Lederle
LEDERLE LABORATORIES
A Division of AMERICAN CYANAMID COMPANY, Pearl River, New York

Community Planning

Continued

Surgeon General Leroy Burney, commenting on the formation of the committee, stated that "One of the greatest health challenges facing the nation today is hospital planning." He explained that the development of more hospital planning groups is essential if we are to make progress in solving the many problems now facing hospitals, particularly in the urban and metropolitan areas.

Some of these problems include spiraling hospital costs and the growing obsolescence of older institutions.

Indianapolis is Pathology Seminar Site

The Indiana Association of Pathologists is presenting its 1960 Twelfth Annual Seminar in co-sponsorship with the U. S. Veterans Administration Hospital.

Subject: Diseases of the Alimentary Tract.

Presented by: Elson B. Helwig, M.D., Armed Forces Institute of Pathology.

Date: May 22, 1960.

Time: 10:00 a.m. (C.D.T.)

Place: Veterans Administration Hospital Auditorium, 1481 West 10th Street, Indianapolis.

A number of slide sets and protocols are available for pathologists who are not members of the Indiana Association of Pathologists who wish to attend. The available sets will be issued to those who apply, in the order of receipt of their applications.

A check for $10.00 should be sent, together with the request for the set to: Dr. Lester H. Hoyt, Secretary, Indiana Association of Pathologists, Methodist Hospital, Indianapolis 7.

All members of the medical profession are cordially invited to attend whether or not they obtain the study sets. Presentation will be by lantern slide projection, illustrating all cases.

Dr. David A. Bickel of South Bend was elected president of the Indiana Obstetrical and Genetical Society at a January meeting.

Education in the U. S. is a passion and a paradox. Millions want it and commend it, and are busy about it, at the same time as they are willing to degrade it by trying to get it free of charge and free of work. Education with us has managed to reconcile the contradictory extremes of being a duty and a diversion, and to elude intellectual control so completely that it can become an empty ritual without arousing protest.—Jacques Barzun, *The House of Intellect* (Harpers).



Springtime

Is Jaguar

XK 150 Time!

Drive the Jaguar XK 150 Sports Convertible

For the greatest driving adventure of your life, take the wheel of a Jaguar XK 150, the world's most famous sports car! Amazing acceleration, dazzling speed . . . with the famous Jaguar XK engine that has earned its reputation for endurance in countless international competitions. Clean, classic styling. Unmatched riding luxury. Unequalled safety with road-race-proved disc brakes. Convertible, hardtop coupe, roadster models. See also the new Jaguar 3.8 litre family sports sedan and the luxurious Mark IX. Convenient terms available.

JAGUAR

2330 NORTH MERIDIAN STREET

MIDWEST DISTRIBUTORS, Inc.

• INDIANAPOLIS



A biochemical compound used to diminish intestinal gas in healthy persons and those patients having digestive disorders ■

KANULASE

Each Kanulase tablet contains Dorase,* 320 units, combined with pepsin, N.F., 150 mg.; glutamic acid HCl, 200 mg.; pancreatin, N.F., 500 mg.; oxbile extract, 100 mg. Dosage: 1 or 2 tablets at mealtime. Supplied: Bottles of 50 tablets.

*DORSEY BRAND OF CELLULASE, EXPRESSED AS DIGESTIVE ACTIVITY UNITS.

SMITH-DORSEY • a division of The Wander Company • Lincoln, Nebraska

Mid-States Public Health Officials Meet in Indianapolis April 27-29

Eleven states will be represented in the forthcoming annual meeting of the Middle States Public Health Association, April 27-29 in Indianapolis.

Approximately 500 representatives of allied health professions and groups will assemble in this 11th annual meeting at the Severin Hotel to discuss "Six Public Health Challenges for the Sixties."

Authorities in public health will discuss the problems which may be encountered during the coming decade on exposure to radiation, civil defense, accident prevention, rehabilitation and other timely subjects.

A. C. Offutt, M.D., Indiana state health commissioner and president of the middle states group, will extend greetings to the assembly at the opening session.

Among authorities who will speak are Nathan H. Woodruff, Ph.D., director, office of health and safety, United States Atomic Energy Commission; Earl O. Wright, chief, division of administration, Ohio Department of Health, and Paul V. Joliet, M.D., chief, accident prevention program, Division of Special Health Services, U. S. Public Health Service.

Others are L. Burton Parker, M.D., chief, Physical Medicine Department, Marion County General Hospital, Indianapolis, and Claire F. Ryder, M.D., chief, health of the aged section, chronic disease program, United States Public Health Service.

Speaker for the annual banquet on Thursday evening is James A. Eldridge, Indianapolis, who will discuss the "Citizen and his Foreign Policy."

Meeting in conjunction with the middle states group will be the Indiana Public Health Association and the Indiana Veterinary Medicine Association.

Arrangements for the convention are being directed by Robert Yoho, director of the bureau of health education, Indiana State Board of Health.

College of Obstetricians and Gynecologists Annual Meeting Scheduled for April 3-6

The American College of Obstetricians and Gynecologists will hold its eighth annual meeting at the Netherland Hilton Hotel, Cincinnati, April 3-6. About 2,000 physicians are expected to attend.

The scientific program on Monday, Tuesday and Wednesday will consist of the presentation of papers by leading obstetricians and gynecologists from all parts of the country, correlated seminars, clinical and breakfast conferences and motion pictures. Every aspect of the specialty will be covered by more than 240 participants in the program.

New Booklet on Venereal Disease Bares Facts on Increasing Incidence

Venereal Disease, Old Plague—New Challenge is a 20-page booklet issued by the Public Affairs Committee. No. 292 in the committee's series of public information pamphlets, the publication is designed to acquaint the public with the facts concerning the rising venereal disease rate in teenagers. It is of particular interest to laymen who are in social hygiene work, and may be obtained at 25 cents per copy from The Public Affairs Committee, 22 E. 38th St., New York City 16.



WABASH VALLEY SANITARIUM—HOSPITAL

Lafayette, Indiana
Telephone Riverside 3-1679

A hospital for the treatment of neuro-psychiatric disorders.

Custodial cases are accepted in limited numbers.

— OPEN STAFF —

DONALD R. KINZER
Manager

Rocky Mountain Cancer Conference Scheduled July 20-21 at Denver

The 14th annual Rocky Mountain Cancer Conference will be held in the beautiful new Denver Hilton Hotel in Denver, Colo., July 20-21, 1960. Nearly 900 physicians from all over the nation are expected to attend the 2-day scientific session, which is worth 10 AAGP Category I credits.

The regional cancer-control meeting is jointly sponsored each year by the Colorado division of the American Cancer Society and the Colorado State Medical Society.

Tentative program plans call for a symposium on "Skin Cancer" on Wednesday morning, July 20 and a symposium on "Thyroid Lumps" on the following morning. Afternoon sessions on both days will be devoted to papers on cancer detection and treatment by six outstanding physicians.

Symposium participants and speakers are: R. Lee Clark, Jr., M.D., Houston, Texas; A. James French, M.D., Ann Arbor, Mich.; Roy L. Kile, M.D., Cincinnati; Wendell G. Scott, M.D., St. Louis; H. W. Schmidt, M.D., Rochester, Minn.; and Willard P. VanderLaan, M.D., La Jolla, Calif.

E. Vincent Askey, M.D., of Los Angeles, president-elect of the American Medical Association, and Warren H. Cole, M.D., of Chicago, president of the American Cancer Society, will also participate in the conference.

The new $30-million Denver Hilton Hotel, site of the Cancer Conference, will open its doors to the public on April 10 of this year. The completely air-conditioned 882 room hotel is one of the most modern in the country and newest in the extensive Hilton chain.

Dr. Francis L. Land, Fort Wayne, was named president-elect of the Indiana Academy of General Practice at a February meeting.

An Indianapolis physician, Dr. Harry Pandolfo, is the organization's current president. Other officers elected for 1961 included Drs. Charles Alvey, vice-president, Frank Green, delegate to the American Academy of General Practice Congress, John Wilson, alternate delegate, Francis E. Brown, treasurer and Charles G. Dosch, executive secretary.



Physician-Patient Suggests Ten Rules For Period After Cataract Removal

Ten rules for persons who have had cataracts removed from their eyes were given recently by a physician who has undergone the surgery.

James M. Mackintosh, M.D., director of education and training for the World Health Organization, Geneva, Switzerland, outlined them in *Hospitals,* Journal of the American Hospital Association.

When a cataract occurs, the lens of the eye first clouds over, then becomes opaque, causing blindness. It is estimated that nearly one quarter of the blindness in the United States results from cataracts.

Treatment consists of removing the eye's lens surgically. Strong glasses then serve as the lens of the eye; in fact, they become the "windows to the world," according to Dr. Mackintosh.

When the eyes' natural lenses are gone and the person depends on glasses, his peripheral or side vision is lost. Dr. Mackintosh commented on this problem by saying:

"Stiff-necked people had better avoid cataract, because width of vision no longer depends upon the sidelong glance, but on the speed and precision of head movements, both vertically and horizontally."

Dr. Mackintosh's rules are:

. . Leave your glasses where you can find them easily. This applies especially to the bedside at night.

. . Keep a spare pair of glasses in a well-marked place known to wife, secretary and self.

. . On entering a room, survey the scene quickly to detect hidden perils like footstools, low chairs, small children lying on the floor and other tripping hazards near the ground.

. . Look around the room to see who is there or you may completely miss one of its inhabitants.

. . Before getting up, make another quick survey in case someone has placed a drink on a table below your level of vision.

. . When walking and you meet someone you know, turn your head rapidly from right to left to make sure that he is not accompanied.

. . In traffic always look several times to left and right before crossing.

. . Avoid occupations that require a great deal of bending, such as gardening, automobile repairs and lifting heavy articles.

. . Don't try to read too long at one time. A half-hour spell, followed by a rest of 10 minutes, is generally enough. The rest period must not be filled with other eye-straining activities such as television or sewing.

. . Avoid contemplating rapidly moving objects, such as movies or swiftly moving games, if this gives a sense of strain.

a logical combination for appetite suppression

meprobamate *plus* d-amphetamine

. . . suppresses appetite . . . elevates mood
. . . reduces tension . . . *without* insomnia, overstimulation, or barbiturate hangover.

anorectic-ataractic

BAMADEX®

MEPROBAMATE WITH D-AMPHETAMINE SULFATE LEDERLE

Each coated tablet (pink) contains: meprobamate, 400 mg.; d-amphetamine sulfate, 5 mg.
Dosage: One tablet one-half to one hour before each meal.

Lederle

LEDERLE LABORATORIES
A Division of AMERICAN CYANAMID COMPANY, Pearl River, New York

Latest Hill-Burton Report Given

The Department of Health, Education and Welfare reports that as of Dec. 31, 1959, Hill-Burton grants for Indiana included 65 projects at a total cost of $69,466,769, including federal contribution of $22,811,302 and supplying 3048 beds completed and in operation.

Twenty-four projects now under construction will cost $25,279,046 of which the Federal contribution will be $6,618,743. They are designed to supply 915 additional beds.

One project, at a total cost of $2,155,450, including a $717,333 federal contribution and supplying 65 additional beds is approved but not under construction.

Announcing

'ACTIFED'®

Decongestant / Antihistamine

THE POTENTIATED DECONGESTANT



provides symptomatic relief of nasal congestion and rhinorrhea of allergic or infectious origin Many patients whose symptoms are inadequately controlled by decongestants or antihistamines alone respond promptly and favorably to 'ACTIFED'.

'ACTIFED' contains:	in each Tablet	in each tsp. Syrup
'Actidil'® brand Triprolidine Hydrochloride	2.5 mg.	1.25 mg.
'Sudafed'® brand Pseudoephedrine Hydrochloride	60 mg.	30 mg.

safe and effective for patients of all ages suffering from respiratory tract congestion

DOSAGE

	TABLETS	SYRUP (5 cc. tsp.)	
Adults and older children	1	2	three times daily
Children 4 months to 6 years of age	½	1	
Infants through 3 months	–	½	

BURROUGHS WELLCOME & CO. (U.S.A.) INC., Tuckahoe, New York

Trudeau TB School Session Offers Unique Opportunities

The Trudeau School of Tuberculosis and Other Pulmonary Diseases, which will hold its forty-fifth session June 6-24, 1960, continues to provide a unique opportunity for training in the field of chest diseases.

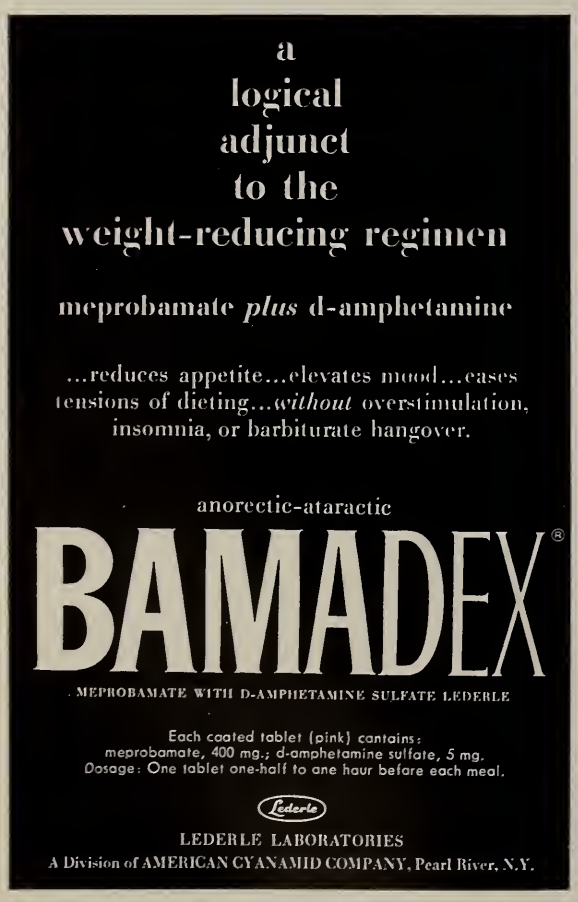
This annual postgraduate course, conducted under the auspices of the Trudeau Foundation and supported by the Hyde Foundation, is able to provide outstanding instruction at a minimal tuition of $100.00 for a three weeks session. Attendance at the Trudeau School carries with it some distinction as well as a thorough review for specialization in pulmonary diseases or for work in public health involving tuberculosis.

In addition to the local medical faculty consisting of some 40 doctors from Saranac Lake, Ray Brook State Tuberculosis Hospital and Sunmount Veterans Administration Hospital, about 30 of the leading teachers and investigators in the Eastern United States and Canada are brought to Saranac Lake each year to lecture or to conduct seminars in their special fields.

Approximately half of the time is devoted to tuberculosis and the other half is divided between such subjects as silicosis, pulmonary fibrosis, emphysema, fungus infection, sarcoidosis, pneumonias and intrathoracic tumors.

The Trudeau School, in its environment, gives its students a chance to combine a great educational experience with an enjoyable holiday in the most beautiful part of the Adirondacks, among pleasant companions. The enrollment is necessarily limited and, therefore, application should be made early. A few scholarships are available for those who qualify.

All inquiries should be addressed to the Secretary, Trudeau School of Tuberculosis and Other Pulmonary Diseases, Box 500, Saranac Lake, N. Y.



Postgraduate Course Given On Cruise to Baltic Ports

Duke University School of Medicine is repeating its combination postgraduate course and overseas vacation trip this summer for the fifth time. The cruise ship, "T. S. Ariadne" of the Hamburg-American Line will sail from Wilmington, N. C., June 5, and from New York June 8.

This cruise will be in the Baltic, visiting Le-Havre, Cuxhaven, Leningrad, Helsinki, Stockholm, Copenhagen and Hamburg. The trip disbands at Hamburg, allowing doctors to travel further or return home by air or by ship.

Lectures will be given on board the Ariadne by members of the Duke faculty and at medical centers in Leningrad, Helsinki, Stockholm and Copenhagen. The program has been approved by the American Academy of General Practice for Category I credit.

Details may be obtained by addressing the Director of Postgraduate Education, Duke University School of Medicine, Durham, N. C.

Nothern Tri-State Medics Plan May Meeting in Toledo

The Northern Tri-State Medical Association will hold its annual meeting at the Academy of Medicine in Toledo, Ohio, on Thursday, May 5. The one-day program opens at 9 a.m., EST. Papers will be read on fractures, uterine bleeding, court testimony, geriatrics and fistula in ano. All physicians are invited to attend. Registration fee and dues for the annual meeting of $5.00 may be mailed to John C. Richter, M.D., Sec.-Treas., 1110 Indiana Ave., LaPorte, Ind. ◄

after milk and rest, why Donnalate?

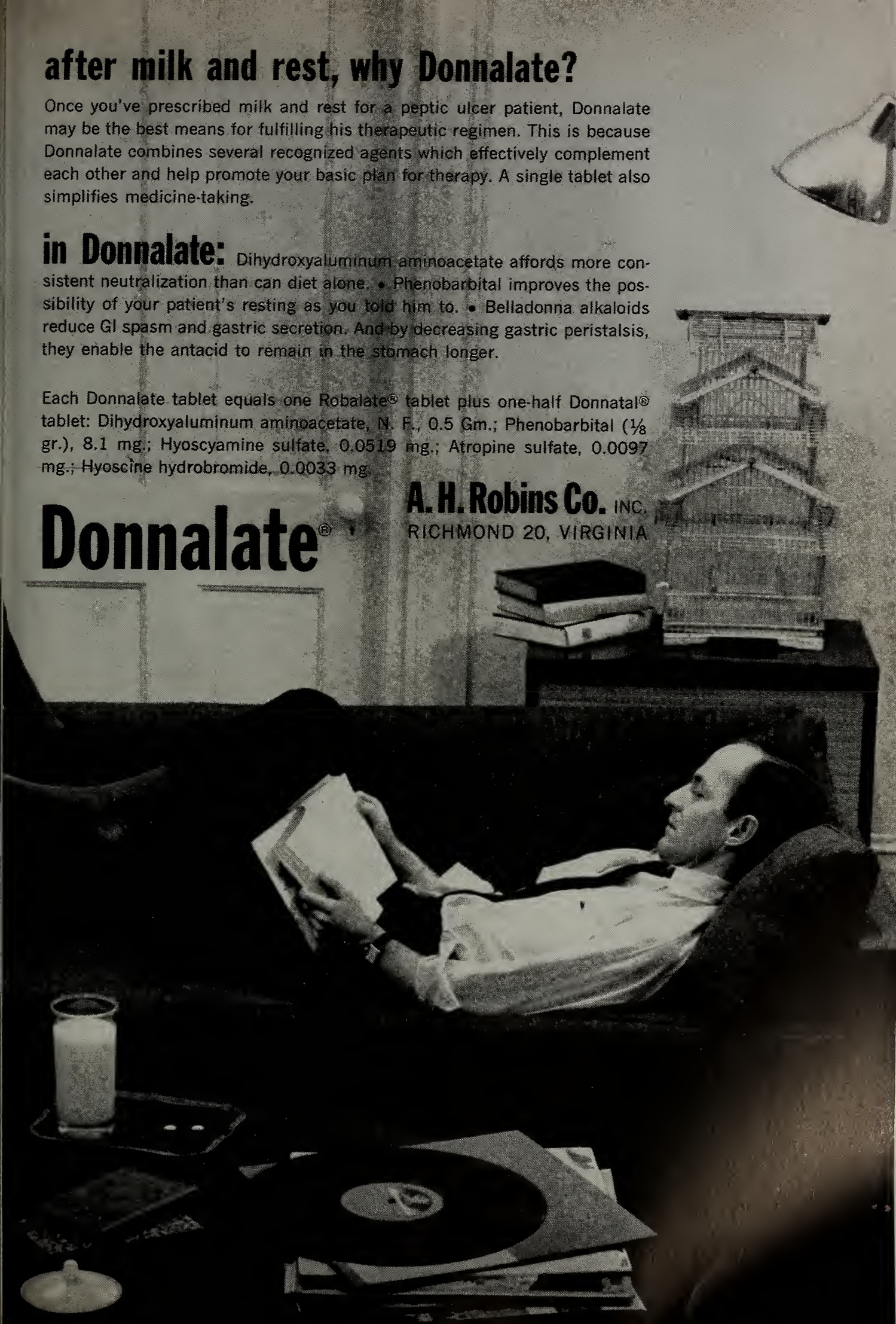
Once you've prescribed milk and rest for a peptic ulcer patient, Donnalate may be the best means for fulfilling his therapeutic regimen. This is because Donnalate combines several recognized agents which effectively complement each other and help promote your basic plan for therapy. A single tablet also simplifies medicine-taking.

in Donnalate: Dihydroxyaluminum aminoacetate affords more consistent neutralization than can diet alone. • Phenobarbital improves the possibility of your patient's resting as you told him to. • Belladonna alkaloids reduce GI spasm and gastric secretion. And by decreasing gastric peristalsis, they enable the antacid to remain in the stomach longer.

Each Donnalate tablet equals one Robalate® tablet plus one-half Donnatal® tablet: Dihydroxyaluminum aminoacetate, N. F., 0.5 Gm.; Phenobarbital (1/8 gr.), 8.1 mg.; Hyoscyamine sulfate, 0.0519 mg.; Atropine sulfate, 0.0097 mg.; Hyoscine hydrobromide, 0.0033 mg.

Donnalate®

A. H. Robins Co. INC.
RICHMOND 20, VIRGINIA



Add 1

Winter Weather Wails; Pastel Papers Pose Problems

by corki

A Frozen Brainchild

(with apologies to Williams S.)

Winter, whyfor art thou?

And winter descended upon the land, pointing a wrathful finger at the poor mortals thereon; a finger that brought howling winds and freezing rains and snow. And the mortals shivered and shoveled as winter's vengeance went on and on . . . and on. People died under that wrath of winter. People cried. People bundled up and slipped and slid in their fight against the monsterous joke of Nature.

And the finger kept on pointing.

Winter Vignettes

Man on ladder, pouring teakettle of steaming water into eaves.

Youngsters, red cheeked, pulling sleds, looking for a hill to slide down.

Icicles, like daggers, intimidating anyone courageous (or stupid) enough to walk beneath them.

Auto grinding out protest as frozen iceblock beneath bumps against ice lumps on street; forever like a weird facsimile of cave stalagmites and stalactites meeting with force.

Man striding down street in his Eskimo-like garb while accompanied by little lady shivering in a more lady-like but much less practical fashion. Isn't this an ironical salute to our society?

Lady slipping on downtown street, fashionable spike heels reaching toward heaven while her deriere is where it oughtn't to be!

Man shoveling more filthy, germ-laden frozen snow into gutters so more cars can get stuck.

The miracle of nature: millions of snowflakes, each a different, delicate pattern, swirling in a playful dance reminiscent of "The Saber Dance."

Woman, swathed in heavy clothing, shoveling walks and removing layer of clothing by layer as the effort works up a little circulation.

That infinite awareness of the amazingly complicated system of human muscles . . . upon awakening the morning after shoveling out from a big snow!

Every columnist having his (or her) say on winter scenes (and why should this column be THAT different!)

Saw-bones

And speaking of columnists, didjasee *Indianapolis Star* columnist Lowell Nussbaum's report of major surgery being performed on a chair at Marion County General Hospital? Hospital carpenters had to extract a "generously-proportioned" (Nussbaum said it, I didn't) doctor who had become stuck in the chair!

No comment necessary!

Two Dollars to Win

A good idea has been initiated by the Orthopedic Frame Company. Employee paychecks now have their withholding tax amount boxed for quick identification. Under it is the inscription "This week you paid (amount) to the Federal Government. Do you know how it is being spent? Have you heard of any waste?"

If this idea takes hold, maybe folks will be-



GOOD SERVICE

lasts long after the sale

When you buy an electrocardiograph*,
the manufacturer has two obligations to you:

. . . to provide the best possible instrument for your needs
. . . and continuing service for as long as you own the instrument.

As a Sanborn owner, you receive this continuing service in many forms, through nearby Branch Offices, Service Agencies and Resident Representatives in 46 cities: "emergency" calls when required, and prompt response to routine requests for supplies and accessories . . . ECG Study Courses (by correspondence); the bi-monthly Sanborn Technical Bulletin; comprehensive instrument Instruction Manuals . . . and a Question and Answer Service for any problems in the use of Sanborn instruments.

When a good product is backed by equally good service, only then do you get your money's worth, as a great many of the more than 30,000 Sanborn owners will agree.

*From Sanborn, you now have a choice of the 2-speed Model 100 Viso-Cardiette . . . its mobile counterpart the Model 100M "Mobile Viso" . . . or the compact, fully portable 18-pound Model 300 Visette.

SANBORN COMPANY

Medical Division, 175 Wyman St., Waltham 54, Mass.

INDIANAPOLIS *Resident Representative* 1635 North Gent Ave., Melrose 2-3768

Add 1

Continued

come more aware of how much of their work effort goes to the government. And when this happens, maybe we'll all be shocked into taking more active interest in government spending, wastes, give-aways, etc. And just maybe we'll get some active work *against* a growing paternalism on the part of big government.

Somehow, I like to spend my own money. How about you?

Tinted Papers an Rx

Seems the science of medicine is getting into just about everything these days. Agent for Champion Papers was telling us about an ophthalmologic study of printing papers which has brought about a new concept in papermaking.

Back in the days of Lincoln's reading by firelight or candle flicker, it was known that a 17-1 contrast ratio was needed if our future president was to gain his self-induced education through reading.

But all of that has changed with the modern trend in lighting. Too much light for so much contrast. That 17-1 black on white causes us to eventually see "ghosts" and we read with less speed and absorb much less of the content.

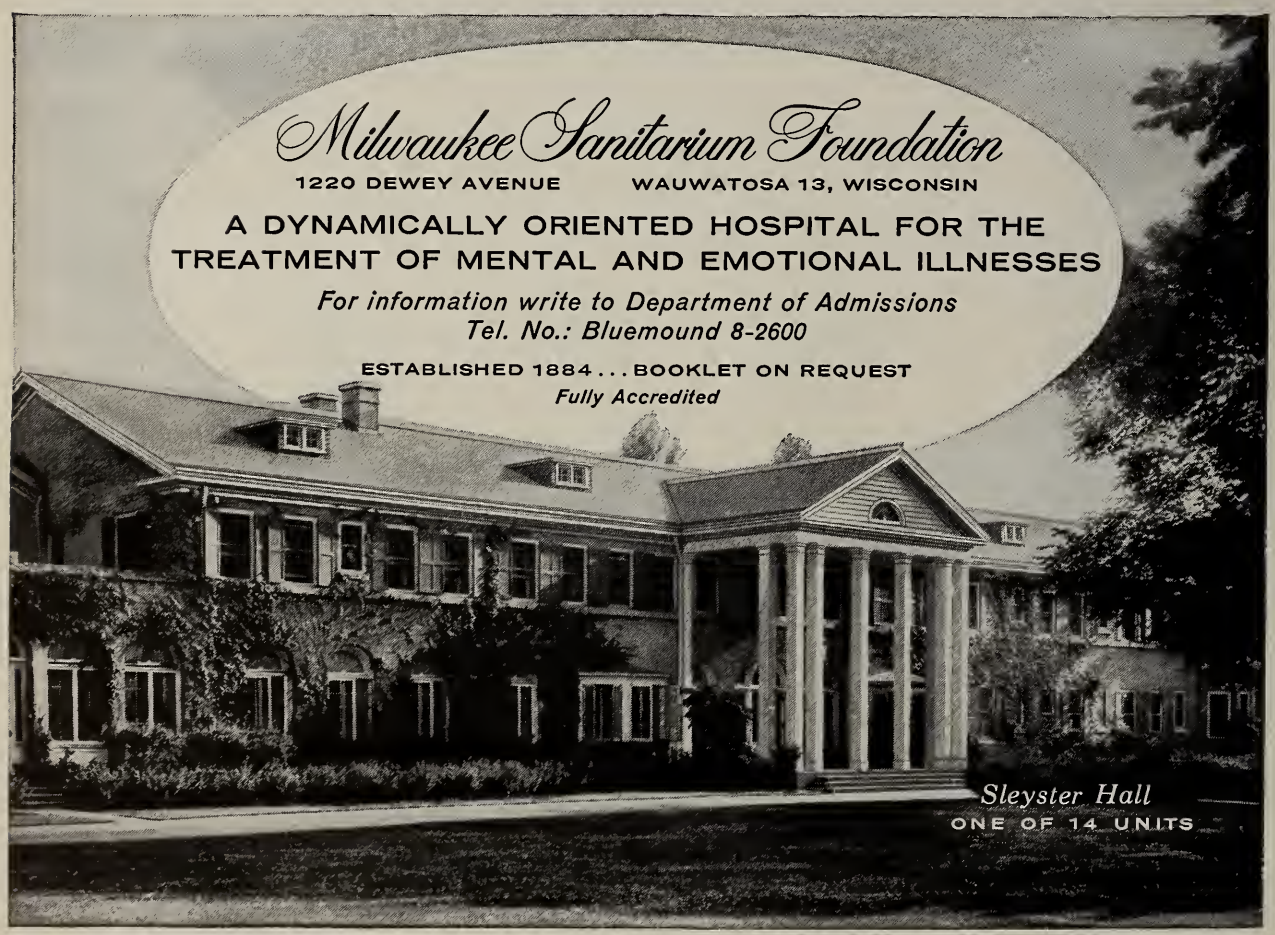
Newly recommended ratio (by ophthalmologists, according to our paper friend) is 8 to 1. And this is achieved by tinted papers with a corresponding color geared to the tint instead of black on white. In case of 4-color reproductions, three standard colors are used but the special color replaces the fourth, normally black. This makes the color reproduction appear more nearly as we see it (according to subject matter, choice of paper tint, etc.).

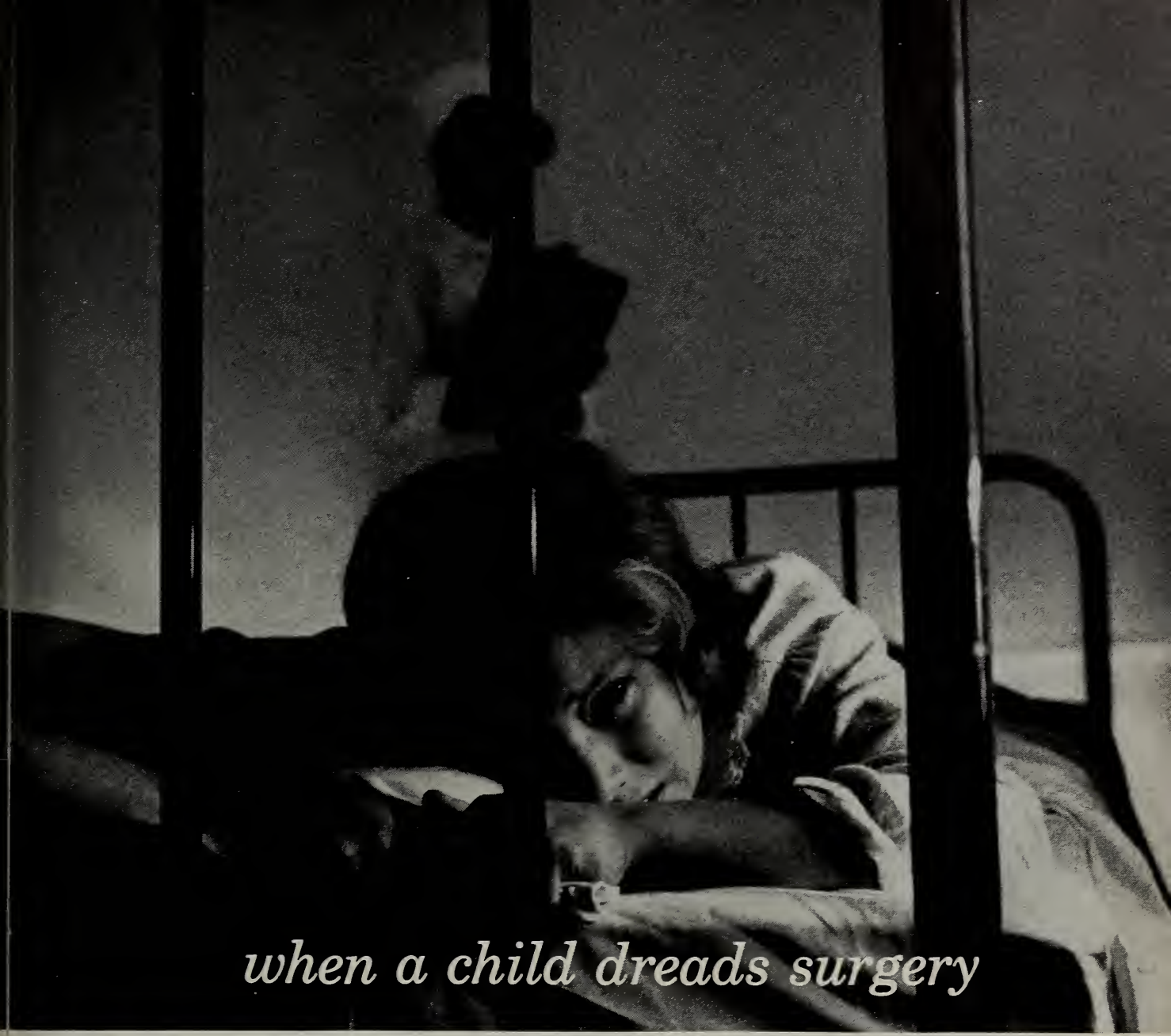
Of course, this makes the job of the publisher (or whatever) take one more complicated step into the unknown. For instance, one 4-color reproduction of a delightful baby in bed was lovely on yellow tones, pink tones and such—but baby looked a little ill on a pastel green. So when the tint is selected, a sharp eye must be kept on types of pictures to be used.

In a medical journal, if we're not careful, we might come up with a green heart or a blue liver! Gad. And all of this because of the ophthalmologists got into the printing paper act!

(Seriously, it makes sense. But, oh, life sure gets complicateder and complicateder!)

Like, blow away, snow. Blow! ◄





Vistaril®

hydroxyzine pamoate

brings reassurance

VISTARIL has been found to be a remarkably effective aid to preanesthetic medication. Its "mild but definite tranquilizing action" quickly calms anxious, fearful children.

Steiner, L., Webb, C., and Adriani, J.: The Preoperative Sedation of Children, Presented before the Southern Society of Anesthesiologists, Annual Meeting, April 23-25, 1959, Birmingham, Alabama.

Oral Suspension—25 mg. per 5 cc. teaspoonful. *Capsules*—25, 50 and 100 mg. *Parenteral Solution* (as the HCl)—25 mg. per cc., 10 cc. vials and 2 cc. Steraject® Cartridges; 50 mg. per cc., 2 cc. ampules.

Professional literature is available on request from the Medical Department.

Pfizer *Science for the world's well-being™* PFIZER LABORATORIES, Brooklyn 6, N.Y.

Deaths . . .

Charles N. Combs, M. D.

This small space in *The Journal,* devoted to the memory of Charles N. Combs, Terre Haute, is in recognition of services for which no measure can be taken and which cannot be represented by any space. His death on Feb. 7 removes a colorful as well as a devoted member of the Indiana State Medical Association. He was recognized by his contemporary leaders in Indiana medicine as an indefatigable worker of absolute dependability—in the phrase of those days, a "wheelhorse."

He was secretary of the ISMA for 15 years at a time when there was no executive secretary and no organized headquarters office. This span of years represents an enormous contribution of concerted effort. He was president of the state association in 1926, and also a delegate to the American Medical Association from 1931 to 1932, and in 1935 was secretary of its Section on Anesthesiology. In addition to these state and national accomplishments, he served as secretary, vice-president and president of the Vigo County Medical Society, president of the Terre Haute Academy of Medicine and president of the Aesculapian Society of the Wabash Valley. He also was a Fellow of the American College of Anesthesiology, and a Diplomate of the American Board of Anesthesiology. He was a director of the Indiana Blue Cross Hospital Service, and served on the Indiana Advisory Hospital Planning Council.



He had a great interest in the history of medicine and of doctors, and collaborated with Edgar F. Kiser in writing "One Hundred Years of Indiana Medicine" for the ISMA centennial. He also compiled many data in regard to doctors in Vigo County.

Even when ill, he did not lose interest in his fellow doctors and their problems. Those who knew him well marveled at the energy poured forth from such a small frame. He was never afraid of work and always responded cheerfully to any call for his services in anesthesia at any time of day or night. He carried on in this way long after his health had begun to fail—still a doctor doing a doctor's work—and even after retirement, often attended hospital staff meetings. The Indiana State Medical Association is indeed fortunate in having had Charles N. Combs as a member for so many years. We here and now salute him, *in memoriam.*—A.W.C.

Rutherford H. Allison, M.D.

Dr. Rutherford H. Allison, LaPorte County general practitioner, passed away Feb. 9.

A graduate of the Meharry Medical College in 1954, Dr. Allison interned at St. Joseph Hospital in South Bend.

Leslie A. Laird, M.D.

Dr. Leslie A. Laird, former North Webster physician and acting superintendent of the Richmond State Hospital, died Jan. 30 at the age of 65.

A former Kosciusko County coroner, he had practiced at North Webster from 1933 to 1947, at which time he accepted the Richmond Hospital post.

Dr. Laird was a graduate of Tri-State College, attended Columbia University, and received his M.D. degree from Indiana University in 1931.

He was a member of the National Psychiatric Association, Elks and the Church of Christ.

J. Don Miller, M.D.

Dr. J. Don Miller, 78, well-known Indianapolis pediatrician, died Feb. 10 at Indianapolis.

Instrumental in introducing and later director of the child feeding clinics in Indianapolis, Dr. Miller was in the general practice of medicine before specializing in pediatrics in 1925. He had been retired for most of the past decade.

Dr. Miller was graduated from Indiana University in 1904, and received his M.D. degree from I. U. Medical School in 1908.

He was a member of the Rotary, Masonic lodge, Scottish Rite and Presbyterian Church.

Continued


in every arthritic state
long-term therapy
with maximum relief of pain
without steroids
Buffered
Pabirin®
Tablets
improved salicylate therapy
SMITH-DORSEY • a division of The Wander Company • Lincoln, Nebraska

Deaths

Continued

Charles Edward Savery, M.D.

A well-known South Bend eye, ear, nose and throat specialist for 45 years, Dr. Charles Edward Savery, died Feb. 13 at his home in Deerfield Beach, Fla.

Retired since 1956, Dr. Savery was a graduate of the Indiana University School of Medicine. He belonged to the Indiana Club and Masonic lodge.

Morrell Simpson, M.D.

A former Bedford physician, Dr. Morrel Simpson, died Jan. 29 at St. Petersburg, Fla., where he lived 13 years.

After his graduation from Kentucky Medical College, Louisville, in 1907, Dr. Simpson establish his practice in Bedford, where he continued until retiring in 1946.

William G. Walker, M.D.

Dr. William G. Walker, 30, East Chicago physician, died Feb. 10 in Indianapolis.

A graduate of Western Reserve University in 1956, Dr. Walker was a member of the staffs of the Indiana Harbor Clinic, East Chicago, and the Hessville Medical Clinic, Hammond.

Theodore L. Williams, M.D.

Dr. Theodore L. Williams, a staff member of the Indiana University Student Health Center since June, 1959, died Feb. 1 at Bloomington Hospital. He was 57.

Former industrial physician with General Motors Corp. in Wilmington, Del., Dr. Williams was a graduate of the Colorado School of Medicine, class of 1934.

He was a member of the Masonic Lodge, El Jebel Shrine, Scottish Rite and Alpha Omega Alpha.

Martin W. Yencer, M.D.

Dr. Martin W. Yencer, 88, retired Richmond physician, died Feb. 22. He was a senior and 50-year member of ISMA.

An 1897 graduate of Central College of Medicine at Indianapolis, Dr. Yencer had practiced at Richmond since 1908. He was a state representative in 1902 and 1904. ◄

Tested . . . and proved . . .

ORAL therapy in diaper rash!



Convenient . . . simply open a capsule and add the contents to the baby's daily formula, or to fruit juice or water. No lotions . . . no rinses . . . no ointments . . . just oral therapy.

Send for samples and literature.

S. F. DURST & CO., INC.
Philadelphia 20, Pa.

Effective therapy! Thousands of pediatricians and general practitioners prescribe Pedameth for ammonia dermatitis—and they continue to prescribe it. Clinical tests have proved its effectiveness. Pedameth is safe because it contains only dl-methionine (0.2 Gm.) one of the essential amino acids. When Pedameth is administered, the pH of the urine is lowered and an as-yet-unknown antibacterial agent appears in the urine. Pedameth works . . . it's the safe, effective, convenient answer to ammoniacal diaper rash.

Prescribe

PEDAMETH®

(dl-methionine DURST)

(Advertisement)

Tetracycline Phosphate Complex (TETREX®)
U.S. PAT. NO. 2,791,609
in the Therapy of PNEUMONIA

Preferably, antibiotic therapy should be based on pretreatment culture of the offending pathogen, but in bacterial pneumonia the problem may well be too pressing to permit the required delay of 24 to 48 hours. A differential diagnosis among bacterial pneumonias, based on such clinical grounds as speed of onset, sepsis and pain may guide the choice of antibiotic for initiation of therapy.

Should clinical judgment dictate that antibiotic therapy be started immediately, at the same time a sputum sample or a subglottic swab can be sent to the laboratory for culture and sensitivity studies. If the response to the first antimicrobial agent proves unsatisfactory, a reasonable basis for changing therapy will then be at hand.

Choosing the Antibiotic

Since therapy must be started at once for bacterial pneumonia, it is advisable to choose a broad-spectrum antibiotic that quickly produces high levels of active agent (e.g., tetracycline phosphate complex, TETREX). Such an antibiotic probably has the best chance of controlling the pathogen, whether it be gram-negative or gram-positive. And if the laboratory report shows that the invading organism is much less sensitive to tetracycline than to other agents, the patient can then be changed to an appropriate antibiotic. If the difference in sensitivity is slight, then the possibility of side effects, sensitization, and toxicity should be evaluated before changing therapy to another antibiotic.

The greatest number of bacterial pneumonias are caused by pneumococci, which respond very well to penicillin, tetracycline, and chloramphenicol. Also, these antibiotics are usually effective against the other gram-positive coccal pneumonias. But penicillin is ineffective against the viral pneumonias and the gram-negative *Hemophilus influenzae* and *Klebsiella pneumoniae*. Although *K. pneumoniae* causes only about 1 to 2 per cent of pneumonia cases on the average,[1] these are apt to be acute and fulminating (Friedländer's pneumonia), with a high mortality rate if not effectively treated. Since pneumococcal pneumonia may be difficult to distinguish clinically from Friedländer's, except by gram-stained sputum smear, it may be wiser to start treatment with an agent also effective against Klebsiella.

Penicillin, however, in addition to having a limited spectrum, also causes many minor and some serious sensitivity reactions. In a recent survey[2] it was found that penicillin produced severe skin reaction. But most important was the observation that anaphylactic shock, with a fatality rate of about 9 per cent, was the most frequent serious reaction. Such severe reactions are almost always associated with parenteral administration.

Tetracycline is also clinically effective in primary atypical pneumonia.[3]

The tetracyclines (e.g., TETREX) have the advantage of a broad range of antimicrobial activity and low toxicity. And in addition, the physician does not have to trouble himself or his patients with repeated blood studies when he prescribes TETREX. Minor reactions such as gastric upsets or mild skin rashes occur occasionally. The most serious side effects are staphylococcal and monilial overgrowth, but these are rare and can be adequately controlled.

No one would deny that appropriate antibiotic therapy has greatly reduced morbidity and saved many lives of patients with bacterial pneumonia. Nevertheless, general supportive measures in the care of patients remain important even today. Especially in the desperately ill patient, antibiotics are not considered as substitutes for the individual evaluation, clinical observation and judgment of the physician.

Some Micro-organisms Susceptible[a] *to Tetracycline* (TETREX)[b]

Streptococcus; Staphylococcus; Pneumococcus; Gonococcus; Meningococcus; *C. diphtheriae; B. anthracis; E. coli;* Proteus; *A. aerogenes; Ps. aeruginosa; K. pneumoniae;* Shigella; Brucella; *P. tularensis; H. influenzae; T. pallidum;* Rickettsiae; Viruses of psittacosis and ornithosis, lymphogranuloma inguinale, primary atypical pneumonia; *E. histolytica; D. granulomatosis.*

a Some strains are not susceptible.

b Table adapted from Goodman, L. S., and Gilman, A.: The Pharmaceutical Basis of Therapeutics. 2nd edition, New York, The Macmillan Co., 1956, pp. 1322-1323.

References: 1. Wood, W. E., Jr.: In: A Textbook of Medicine. Edited by Cecil, R. L., and Loeb, R. F., 9th edition, Philadelphia, W. B. Saunders Co., 1955, p. 145. 2. Welch, H.; Lewis, C. H.; Weinstein, H. I., and Boeckman, B. B.: Severe reactions to antibiotics. A nationwide survey. Antibiotic Med. & Clin. Ther. 4:800 (Dec.) 1957. 3. Keefer, C. S.: The choice of an anti-infective agent. In: Drugs of Choice, 1958-1959. Edited by Walter Modell, St. Louis, The C. V. Mosby Co., 1958, p. 135.

BRISTOL LABORATORIES INC., SYRACUSE, NEW YORK

District, County News



ATTENDING THE 11TH DISTRICT legislative meeting at Kokomo Feb. 21 were (left to right) Drs. L. J. Hillis, C. L. Wise and Donald K. Winter, legislative commission member; Mrs. Max Adams, Dr. Adams, 11th District councilor; Mrs. Hillis, Dr. Earl W. Bailey, alternate councilor; Dr. L. L. Hill, Mrs. Donald K. Winter, Miss Helen Barnett, Mrs. Russell J. Morrical and Dr. and Mrs. George M. Jewell. Dr. Morrical also attended.



—GRINDSTAFF PHOTOS

10TH DISTRICT PHYSICIANS and guests who attended a Feb. 11 meeting at Gary included (left to right) Dr. Leon J. Armalavage, Lake County Medical Society secretary, Dr. F. F. Boys, president of the Lake County Medical Society; Dr. and Mrs. Ralph Eades, Dr. Philip Rosenbloom, legislative chairman of Lake County Medical Society; John Twyman, Lake County executive secretary, and Dr. J. P. Vye, Tenth District councilor.

First District

Twelve members of the First District Medical Society met at Evansville on Feb. 9 for a legislative meeting.

Second District

Physicians of the Second District attended a legislative meeting at Sullivan on Feb. 24. Ten members were present.

Third District

The Third District Medical Society met Feb. 17 at French Lick for a legislative meeting. Seven were in attendance.

Sixth District

Fifteen members and guests attended the Sixth District legislative meeting at Rushville Feb. 10.

Twelfth District

Sixteen members of the Twelfth District Medical Society met at Fort Wayne Feb. 24 for a legislative meeting.

Thirteenth District

Nineteen members of the Thirteenth District Medical Society met at Plymouth Feb. 17 for a legislative conference.

Adams

Thirteen members of the Adams County Medical Society met at Decatur Feb. 9 for a general business meeting and medical discussion.

Bartholomew-Brown

Dr. Herman Echsner is the new president of the Bartholomew-Brown Medical Society. Assisting him will be Drs. Richard O'Bryan, vice president; Ben Ranck, secretay-treasurer; David Adler and Robert Seibel, delegates, and Robert Jacobs and Kenneth D. Schneider, alternate delegates.

At a Jan. 13 meeting, Dr. Alex Carroll spoke on the subject, "Get Excited About the Stork Market, But Not Too Excited." Continued

CERTIFIED
prosthetic facilities in over 30 cities

Hanger offices throughout the United States have been approved by the American Board for Certification in Orthotics and Prosthetics as "Certified Prosthetic Facilities". Each of the more than 30 offices offers one or more Prosthetic Appliance Technicians approved by the ABCOP as "Certified Prosthetists".

These are more "certified" facilities and technicians than offered by any other manufacturer. "Certification" plus Hanger's complete line of arm and leg appliances for all types of amputations, guarantees every doctor an excellent chance for the successful rehabilitation of his amputee patients.

Hanger PROSTHESES

1529-33 N. Illinois St., Indianapolis 2, Ind.
3108 Burnet Avenue, Cincinnati 29, Ohio
Fairfield at Pontiac, Fort Wayne, Ind.
418 N. Main St., Evansville, Ind.



greater activity

unsurpassed G.I. toleration

sustained peak action

extra-day protection against relapse

NOW...THE EXTRA BENEFITS OF BROAD-SPECTRUM

DECLOMYCIN®

Demethylchlortetracycline Lederle

IN THE NEW, CHERRY-FLAVORED **SYRUP**

75 mg./5 cc. tsp., in 2 fl. oz. bottle—3-6 mg. per lb. daily in four divided doses

LEDERLE LABORATORIES, a Division of AMERICAN CYANAMID COMPANY, Pearl River, New York

County, District News

Continued

Carroll

Dr. Donald C. Fields, Lafayette, spoke on "Vascular Surgery Occlusive Arteriosclerotic Disease" at the Jan. 20 meeting of the Carroll County Medical Society. Thirteen members and guests attended.

"Treatment of Influenza" was the subject of discussion at the society's Feb. 17 meeting which 14 members and guests attended.

Clinton

Dr. Earl Applegate spoke on "Hospital Constitutions" at the Feb. 16 meeting of the Clinton County Medical Society. Fourteen attended.

Dearborn-Ohio

Dr. Joseph Ghory of Cincinnati, Ohio spoke to members of the Dearborn-Ohio Medical Society on "Pediatric Allergy" at their Feb. 18 meeting.

Delaware-Blackford

Physicians and attorneys of Delaware and Blackford counties gathered for their annual joint meeting March 29. It was the fourth in a series of combined meetings, the program being a continuation of a series of moving pictures produced by the Legal Bureau of the American Medical Association in cooperation with the American Bar Association, in collaboration with the Wm. S. Merrell Co. Pharmaceutical Research Laboratories.

The fourth film, entitled "A Matter of Fact," illustrates the importance of postmortem examinations by qualified pathologists and is based on a coroner's investigation of a suspected murder in which a man faces murder charge in the death of his wife.

Following the film, a discussion of mutual problems concluded the meeting.

Fayette-Franklin

Dr. Bertram W. Sanders is the new president of the Fayette-Franklin Medical Society. Other 1960 officers include Drs. Perry Seal, vice-president; Joseph L. Steinem, secretary-treasurer; W. F. Kerrigan and H. N. Smith, delegates; and George M. Ellis and Dr. Seal, alternate delegates.

Floyd

William H. Garner, M.D., spoke on the "Relative Value Scale" at a Feb. 12 meeting of the Floyd County Medical Society. Twenty-six members attended.

THE HARDING SANITARIUM

WORTHINGTON
OHIO

For the Diagnosis and Treatment of Psychiatric Disorders
and with
Limited Facilities for the Aging

GEORGE T. HARDING, M. D.
HARRISON S. EVANS, M. D.
Medical Directors

CHARLES W. HARDING, M.D.
Clinical Director

GEORGE T. HARDING, Jr., M. D.
HERNDON P. HARDING, M. D.
ARNOLD L. NIELSEN, M.D.
ROBERT L. SMITHWOOD, M. D.
W. W. WINSLOW, M.D.

GRACE M. COLLET, Ph.D.
VERNON W. SHAFER, Ph.D.
Clinical Psychologists

MARY JANE McCONAUGHEY, M.S.W.
BENJAMIN E. WHEATLEY, M.S.W.
Psychiatric Social Workers

PAULINE L. TOOILL, R. R. L.
Medical Record Librarian

JAMES L. HAGLE, M. B. A.
Administrator

ESTHER L. SIMPSON, R. N.
Director of Nurses

Phone: Columbus TUXEDO 5-5381

Fountain-Warren

Four members and five guests of the Fountain-Warren Medical Society met at Attica Feb. 4 for a business meeting.

Fulton

Officers for 1960 of the Fulton County Medical Society are Drs. Howard H. Rowe, president; Charles L. Richardson, vice-president; E. V. Herendeen, secretary-treasurer, and Dean K. Stinson, delegate.

Hendricks

Seventeen members and wives attended the Hendricks County Medical Society legislative meeting on Feb. 9.

Jefferson-Switzerland

Twenty members of the Jefferson-Switzerland Medical Society met Feb. 2 for a legislative meeting.

Knox

At a joint meeting of the Knox County Medical Society and Auxiliary on Feb. 16, the group conducted a legislative discussion and then were entertained by a style show.

OVER 80 YEARS' SPECIALIZED EXPERIENCE IN THE RESTORATIVE TREATMENT OF

"THE PROBLEM DRINKER"

At The Keeley Institute your patients are assured of receiving:

- the most modern, coordinated, comprehensive, rehabilitative regimen
- in addition to medical, nutritional and physiotherapeutic treatment, we also offer psychiatric diagnosis and psychotherapy
- full cooperation throughout with the referring physician
- in addition to the care of the alcoholic we also treat narcotic and drug addiction
- surprisingly low cost—to cover all medical care, medicines, laboratory work, room and excellent cuisine

You can obtain more detailed information by writing us direct.

WE WELCOME YOUR REFERRALS...

THE KEELEY INSTITUTE
DWIGHT, ILLINOIS

Member American Hospital Association, Member Illinois Hospital Association. Licensed by the Department of Public Health, State of Illinois.

Kosciusko

Dr. Hossein Hashemi has been elected president of the Kosciusko County Medical Society. Assisting him in 1960 will be Drs. Carl E. Shrader, vice-president, and Dean R. Bahler, secretary-treasurer.

Lake

Lake County Medical Society members saw a film on the history of flying at their Feb. 10 meeting.

The society has announced that 1960 delegates will include Drs. W. R. Troutwine, Peter Stecy, Nicholas Egnatz, P. J. Rosenbloom, Ray Elledge and H. R. Stimson.

Alternate delegates are Drs. A. F. Gregoline, C. F. Bradley, J. B. Nicosia, G. M. Young, F. F. Premuda and Michael Shellhouse.

LaPorte

A Chicago physician, Dr. Link Kessler, spoke to members of the LaPorte County Medical Society on "Practical Management of Diabetes" at their Feb. 16 meeting. Twenty-four attended.

Lawrence

Members of the Lawrence County Medical Society met at Bedford Feb. 3 for a general business meeting. There were 21 present.

Morgan

Dr. Robert VanBokkelen is the new president of the Morgan County Medical Society. Other officers include Drs. James Farr, secretary-treasurer; Loren Taylor, delegate, and Leon Gray, alternate delegate.

Orange

Members of the Orange County Medical Society met at French Lick on Feb. 2 for a general business meeting.

Perry

Six Perry County Medical Society members met at Cannelton Feb. 2 for a general business meeting.

Putnam

Twelve of the Putnam County Medical Society's 14 members met at Greencastle Feb. 12 for a program on sex education in the county schools.

Ripley

Dr. Bill E. Freeland was speaker at the Feb. 11 meeting of the Ripley County Medical Society. Seven members attended. Continued

County, District News

Continued

Rush

Dr. John Mertz, of Indianapolis, spoke on "Cryptorchidism" at the Feb. 11 meeting of the Rush County Medical Society.

The 14 members and one guest present also discussed recent developments in medical legislation.

Steuben

Dr. Robert Barton has been elected president of the Steuben County Medical Society. Assisting him will be Drs. Wayne Schrepferman, vice-president, and Lloyd McCormack, secretary-treasurer.

Tippecanoe

Forty-eight members of the Tippecanoe County Medical Society met Feb. 9 for a legislative meeting.

Vanderburgh

WFIE Television, Evansville, has donated one-half hour of public service time to the Vanderburgh County Medical Society for broadcast of a series of 13 weekly medical programs which began Feb. 28. Members have volunteered their time to appear on the various panels.

At the January society meeting, Dr. R. S. Griffith, of Lilly Clinic, Marion County General Hospital, presented the scientific program on "Use and Misuse of Antibiotics."

Wayne-Union

Dr. Charles Fisch of Indianapolis spoke on "Stress and Work in Coronary Heart Disease" at the Feb. 9 meeting of the Wayne-Union Medical Society. Forty members attended the meeting.

Wells

Dr. Walter Judson of Indiana University spoke on "Cinecardioangeographic Studies of Aortic and Mitral Valve Action" at the Feb. 15 meeting of the Wells County Medical Society.

The 18 members present voted to provide awards to two high school students for science fair projects. ◄

———

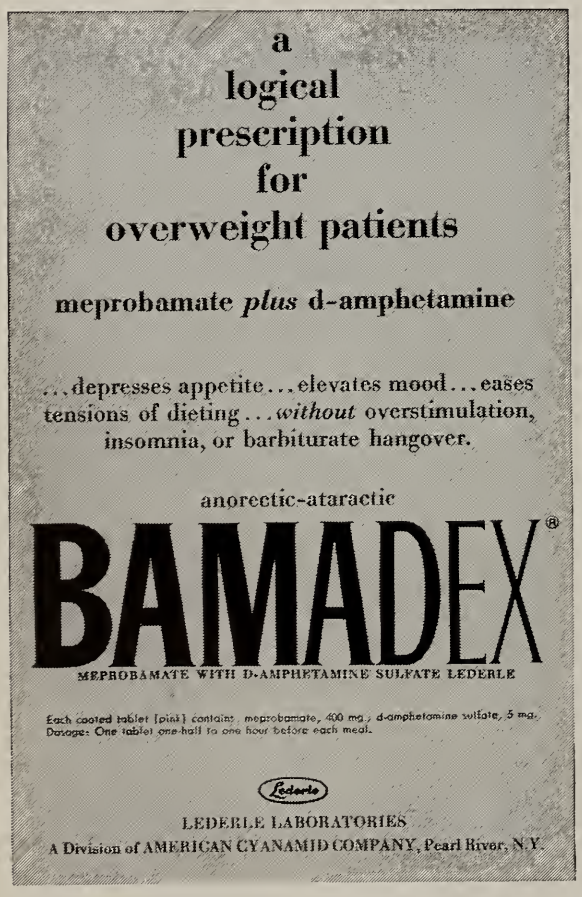
Overheard during an intermission at the Met, one Edwardian lady to another: "We were in the habit of going abroad every summer because of the mosquitoes."—*New Yorker.*

———

At a cocktail party, attended by college prof's and various men of letters, somebody passed out and the cry went up, "Is there a doctor in the house?" There were several answers, "Of what?"—*Phoenix Flame,* Phoenix Metal Cap Co.



"It's quite normal for you to want to kick me in the shins after I gave you a shot; but you must remember—I'll kick you back!"



Commission Meetings

Public Health

January 24, 1960

The meeting of the Commission on Public Health was called to order at 1:45 p.m., Sunday, Jan. 24, by Dr. Emmett B. Lamb, chairman.

Present were Drs. Howard T. Hammel, Richard C. Swan, William Baughn, Joseph E. Dudding, Robert K. Webster, John A. Davis, Forrest J. Babb, E. S. Jones, and John R. Stanley and E. S. Rifner, as well as guests—Dr. Andrew Offutt, Dr. George Davis and Mr. Johnson, a guest of Dr. Jones, president of the board of Directors of the Methodist Hospital, Gary.

Dr. Lamb said a few words concerning the problem of the aged and aging. He refers to the meeting which was held on Jan. 11, at which time Dr. Louis M. Orr, president of the American Medical Association, spoke to a large group in Indianapolis concerning the Forand Bill.

Doctor Lamb asked Dr. George Davis to say a few words concerning the problem of the aging. Dr. Davis, chairman of the Indiana Commission on Aging and Aged, discussed the activities and make-up of his commission. Dr. Davis mentioned that he knew it had been said that the medical profession had been described as "obstructionists," but he definitely did not agree with this.

He told about some of their regional meetings. He said the question had been raised at various Regional Meetings of, "Why is the AMA opposed to the Forand Bill?" In every meeting since the question was originally asked, this question had been answered. He said he thought this group would be interested in the make-up of this commission.

Dr. Davis is chairman, representing, "Adult Education;" Dr. Hunsucker, member of the faculty at Purdue; there are two from colleges—Dr. Yaeger, of Indiana University Extension, and Dean Burkhart, of Ball State—Mrs. Swan, a member of the staff of the T. B. Association; Jesse Dickinson, a State Senator, Mr. Wyrick, assistant director of a steel company, Mr. Wright, secretary-treasurer of the State CIO-AFL—Dr. Nathan Salon, physician; Mrs. Geltz, housewife; Jack Brawn, industrialist; Walter Bischoff, banker; Bruce Savage, realtor; Mr. Miller, architect; an attorney from Indianapolis (he couldn't re-call his name); Lynn Stuart, a businessman; Dr. Andrews, member of Indiana University Medical School staff; Mr. Beck, minister, first chairman of the commission, Dr. Leeds, secretary of the commission.

They have committees on health, employment, income, housing, research, community organization, recreation, inter-departmental activities and publications.

He feels that their chief function is to alert the people of the state that there is a problem here. He said that a difficult point is how to get the people to realize the problem and still not set up the people over 65 as a minority group.

Dr. Davis talked to the group concerning some of the activities of the Indiana commission along the fields of recreation, housing and health. Dr. Davis talked about the plans for the White House Conference on Aging. He said the next Governor's Conference will be held in September, 1960.

He said the commission does not believe this is a program which can be settled on a state basis—he believes it should be a local concern.

He said the commission has interested itself in a variety of things. He said they meet with different groups. They met with past governors of Rotary recently, they have met with people who are responsible for the Masonic Home and also with church groups.

They have been trying to formulate a list of state organizations.

He said that our allotment of delegates to the White House Conference is 44. This 44 is exclusive of representatives of organizations that might be sending representatives to the conference.

Dr. Lamb thanked Dr. Davis and mentioned that this Indiana commission is not interested in health alone, but also in other activities pertaining to the aged.

Dr. Jones mentioned the AMA Conference on Aging, in Washington, which he attended last June. He suggested to Dr. Davis that a committee on psychiatric problems be appointed. Dr. Davis believes this is a good idea.

Dr. Hammel asked if the Indiana commission places a large responsibility on the family unit? Dr. Davis said that they are certainly not trying to take it away from the family unit.

Dr. Webster talked concerning the budget and working of the welfare budget.

Dr. Offutt mentioned the fact that they have been working on the nursing home problems.

Dr. Stanley said he doesn't believe the Welfare Department recognizes the fact that there are any in-between cases. They either qualify for welfare, or they don't.

Dr. Jones wondered if Dr. Davis could send copies of the material concerning the activities of the Indiana commission to Dr. Lamb, so that this may be turned over to the State Medical Association for publication in the *Journal* and News Letter.

The meeting recessed for ten minutes for separate committee meetings, and reconvened at 3:30 p.m.

Dr. Offutt brought up the problem of the extreme difficulty they are having in getting people to serve as county health officers. He asked this commission for any suggestions.

Dr. Webster mentioned that he was to give a report on immunization. He found that there are only 14 departments of health in the State of Indiana, so he doesn't know how to make a report on this.

Dr. Webster continued that the county health officer is a burdensome job, which pays practically nothing.

Dr. Lamb said he believes that all this commission can do is to make recommendations.

Dr. Babb said that if someone from the outside asks us, an an individual doctor, what the "score" is, and we don't know, we find out.

Dr. Jones moved the secretary of the State Board of Health, at the earliest convenience to him, call a meeting of the county commissioners of the state, together with any health officers he deems necessary for discussion of this problem. Dr. Hammel added that we have publicity on this subject in the *Bulletin;* Doctor Webster added that a copy of the resolution be sent to the Chairman of the Council. Dr. Jones accepted these additions; Dr. Webster seconded the motion; motion carried.

Dr. Swan asked that Dr. Webster, as chairman of the Immunization Committee, think further about a resolution concerning mass immunization.

Dr. Swan mentioned that he will send a copy of the letter which was prepared, giving the individual doctor's side of the question concerning the problem of mass immunization in Madison County, to all members of the commission.

Dr. Lamb asked Dr. Rifner for a report of the Committee on Rural Health.

Dr. Rifner mentioned the suggestion which had been made previously of sending more than one letter to the juniors and seniors concerning Junior-Senior Day. He said that he has found the quarters change in March, so that if we can get one letter out in February and one in March after the quarters change, this will be good.

He continued that it was planned to not have a lengthy program, but that we could seat these people so that there would be one member of the commission at each table, so that they could be asked questions by the students.

Dr. Babb suggested a question and answer period for Junior-Senior Day.

Dr. Lamb will talk with Mr. Waggener about the date and place for the Junior-Senior Day.

Dr. Swan said he has no report on the Committee on Industrial Medical Practices and Programs.

Dr. Baughn said there is no report on the Committee on Conservation of Hearing and Vision.

Dr. Webster asked if some of the commision members will write down suggestions for the resolution for which they have asked him to write.

Dr. Hammel reported as chairman of the Traffic Safety Committee. He said that he feels it is very hard to interest people along this line.

Dr. John Davis moved we send Dr. Rifner to the meeting of the Rural Health Conference in Grand Rapids, Mich., to be held this spring. Dr. Hammel seconded the motion; motion carried.

It was agreed that probably the next meeting would be held on Junior-Senior Day.

Meeting was adjourned at 4:40 p.m.

Constitution and By-Laws

Sunday, January 17

The meeting of the Commission on Constitution and By-Laws was called to order at 2:05 p.m., Sunday, Jan. 17 by Dr. Charles Jones, chairman.

Present were Drs. William M. Sholty, Gordon S. Fessler, Charles A. Jones, Dillon Geiger, A. W. Cavins, John B. Cleveland and Truman E. Caylor.

Dr. Geiger moved we dispense with the reading of the minutes of the Feb. 22, 1959, meeting of the commission. Dr. Caylor seconded the motion; motion carried.

Dr. Cleveland stated that the commission met on Oct. 9, at which meeting the officers were elected.

Dr. Caylor moved the minutes of the Oct. 9, 1959, meeting be accepted. Dr. Fessler seconded the motion; motion carried.

The error which was made by the reference committee was discussed by the commission. Dr. Cavins moved that the resolution regarding the election in absentia be repeated in our annual report and that the headquarters office be requested to publish this again in the *Journal.* Dr. Cleveland seconded the motion; motion carried.

Dr. Cleveland said that the speaker for the House of Delegates was considered by the Reference Committee. They wanted to study this further in regard to the appointment power of the speaker against the president. This was discussed by the commission. Dr. Cavins said that when this was considered before all the available past presidents were polled and the vast majority thought it would be a good idea. This was the reason they felt it would be all right to set up the mechanism for this. Dr. Cavins gave a few other points of history on this particular matter.

The recommendations of the Reference Committee concerning a speaker and vice speaker are read and discussed at length.

Dr. Cavins moved that this commission take no further action on this matter, so that this subject will come up for action at the next meeting of the House of Delegates in the same form as the Reference Committee suggested. Dr. Cleveland seconded the motion; motion carried.

Other actions of the Reference Committee were reviewed by this commission. (Loss of vote, if they fail to send anything to the Headquarters Office concerning changes in their Constitution—also, the fiscal year, which was recommended by the Wolf Management Service, this is fiscal year for purposes of accounting.) Dr. Cavins reviewed this matter of the fiscal year.

Dr. Cleveland handed out copies of his proposed model constitution for a medical society to those present.

Squibb Announces Chemipen

Squibb Alpha-Phenoxyethyl Penicillin Potassium

new chemically improved penicillin which provides the highest blood levels that are obtainable with oral penicillin therapy



As a pioneer and leader in penicillin therapy for more than a decade, Squibb is pleased to make Chemipen, a new chemically improved oral penicillin, available for clinical use.

With Chemipen it becomes possible as well as convenient for the physician to achieve and maintain higher blood levels—with greater speed—than those produced with comparable therapeutic doses of potassium penicillin V. In fact, Chemipen is shown to have a 2:1 superiority in producing peak blood levels over potassium penicillin V.*

Extreme solubility may contribute to the higher blood levels that are so notable with Chemipen.* Equally notable is the remarkable resistance to acid decomposition (Chemipen is stable at 37°C. at pH 2 to pH 3), which in turn makes possible the convenience of oral treatment.

And the economy for your patients will be of particular interest—Chemipen costs no more than comparable penicillin V preparations.

Dosage: Doses of 125 mg. (200,000 u.) or 250 mg. (400,000 u.), t.i.d., depending on the severity of the infection. The usual precautions must be carefully observed with Chemipen, as with all penicillins. Detailed information is available on request from the Professional Service Department.

Supply: Chemipen Tablets of 125 mg. (200,000 u.) and 250 mg. (400,000 u.), bottles of 24 tablets. Chemipen Syrup (cherry-mint flavored, nonalcoholic), 125 mg. per 5 cc., 60 cc. bottles.

*Knudsen, E. T., and Rolinson, G. N.: Lancet 2:1105 (Dec. 19) 1959.

'CHEMIPEN' IS A SQUIBB TRADEMARK.

SQUIBB

Squibb Quality—the Priceless Ingredient

This proposed copy, as well as the proposed Model Constitution and By-Laws from the AMA were discussed at length.

Dr. Fessler moved that we take these copies home and study them and report back on them at the next meeting, and that the Headquarters Office make extra copies and send them to the commission members. Dr. Geiger seconded the motion; motion carried.

Mr. Waggener reviewed a few matters which he felt the commission might wish to discuss. One was senior membership.

Dr. Cavins stated that senior membership is based on attained age. The commission decided that they do not need a motion on this. This is an administrative matter.

Another matter concerned the last day of the meeting of the House which would be on the last day of the annual meeting.

Dr. Cavins asked what the Council suggests about this. (It was explained that this is merely brought up for discussion.)

Also, the chapter of the constitution on Medical Defense was discussed.

Dr. Fessler moved we take Mr. Waggener's suggestion and that as far as we are concerned, we leave that in the Medical Defense to malpractice suits, and refer the question to the Council, because he feels that the Council would be better qualified to say if it should come from the general fund or not. Dr. Cavins seconded the motion; motion carried.

Dr. Fessler wondered if the Commission on Public Relations could do a little work along this line.

It was decided to hold the next meeting of the commission at the Student Union Building at 1:00 p.m., Sunday, Apr. 24.

Meeting was adjourned at 4:15 p.m.

Legislation

December 16, 1959

Dr. Wood called the meeting to order at 2:10 p.m., Wednesday, Dec. 16, 1959, at the Student Union Building, Indiana University Medical Center, Indianapolis.

Present were Drs. Walter L. Portteus, Lee J. Maris, Eugene F. Senseny, Joseph Weber, Otis Bowen, Donald Kerr, Joe M. Black, Paul R. Tindall, Paul T. Lamey, and Don E. Wood. Guests present were Art Tiernan, Reuben Dalbec, Mrs. Otis Bowen, Mrs. Mary Black, James A. Waggener, Robert Amick and Howard Grindstaff. Mr. Hollowell and Mr. Hamil were also present.

The AMA film on the Forand Bill was shown to the group.

Dr. Wood made a few remarks after the showing of this firm, urging that groups, such as mentioned in the film be contacted. Dr. Wood continued to say that we must not be dilatory—we must be forward in our thinking. We must get this work done at the county level.

Dr. Wood stated that the woman's auxiliary has been asked to have representatives here, as they wish the auxiliary to be fully informed. It is asked that contacts be set up in each community to be made to the Senators and Congressmen. It was urged by Dr. Wood that all who can possibly be contacted, be so contacted for this purpose. The cost to the American taxpayer will be so great, and this must be stressed with all these people. We really have something to fight for—not just to be against something. The doctors have an interest in this as individuals and as taxpayers, not on the basis of physicians or socialized medicine.

Dr. Wood urged the reporting of all resolutions adopted in each county be sent to the headquarters office, and also sent to the Congressmen. This is most important.

Dr. Wood stated that we have the names of all family physicians of the Congressmen and Senators. Make sure that this particular individual is made aware of all the activities concerning this problem. Physicians in the county should undertake to cover the Congressman's personal physician's place if it is found necessary that he go to Washington to see his Congressman.

The Norbury Sanatorium

Established 1901 — Incorporated
Licensed — Jacksonville, Illinois

FRANK GARM NORBURY, A.M., M.D., Medical Director
HENRY A. DOLLEAR, M.D., Superintendent
FRANK B. NORBURY, M.D., Physician

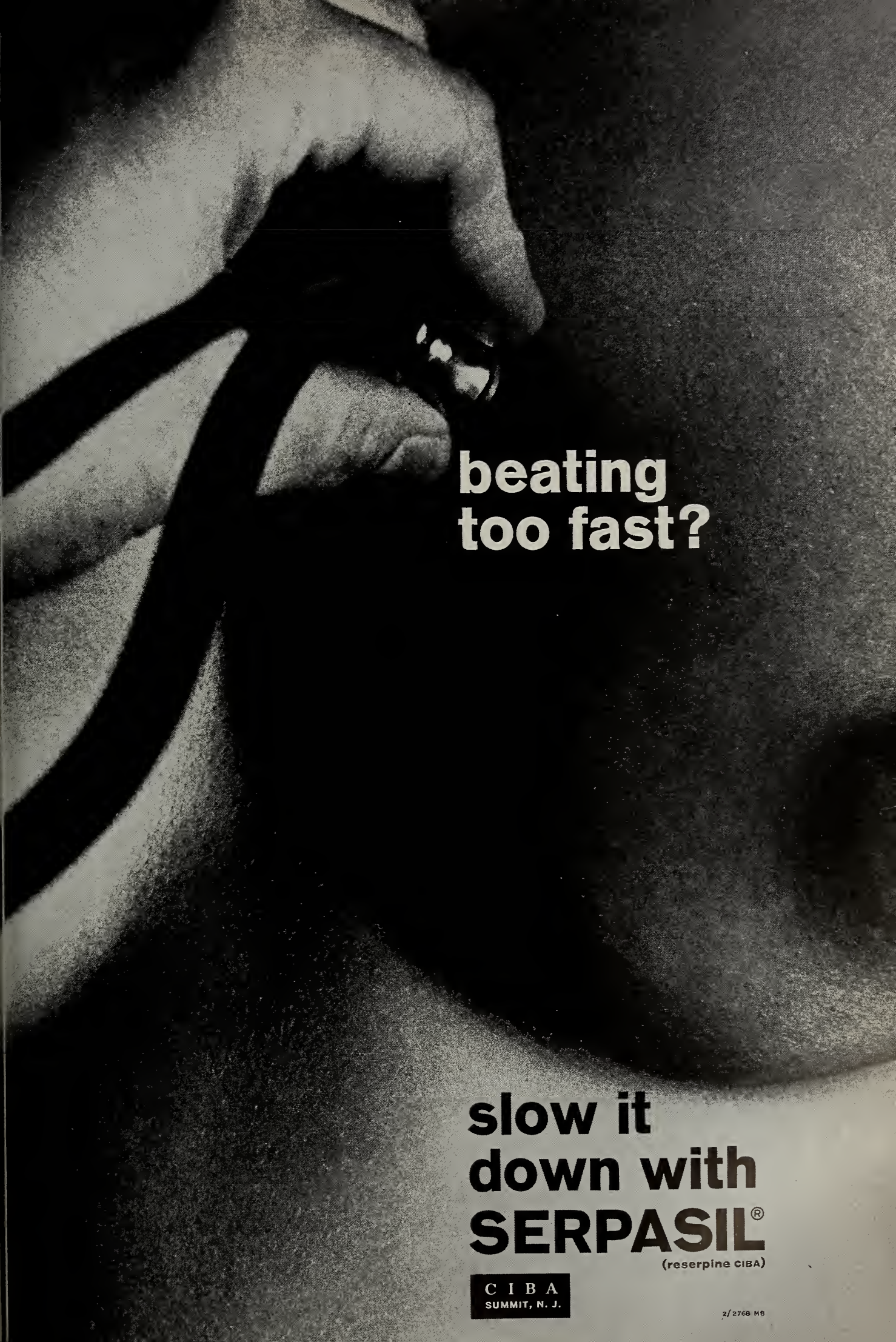
Operating

Maplecrest—

Restful, congenial homelike surroundings are combined with the most modern diagnostic and therapeutic equipment.

Maplewood—

Most comfortable home for individuals requiring rest, scientific diagnosis and treatment. Fireproof construction.


beating
too fast?
slow it
down with
SERPASIL®
(reserpine CIBA)
CIBA
SUMMIT, N. J.
2/2768 MB

Dr. Wood said that we have to formulate some way of raising funds to get this job done in the future. We have to follow up on all this from the commission level.

Dr. Wood stated that the matter of timing has to be just right on this.

Mr. Dalbec was asked to say a few words to the group concerning this problem.

Mr. Dalbec stated that he covers 12 states on this problem and that Indiana has been listed as a state which will work very hard on this problem.

Mr. Dalbec said that 12 Congressmen have introduced exactly the same kind of legislation as the Forand bill.

He added that we know this is going to happen within the next three or four months, although we do not know at this time just when it will be. "We think you should have resolutions just as soon as you can get them." Letter writing could take place at any time, he said. The campaign itself should wait until the time is ripe and as much notice as possible will be given on this, he concluded.

Dr. Portteus said that the auxiliary might be able to make a listing of all organizations in each county. He thinks we have to reduce the cost of this to every day living costs. He also thinks we should get to the individual physicians and let them know just what this would mean to them.

Mr. Tiernan stated they are quite conscious of this problem in his county. He said they have had this film on the Forand bill at one of their county meetings and also Mr. Dalbec has spoken to them. They are planning an active campaign on this, according to Mr. Tiernan.

Dr. Tindall asked if the Forand bill will be referred again to a Reference Committee in Congress or does this same congress carry this same bill?

Dr. Tindall also wondered why we could not all write to the Reference Committee concerning this. Mr. Dalbec agreed this would be a good idea.

Mr. Dalbec mentioned that the original letter should be sent to your own Congressman, with copies being sent to the members of the Reference Committee.

Dr. Tindall thought a letter or resolution from a chamber of commerce would be more important than a garden club.

Dr. Lamey reported that he has been told that the Congressmen pay more attention to individual letters than they do to resolutions.

Dr. Senseny said he has asked patients what they know about the Forand bill. "When you first tell them about it, they think it sounds like a wonderful idea—then it has to be explained to them."

Dr. Senseny felt that a big problem is getting doctors to attend the county medical society meetings and to take an interest in this problem.

Dr. Bowen asked if we have other organizations doing this same sort of work to get resolutions?

Dr. Wood believed this is very important.

Dr. Wood would like to propose the following idea: On the state level, from this commission, that we invite all of the heads of these various organizations to a dinner on Jan. 11. Dr. Orr is to be here on Jan. 12. Does this commission feel that it would be a good idea to have this meeting, with Dr. Orr speaking to these organization heads? Dr. Wood felt that we can improve the relationship between these different groups and we can also get the idea across concerning this problem.

Dr. Weber thought it would be a good idea.

Dr. Black also thought it would be an excellent idea; however, he said he believes there is the time issue of getting ready for this dinner. Dr. Black definitely thinks the American public needs to be made aware of this problem.

Dr. Maris feels that money spent on public relations would be profitable.

Dr. Weber asked if these district meetings to which they referred earlier are going to be arranged, or is that going to be up to the individual commission member to plan these district meetings.

Dr. Wood said that the commission members should see that all counties in their district have their meeting—then they in turn arrange a meeting to be held with heads of other groups.

COOK COUNTY GRADUATE SCHOOL OF MEDICINE

INTENSIVE POSTGRADUATE COURSES
STARTING DATES—SPRING-SUMMER, 1960

General Practice Review, Two Weeks, July 11
Surgical Technic, Two Weeks, May 16, June 6
Basic Electrocardiography, Two Weeks, May 16
Advanced Electrocardiography, One Week, June 20
Surgery of Colon and Rectum, One Week, June 20
General Surgery, One Week, May 23
Gallbladder Surgery, Three Days, June 20
Surgery of Hernia, Three Days, June 23
Board of Surgery Review, Part II, Two Weeks, August 8
Gynecology, Office and Operative, Two Weeks, June 20
Obstetrics, General and Surgical, Two Weeks, May 16
Diseases of the Chest, One Week, May 23
Breast and Thyroid Surgery, One Week, May 23

Numerous other courses will be offered by the Divisions of Internal Medicine, Surgery, Gynecology, Obstetrics, Urology, Radiology and Dermatology.
Circulars available upon request.

TEACHING FACULTY—ATTENDING STAFF OF COOK COUNTY HOSPITAL

Address: Registrar, 707 South Wood Street, Chicago 12, Illinois

Dr. Kerr stated that it looks to him like we are going to have to get something more than what it is going to cost tax wise.

Mr. Waggener said this commission should make a good start on laying out a program for fighting this.

Mr. Waggener reviewed the census regarding citizens of Indiana, age 65 and over.

Dr. Senseny said he would like to have a copy of the figures which were read by Mr. Waggener.

Mr. Dalbec agreed they have one basic argument. Should this bill pass, the doctor would get paid for taking care of the older group—if they wanted to be selfish, they would be for it.

Mr. Dalbec also told the group that the AMA offers someone to help them set up their district meetings. They will also have some help for the woman's auxiliary.

Dr. Wood said that the commission members will be responsible for seeing that this film on the Forand bill has been shown to the doctors in their district—also that the doctors have been told and have been informed concerning this, and that the legislative chairman in each county society will make his effort towards arranging for meeting with these various groups—be sure to see that they get their resolutions and send them in.

The woman's auxiliary will help in the same way.

Dr. Wood stated that if any of the commission members need help along this line, to please get in touch with the state office. If we can't do this from the state office, we shall get help from the AMA.

Dr. Weber asked if this film on the Forand bill is shown to the lay groups?

Dr. Wood said no it is not.

Dr. Wood said we must decide on the Jan. 11 dinner.

Dr. Lamey moved we try the dinner on Jan. 11; Dr. Weber seconded the motion; motion carried.

Dr. Wood suggested that each in their own county will know people who would have a special interest in this and people who should be invited. Those people who are invited over the state, if they happen to fall in a county of the particular commission member, should make arrangements to see that they get here to the dinner. When tickets are sent out, they will be assigned a table and commission members will be seated at certain tables.

The business of collecting funds was mentioned by Dr. Wood.

Dr. Wood asked if the commission would like to recommend to the Council for their consideration the possibility of establishing a second organization—let's call it Indiana Health Foundation—it would be separate from the Indiana State Medical Association but actually a political action committee.

Dr. Bowen said that it seems to him that in an organization like this, you would be running into much difficulty.

Mr. Hollowell made a few remarks concerning this.

This matter was discussed at length.

Dr. Kerr moved this problem be referred to the Council. Dr. Portteus seconded the motion; motion carried.

Dr. Wood reported that the Executive Committee would like for this group to implement the impartial board. "We asked the county societies in the northern area to submit a list of names in all categories and see if they would be willing to serve."

Mr. Hollowell said a few words concerning this.

Dr. Lamey moved we favor this plan to go to the Executive Committee or the Council for action and approval on the local basis. (This motion was withdrawn).

Dr. Lamey moved that the commission on legislation go on record as cooperating with the Federal judges and go on record as favoring this suggestion and that it be referred to the Council for proper action. Dr. Kerr seconded the motion: motion carried.

Dr. Wood stated that he would get information on this to Dr. Bowen for presentation to the Council.

Dr. Weber moved that the plan that we set up in working out the Forand bill be adopted. Dr. Kerr seconded the motion; motion carried.

Dr. Wood read Resolution No. 4. Dr. Wood believes that all we need to do is appoint a committee of this commission to study the present law and see what is needed to change this law so that all coroners will be M.D.'s. The committee is to report back to the next commission meeting.

We shall ask Mr. Hollowell to draw up a proposed bill. Dr. Wood will help him with it so far as policy is concerned. This will be for presentation to the next meeting of this group.



IT ALL ADDS UP!

+ Friendly and well trained personnel

+ 33 Modern Laboratories

+ Blue Ribbon ℞ Service

+ Finest optical supplies

+ Guaranteed satisfaction

It's easy to do business with White-Haines

The WHITE-HAINES OPTICAL COMPANY

Blue Ribbon Rx Quality for Over Half a Century

INDIANAPOLIS, SOUTH BEND and TERRE HAUTE

GENERAL OFFICES: COLUMBUS 16, OHIO

Dr. Black moved that we ask Mr. Hollowell to draw up a proposed bill concerning this resolution for presentation to the next meeting of this group with help, so far as policy is concerned, from Dr. Wood. Dr. Maris seconded the motion; motion carried.

Dr. Wood read Resolution No. 8.

Dr. Black moved that we ask Mr. Hollowell to draw up a proposed bill concerning this resolution for presentation to the next meeting of this group with help, so far as policy is concerned, from Dr. Wood. Dr. Maris seconded the motion; motion carried.

Dr. Wood referred to Resolution B concerning the Forand bill.

The meeting adjourned at 4:15 p.m.

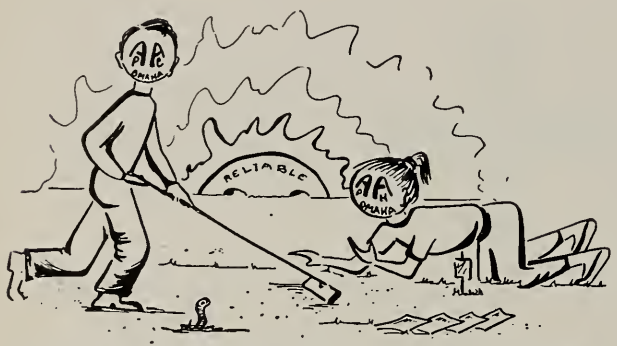
Medical Economics and Insurance

January 10, 1960

The Commission on Medical Economics and Insurance met at the Indiana University Student Union Building, Indianapolis, at 1:00 p.m. (CDT), Sunday, Jan. 10, 1960. Luncheon was served at 1:00 p.m., and the meeting followed.

Those doctors present were: J. L. Arbogast, John W. Beeler, Robert N. Bills, E. T. Edwards, William H. Garner Jr., R. P. Good, Albert T. Jones, William D. Scharbrough, Morris D. Wertenberger and Lowell I. Thomas.

John B. Twyman, executive secretary of the Lake County Medical Society, also attended.



PROTECTION AGAINST LOSS OF INCOME FROM ACCIDENT & SICKNESS AS WELL AS HOSPITAL EXPENSE BENEFITS FOR YOU AND ALL YOUR ELIGIBLE DEPENDENTS

ALL PREMIUMS COME FROM

PHYSICIANS SURGEONS DENTISTS

ALL BENEFITS GO TO

PHYSICIANS CASUALTY & HEALTH ASSOCIATIONS

OMAHA 31, NEBRASKA

Since 1902

Handsome Professional Appointment Book Sent to you FREE upon request.

Those commission members absent were, Drs. John L. Langohr, Wendell C. Stover, Hubert T. Goodman, Murray E. Harden and George E. Paine.

In the absence of the chairman, Dr. John Langohr, the meeting was called to order by the vice-chairman, Dr. E. T. Edwards, at 2:05 p.m.

The minutes of the meeting of Nov. 8, 1959, were read by the secretary and approved by the commission.

Dr. Edwards asked that No. 7 of the minutes of the Oct. 9, 1959 meeting be supplemented by the following to be inserted after, "The coal miners are different": "Discussions with the U. M. W. area medical director have the advantage of doctors talking to doctors, in contrast to laymen composing union liaison committees. Even so, there are many times when such discussions end unfavorably."

Dr. Arbogast moved the inclusion of this supplement to the Oct. 9, 1959 minutes. Dr. Wertenberger seconded, and the motion carried.

The secretary read a letter addressed to Dr. John Langohr from Dr. George Paine, relating to No. 7 of the Oct. 9, 1959 minutes and registering his "opposition to the decision of our committee opposing a liaison committee with labor."

No action was taken. Dr. Paine's letter is in the secretary's file.

Dr. Edwards reported on his meeting with the Council that morning at which there was discussion of: (1) relative value study, (2) Blue Shield riders for combined care and (3) medical care for welfare patients in the various counties.

Relating to (1) it was suggested that we commission members explain the pro's and con's of relative value schedules in our own districts, at county or district meetings, verbally, without extensive printing and mailing expense.

Relating to (2) we were advised there is a Blue Shield meeting Jan. 17, 1960, at which time riders for combined care, and changes in Blue Shield forms for dividing fees will be discussed.

Relating to (3) the Council wants more time for consideration of this subject and to learn what Blue Shield wants to do in regard to a welfare program.

Dr. Jones moved that the subject of the state association advocating any welfare medical program, through Blue Cross-Blue Shield be referred to the commission on Governmental Medical Services Meeting Wednesday, Jan. 13, 1960. Motion seconded by Dr. Wartenberger, and passed.

Dr. Beeler presented for our consideration a Blue Shield endorsement which has been prepared by Blue Shield actuaries in response to the request for in-hospital medical service for surgical patients by a physician other than the operating surgeon. (A copy of this endorsement accompanies these minutes.)

After some discussion, Dr. Arbogast moved that we approve having Blue Shield offer this endorsement. Dr. Beeler seconded the motion, and it was carried.

Dr. Beeler discussed the matter of a schedule of fees for the surgical assistant. Blue Shield does not want to be the agency to determine such an indemnity

schedule. They want this commission or the Council to give them help in determining an indemnity schedule acceptable for the whole state. It was pointed out that indemnities will have to be uniform for all counties throughout the state, and at present, there is considerable variation from one community to another insofar as surgical assistant's fees are concerned.

Dr. Arbogast moved that this matter of assistant's indemnity schedule be referred by Blue Shield to the Surgical Section of the Indiana State Medical Association and/or to the Indiana Section of the American College of Surgeons for them to formulate a state-wide acceptable plan; that this Commission would be agreeable to some feasible plan formulated by the surgeons.

Dr. Garner seconded the motion.

In discussion, Dr. Edwards advocated that the assistant surgeon's indemnity be less than that for the anesthetist.

Dr. Thomas suggested that indemnities for assistants be set at minimum levels to avoid the tendency to increase surgical costs.

Dr. Arbogast's motion carried.

Dr. Beeler, discussing the transfer of x-ray and laboratory fees from Blue Cross to Blue Shield, reported that hospital administrators feel the transfer would be costly, difficult, and expensive to patients, and they favor the status quo. (Refer to a letter from Jack Hahn, superintendent of Methodist Hospital, Indianapolis.) Blue Cross is full pay. Blue Shield indemnities are partial pay and the patients would suffer loss.

Dr. Arbogast moved we accept Dr. Beeler's report. Motion was seconded and passed.

Dr. Jones discussed relative value schedules. He favors discussion before all county medical societies. The Indianapolis district meeting report should be sent to the counties and discussed there. He pointed out that Indiana has voted against a fixed fee schedule, and a relative value schedule, he feels, is a fee scale. The state association should not adopt a fixed value scale, he feels, because fees should be an individual thing.

As to Blue Shield benefiting from a relative value schedule, he points out that for years the Blue Shield claim forms have requested the information of what surgeon's fees are, as submitted on the Blue Shield blanks, and with this information they should be able to adjust their fees when necessary.

By consent, the next meeting of the commission was set for Sunday, Mar. 20, 1960, 1:00 p.m. (CDT), Student Union Building, Indianapolis.

The meeting adjourned at 4:10 p.m.

Blue Shield Endorsement for Special In-Hospital Medical (30 Day)

It is agreed that in addition to all other indemnities and benefits provided in the Blue Shield Certificate of Membership, Blue Shield will provide payment for medical service in the hospital for medical care of surgical patients by a physician other than the operating surgeon as follows:

After one full day of confinement or at least 18 consecutive hours as a bed patient in a hospital under the advice of a physician, up to $3.00 for each day on which one or more physicians make one or more calls, but for not more than a total of thirty (30) days for each hospital admission, providing that ninety (90) days must elapse between discharge and re-admission for the same condition following each thirty (30) days during each successive period of twelve (12) months beginning with the effective date of coverage for the member or any dependent.

In consideration of the payment of an additional Membership Fee, in accordance with the following, this Endorsement forms a part of the Blue Shield Certificate of Membership.

Single Certificate--$0.19 Family Certificate--$0.41

IN WITNESS WHEREOF:

Above for	$4.00	for	30 days—Single	$.25	Family	$.55
Above for	5.00	for	30 days—Single	.31	Family	.69
Above for	3.00	for	120 days—Single	.24	Family	.51
Above for	4.00	for	120 days—Single	.30	Family	.65
Above for	5.00	for	120 days—Single	.36	Family	.79

◄

Association News

Executive Committee

February 17, 1960

Roll call showed the following present: Don E. Wood, M.D., chairman; Wendell E. Covalt, M.D.; Earl W. Mericle, M.D.; Maurice E. Glock, M.D.; Okla W. Sicks, M.D.

Frank B. Ramsey, M.D., editor of *The Journal*; Robert Hollowell, attorney, and James A. Waggener, executive secretary.

Guests: Mrs. J. M. Black, president, and Mrs. E. L. Rigley, president-elect, Woman's Auxiliary to the Indiana State Medical Association; J. M. Black, M.D., Council Liaison Committee, Medical School; J. E. Pilcher, M.D.; John W. Beeler, M.D.; Jack Hendricks, M.D.; Verne K. Harvey, Jr., M.D.

Mrs. J. M. Black, president, and Mrs. E. L. Rigley, president-elect of the Woman's Auxiliary, appeared before the Executive Committee and reported on the program of the State Auxiliary and their efforts on nursing scholarships, educational programs on legislation, and the expenditure of the funds provided by the association during the past year. They reported that $100.00 was used for membership work, $500.00 for their annual convention and $400.00 for the October meeting. Mrs. Black also mentioned the health citation award and that they would have the names of the

Lifts depression...



You see an improvement within a few days
Thanks to your prompt treatment and the smooth action of Deprol, her depression is relieved and her anxiety and tension calmed – *often in two or three days.* She eats well, sleeps well and soon returns to her normal activities.

as it calms anxiety!

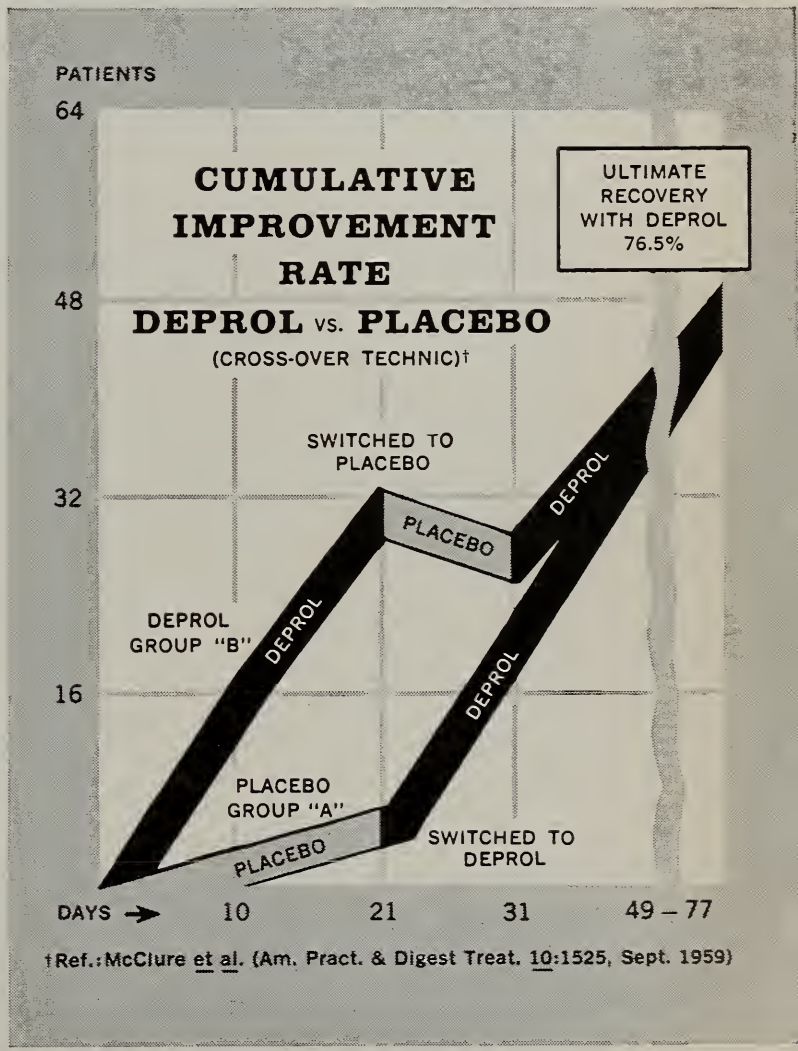
Smooth, balanced action lifts depression as it calms anxiety... rapidly and safely

Balances the mood – no "seesaw" effect of amphetamine-barbiturates and energizers. While amphetamines and energizers may stimulate the patient – *they often aggravate anxiety and tension.* And although amphetamine-barbiturate combinations may counteract excessive stimulation – *they often deepen depression.*

In contrast to such "seesaw" effects, Deprol lifts depression as it calms anxiety – both at the same time.

Acts swiftly – the patient often feels better, sleeps better, within two or three days. Unlike the delayed action of most other antidepressant drugs, which may take two to six weeks to bring results, Deprol relieves the patient quickly – often within two or three days.

Acts safely – no danger of liver damage. Deprol does not produce liver damage, hypotension, psychotic reactions or changes in sexual function – frequently reported with other antidepressant drugs.



†Ref.: McClure et al. (Am. Pract. & Digest Treat. 10:1525, Sept. 1959)

BIBLIOGRAPHY *(11 clinical studies, 764 patients):*

1. Alexander, L. (35 patients): Chemotherapy of depression – Use of meprobamate combined with benactyzine (2-diethylaminoethyl benzilate) hydrochloride. J.A.M.A. 166:1019, March 1, 1958. **2.** Bateman, J. C. and Carlton, H. N. (50 patients): Meprobamate and benactyzine hydrochloride (Deprol) as adjunctive therapy for patients with advanced cancer. Antibiotic Med. & Clin. Therapy 6:648, Nov. 1959. **3.** Bell, J. L., Tauber, H., Santy, A. and Pulito, F. (77 patients): Treatment of depressive states in office practice. Dis. Nerv. System 20:263, June 1959. **4.** Breitner, C. (31 patients): On mental depressions. Dis. Nerv. System 20:142, (Section Two), May 1959. **5.** Landman, M. E. (50 patients): Choosing the right drug for the patient. Submitted for publication, 1960. **6.** McClure, C. W., Papas, P. N., Speare, G. S., Palmer, E., Slattery, J. J., Konefal, S. H., Henken, B. S., Wood, C. A. and Ceresia, G. B. (128 patients): Treatment of depression–New technics and therapy. Am. Pract. & Digest Treat. 10:1525, Sept. 1959. **7.** Pennington, V. M. (135 patients): Meprobamate-benactyzine (Deprol) in the treatment of chronic brain syndrome, schizophrenia and senility. J. Am. Geriatrics Soc. 7:656, Aug. 1959. **8.** Rickels, K. and Ewing, J. H. (35 patients): Deprol in depressive conditions. Dis. Nerv. System 20:364, (Section One), Aug. 1959. **9.** Ruchwarger, A. (87 patients): Use of Deprol (meprobamate combined with benactyzine hydrochloride) in the office treatment of depression. M. Ann. District of Columbia 28:438, Aug. 1959. **10.** Settel, E. (52 patients): Treatment of depression in the elderly with a meprobamate-benactyzine hydrochloride combination (Deprol). Antibiotic Med. & Clin. Therapy 7:28, Jan. 1960. **11.** Splitter, S. R. (84 patients): The care of the anxious and the depressed. Submitted for publication, 1959.

Dosage: Usual starting dose is 1 tablet q.i.d. When necessary, this may be gradually increased up to 3 tablets q.i.d.

Composition: 1 mg. 2-diethylaminoethyl benzilate hydrochloride (benactyzine HCl) and 400 mg. meprobamate.

Supplied: Bottles of 50 light-pink, scored tablets. Write for literature and samples.

Deprol®

WALLACE LABORATORIES / *New Brunswick, N. J.*

CD-1519

candidates for this for review by the Executive Committee at their next meeting.

Upon motion of Drs. Mericle and Glock the Woman's Auxiliary was given $1,000.00 for their work during the current year.

Mrs. Black also commented that according to their constitution and bylaws they could not make changes without the approval of the Indiana State Medical Association, and they desired to amend their bylaws to provide for renaming of certain committees. This was approved upon motion of Dr. Glock and taken by consent.

State and County Health Officers

Dr. Verne K. Harvey, Jr., appeared before the committee, representing Dr. A. C. Offutt, and brought to the attention of the committee the State Board of Health's continued problems in obtaining physicians to serve as city and county health officers.

Treasurer's Office

The statement of income and budget balances, and the treasurers' report, were approved by consent.

Membership Report

Number of members as of January 31, 1959 2,375

1960 members as of January 31, 1960:

Full dues paying	1,924
Interns	7
Residents	99
Council remitted	23
Senior	241
Military	31

Total 1960 members as of January 31, 1960 2,325

Loss over last year 50

Number of members December 31, 1959 4,256

Number of AMA members as of January 31, 1959 1,611

1960 AMA members: Dues paying 1,886

Exempt, but active 535

Total 1960 AMA members as of January 31, 1960 2,421

Gain over last year 810

Number of AMA members as of December 31, 1959 4,120

Number who have paid state dues but not AMA dues in 1960 62

As instructed at the Jan. 9, 1960 Executive Committee meeting, the secretary presented several types of membership cards for senior members, and upon motion of Drs. Glock and Mericle the committee approved a plastic card and directed that the card be issued with the notation, "Senior Member," on it.

Headquarters Office

Science Fair appropriation. The secretary presented the action of the Council in which $5,000.00 was appropriated for the National Science Fair to be held in Indianapolis, and asked for authority to write this check. The above amount was ordered paid upon motion of Drs. Mericle and Sicks.

Dr. Mericle reported on the activities of the Executive Committee of the National Science Fair in planning for the National Science Fair to be held in Indianapolis in May, 1960.

Insurance report forms. The secretary reported that the printer was receiving many orders for the standardized insurance reporting forms.

Spring Council meeting. The secretary discussed the action of the Council concerning holding the April Council meeting at the AMA headquarters in Chicago, with two possible dates, April 10 and April 24, being selected. He reported that it is difficult to arrange for the AMA facilities on a Sunday and that the AMA officials feel that should the Council meet in Chicago ample time should be allowed for the members of the Council to meet with the various department heads of the AMA. By consent it was agreed that the Council would meet on Sunday, April 10, 1960 at the I. U. Medical Center, Indianapolis, and that the councilors be so notified.

Medicare Contract. Revisions in the Medicare contract were presented. Mr. Hollowell stated he had reviewed these revisions and had found them in order. Upon motion of Drs. Glock and Sicks, the president was authorized to sign the contract.

Legislation

National

House Resolutions 10 and 4700 were discussed by Dr. Wood.

The secretary presented the matter of the annual Washington meeting with the Indiana delegation during the United States Chamber of Commerce meeting to be held May 2-4. It was recalled that previous action asked the Indiana delegation to stay longer in order to serve as delegates for the United States Chamber of Commerce meeting. The secretary pointed out that in past years the Indiana dinner had been given on Monday night, which would be May 2, and also that the majority of the Indiana delegation will be in Indiana at that time inasmuch as the primary election will be on May 3. He read a letter from Mace Broide, administrative assistant to Senator Hartke, in which he stated that the majority of the delegation will be back in Washington by May 4.

By consent it was agreed that the Indiana dinner be held on Wednesday night, May 4, rather than on Monday, May 2.

The chairman read a letter which he had received from Congressman Joseph W. Barr on the Forand bill.

Organization Matters

The attorney discussed the Attorney General's opinion on nurses administering anesthetics as well as the discussion within the radiological group in the State of Indiana concerning the practices of radiologists and the transfer of professional services from Blue Cross to Blue Shield as authorized by the last House of Delegates meeting.

Internal Revenue Service—Regulations on Lobbying. The attorney also discussed the ruling of the Internal Revenue Service regarding expenditures of funds for lobbying activities and the activities of the United States Chamber of Commerce in this field.

A letter from Dr. Richard Swan, president of the Madison County Medical Society, was read.

The secretary presented a statement received from the American Medical Association entitled, "Guide for Industrial Immunization Programs," which had been prepared by the AMA Council on Industrial Health and approved by the board of Trustees of the AMA. It was asked whether or not this statement is to be considered as a policy as far as the Indiana State Medical Association is concerned. Upon motion of Drs. Mericle and Glock copies of this statement are to be sent to the members of the Council and this item is to be placed on the Council agenda for discussion at the April meeting. At the same time this matter is to be referred to the Commission on Public Health with a request that the Commission make a report of its recommendations regarding this statement at the April Council meeting.

The secretary read a motion prepared by the Commission on Voluntary Health Agencies directed to the Executive Committee. Upon motion of Drs. Covalt and Sicks this matter was tabled pending wording of the formal resolution which was proposed.

State Conference on Social Work membership in the amount of $15.00 was approved on motion of Drs. Covalt and Sicks.

A letter was read from Mrs. F. A. Sawyer stating that her father, a Fifty-Year Club member, had passed away and his Fifty-Year Club pin was buried with the body. Mrs. Sawyer requested another pin. Upon motion of Drs. Mericle and Sicks, it was voted that the Association should send Mrs. Sawyer a pin as a gift.

New Business

Attention was called to the article appearing in *The Indianapolis Star* concerning the action of the ophthalmologists of Indianapolis in banding together to keep the practice of Dr. Joseph B. Quigley going during his recuperation from his automobile accident. Upon motion of Drs. Mericle and Covalt a suitable citation is to be prepared for the ophthalmology group and this matter also is to be called to the attention of other physicians in the News Flash.

The Journal

The secretary brought up the question of increases in printing costs during the past two years and discussed the transaction he had had with the State Journal Advertising Bureau, which has proposed an increase in advertising rates for all members of the State Journal Advertising Bureau. The increase proposed by the State Journal Advertising Bureau was approved upon motion of Drs. Covalt and Sicks.

Future Meetings

The secretary reported that the Commission on Public Health had voted to request permission for Dr. E. S. Rifner to attend the AMA's National Rural Health Conference at Grand Rapids, Michigan, Feb. 25-27, 1960. Doctor Rifner's attendance was approved on motion of Drs. Glock and Covalt.

The secretary called attention to the annual meeting of the Indiana Academy of General Practice, which is to be held in Fort Wayne on Feb. 23-25, and the Indiana State Chamber of Commerce Aircade, to be held in Indianapolis Feb. 19.

The secretary asked who planned to attend the AMA's annual session in Miami the week of June 12, 1960, and who would need housing.

There being no further business the meeting was adjourned. The Executive Committee will meet again at 3 p.m., Wednesday, March 16, 1960 at the I. U. Student Union Building, Indianapolis. ◄

NEW MEDICAL SCHOOL FACILITIES

Indiana University recently dedicated its Medical Science Building, a major step in improvement of medical education. Despite these increased facilities and partly due to the depreciating dollar, the medical schools need your financial support. Please help the school of your choice through American Medical Education Foundation.

"Only when people make some kind of financial sacrifice for their schools do they take an active and wholesome interest in education."

Mail your AMEF Contribution to

AMEF—Indiana State Medical Association

1021 Hume Mansur Bldg.

Indianapolis, Ind.



The Journal of the INDIANA STATE MEDICAL ASSOCIATION

May 1960

Office of Publication:
1019 Hume Mansur Building, Indianapolis, Indiana

$1.00 per copy
except Yearbook
$5.00 per year

Contents

SPECIAL FEATURES

Duties of the Medical Expert in Court, James V. Donadio, LL.B., Indianapolis 851
AMA 109th Annual Meeting: Forum by 2,000 Medical Men 861
AMA Scientific Symposium 855

EDITORIALS

Practical Politics and Doctors 858
Growth, Sales and Profits in Drug Industry 859
From AMA: The Needy and the Near-Needy Physician 859

REGULAR FEATURES

Month in Washington 816
Fourth Estate (A special feature on the Forand bill) 824
Blue Shield: Continued Expansion (one of a series) 832
Wanted: Physicians, Locations 834
President's Page 863
The Woman's Auxiliary 1046
About Our Cover 1048
Medical Panorama—Needed: A Pharsighted Pharoah 1050
Indiana State Board of Health Monthly Report 1051
News Notes
Indiana Physician Named National Blue Shield Officer 1052
Indiana Grad Chosen Markel Scholar 1052
Camp Jim Riley Opens for the Handicapped 1053
Hoosier Heads Radium Group 1053
AEC to Study Pacific Waste Disposal Sites 1054
AMA Meeting Golfers Will Stage Tourney 1056
Polyunsaturated Fatty Acids Can Reduce Cholesterol 1057
OB-Gyn Board Exams Open 1058
I.U. School of Medicine Ranks Fifth 1058
Add 1 by corki 1059
Deaths 1065
District, County Society News 1065
Chinese Ambassador to Speak Before First District Members 1065
Lighter Vein 1069
AMEF 1070

YEARBOOK SECTION

Membership Roster:
Alphabetically 869
By County 901
Woman's Auxiliary, Officers, Chairmen 937
Table of Contents to Special Yearbook Section 963

BUSINESS

Association News: Executive Committee, March 10, 1960 1068

EDITORIAL AND ADVERTISING INFORMATION

All articles must be typewritten, double-spaced with margins of one inch.

Photographs should be printed on glossy paper. Negatives cannot be used.

Illustrations are desirable. Selection of illustrations submitted at discretion of editor and editorial board members. Cost of color illustrations must be shared by the author.

Contributors are responsible for all statements made in their articles. The editors and editorial board members may not be in agreement with all views expressed by authors, but it is desired to give all authors as great latitude as possible. However, the right is reserved to reduce in length or reject any article.

Articles are accepted for publication with the understanding that they are submitted for exclusive publication in THE JOURNAL of the Indiana State Medical Association.

Communications dealing with editorial matter should be sent to Frank B. Ramsey, M.D., Editor, 1802 North Illinois Street, Indianapolis 2, Indiana. All other communications should be sent to THE JOURNAL of the Indiana State Medical Association, 1019 Hume Mansur Building, Indianapolis 4, Indiana.

Advertising rates will be furnished on request. Copy must be received by the 5th of the month preceding month of issue. (Scientific manuscripts must be received at least two weeks earlier if geared for a specific issue.)

Entered as second class matter January 25, 1933, at the Postoffice at Indianapolis, Indiana. Copyright, 1960, by the Indiana State Medical Association. Published monthly at 1019 Hume Mansur Bldg., Indianapolis 4, Indiana.



ALPEN is the oral penicillin that provides on a fasting stomach peak antibiotic blood levels approximately twice as high as oral potassium penicillin V... and significantly higher than I. M. penicillin G.

Some strains of staphylococci resistant to other penicillins exhibit in vitro sensitivity to potassium phenethicillin.

ALPEN has greater freedom from the G. I. sequelae (overgrowth of resistant flora) sometimes observed with broad spectrum -mycins.

ALPEN gives much higher antibiotic levels within the first hour of ingestion by the well-tolerated oral route.

WHEN TO USE ALPEN Recommended in the treatment of infections caused by pneumococci, streptococci, gonococci, corynebacteria, and penicillin-sensitive staphylococci.

HOW TO USE ALPEN Depending on the severity of the infection, 125 mg. (200,000 units) or 250 mg. (400,000 units) three times daily may be used. In more severe or stubborn infections, a dosage of 500 mg. (800,000 units) t.i.d. may be employed. In beta hemolytic streptococcal infections, treatment should be continued for at least ten days.

PRECAUTIONS The usual precautions in the administration of oral penicillin should be observed. For further details see package literature.

Tablets: 125 mg. and 250 mg., bottles of 25 and 100. Powder for Oral Solution (lemon-lime flavored), 1.5 Gm. bottle (125 mg. per 5 cc. teaspoonful).

this is the tablet that gives higher peak antibiotic blood levels

HIGHER THAN I. M. PENICILLIN G
HIGHER THAN POTASSIUM PENICILLIN V

ALPEN

ALPEN™—potassium phenethicillin

Schering



MONTH IN WASHINGTON

This summary of what is happening in Washington is prepared by A.M.A.'s Capital office and airmailed to *The Journal* on the ninth of each month preceding month of issue.

Washington, D. C.-Defeat of the Forand bill in the House Ways and Means Committee highlighted developments on the issue of legislation to provide more Federal health care for the aged.

The committee voted 17 to 8 on March 31 to shelve the Forand bill which would increase Social Security taxes to provide surgical benefits and limited hospitalization and nursing home care for Social Security beneficiaries, except the disabled.

However, the issue remained very much alive.

The Eisenhower administration and congressmen were separately considering various alternative proposals to provide additional health care for the aged, but outside the Social Security system. And the action of the House committee did not rule out the possibility of Forand-type legislation being brought up in the Senate later this session.

The House committee vote against the Forand bill came during the drafting of an omnibus measure of revisions in the Social Security program. The committee voted tentatively to bring physicians under Social Security.

The committee also favored elimination of the requirement that a disabled person must be 50 years or older to be eligible for Social Security payments.

Arthur S. Flemming, Secretary of Health, Education and Welfare, said the Administration was considering a plan for Federal payments to the states to help needy old persons buy private health insurance on a voluntary basis. He said he hoped the plan would be ready for submission to Congress by late April.

REPUBLICANS INTRODUCE LEGISLATION

Sen. Jacob K. Javits (R., N. Y.) and seven other Republican senators introduced similar legislation in the Senate. The bill called for the Federal government and states jointly putting up about $1 billion a year to help persons 65 years and older, and their spouses, to buy

Continued on page 820

acceptance...



Neo-Aristoderm*

Triamcinolone Acetonide-Neomycin LEDERLE

FOAM



several factors indicate NEO-ARISTODERM Foam for topical treatment of dermatoses:

(1) The Active Ingredients
Triamcinolone Acetonide — with therapeutic efficacy equal to or greater than that of topical hydrocortisone — in one-tenth the concentration;[1,2] plus neomycin—a leading topical antimicrobial agent.

(2) The Vehicle
NEO-ARISTODERM Foam spreads readily without irritation or burning. It can be applied to oozing, crusted, severely inflamed and injured skin, or to mucous membranes. There have been no reactions of primary irritation or allergic sensitization to date.

(3) Patient Acceptance
NEO-ARISTODERM Foam *is neat—not messy or sticky*. Patients like the attractive push-button dispenser and the richness of the foam. This helps to assure faithful adherence to your instructions.

Triamcinolone Acetonide 0.1%, Neomycin Sulfate 0.35% 15 cc. Push-button dispenser

References: 1. Kanof, N. B., and Blau, S.: *New York J. Med.* 59:2184 (June 1) 1959.
2. Smith, J. G., Jr.; Zawisza, R. J., and Blank, H.: *A.M.A. Arch. Dermat.* 78:643 (Nov.) 1958.

Lederle LEDERLE LABORATORIES, A Division of AMERICAN CYANAMID COMPANY, Pearl River, New York

*TRADEMARK

Continued from page 816

private health insurance. The coverage would include physicians' care in home and office, diagnostic services, hospitalization and nursing home care.

Another plan being considered by some other members of Congress would broaden the Federal-state public assistance program to provide more health care for needy older persons.

Both President Eisenhower and Vice President Nixon reiterated their opposition to any compulsory health plan such as the Forand bill. The President told a news conference that such plans would be a definite step toward socialized medicine. He proposed that medical care for the aged be improved through further development of voluntary health insurance programs.

Vice President Nixon gave his position in a letter to physicians who had communicated with him about the matter.

"The Vice President, throughout his career as a public official, has consistently opposed and will continue to oppose any compulsory health insurance program," the letter said. "This, of course, includes the Forand bill...."

"He believes that the best way to handle the problem of people over 65 who do not have and cannot afford health insurance is through a program which will enable those who desire to do so to purchase health insurance on a voluntary basis."

DEMOCRATS BACK FORAND-TYPE BILLS

On the other side, three candidates for the Democratic nomination for President--Sens. John F. Kennedy (Mass.), Hubert H. Humphrey (Minn.) and Stuart Symington (Mo.)--said they would push for passage of Forand-type legislation.

The AFL-CIO continued its all-out campaign in support of the Forand bill. Leaders of the labor union repeatedly attacked the American Medical Association for opposing the bill.

One of the attacks prompted Dr. Louis M. Orr, Fla., to protest in a letter to AFL-CIO President George Meany against the union's "deliberate distortions of the truth, perversions of the truth and outright untruths."

Dr. Orr charged that allegations in a political memorandum of the AFL-CIO's Committee on Political Education (COPE) "not only...attempt to impugn the motives and competence of the nation's physicians, but they seek to mislead labor's rank and file, the members of Congress and the American people as a whole."

"When the AMA opposes any legislative health measure, it does so because its members believe that it would lead to poorer—not better—health care for the people of this country," Dr. Orr said.

Senate Republican leader Everett M. Dirksen (Ill.) also defended the AMA as well as the Eisenhower Administration against the attacks when AFL-CIO leaders repeated them in testimony before the Senate Subcommittee on Problems of the Aged and Aging.

Continued



for the acute asthmatic attack elixir synophylate®

(Theophylline Sodium Glycinate)

RAPID ORAL CONTROL WITHOUT G.I. IRRITATION

ELIXIR SYNOPHYLATE relieves wheezing and dyspnea in 5 to 10 minutes after a single dose. Significant blood levels are achieved in 15 minutes, persisting for at least 4 hours.

Because of its built-in buffer, theophylline sodium glycinate [SYNOPHYLATE] is "tolerated in larger doses than are possible with other theophylline preparations,"[1] including aminophylline.[1-3]

the most potent theophylline elixir available... may avoid need for I.V. injection

1. A.M.A. Council on Drugs: New and Nonofficial Drugs 1959, Philadelphia, Lippincott, 1959, p. 389. 2. United States Dispensatory (Osol-Farrar), ed. 25, Philadelphia, Lippincott, 1955, p. 1412. 3. Grollman, A.: Pharmacology and Therapeutics, ed. 3, Philadelphia, Lea & Febiger, 1958, p. 208.

Each tablespoonful (15 ml.) contains 0.33 Gm. (5 gr.) equivalent to 0.16 Gm. (2½ gr.) Theophylline U.S.P. Supplied: Bottles of 1 pint and 1 gallon.

Literature on request.

...particularly useful for children

Products Born of Continuous Research

THE CENTRAL PHARMACAL COMPANY Seymour, Indiana

Continued

Sen. Dirksen denounced them as "gratuitous slurs," "stinking statements," "invidious...insane charges" which constituted "an absolute disservice to the country."

ASSERTS GREATEST PROBLEM IS "ISOLATION"

Dr. James A. Appel, Lancaster, Pa., a member of the AMA Board of Trustees, testified before the Senate Subcommittee that the greatest health problem faced by older people is "their isolation from the rest of society." He said:

"The health problems of the aged can only be solved within the context of total health. They involve far more than hospitals or a doctor's care. They involve the older person's other requirements in life, whether these be housing, recreation, community understanding and acceptance, the right to be useful, the courtesy of being treated as individuals, or the opportunity of living as self-reliant, respected members of society."

As for an aged person being denied medical care because of a lack of money, Dr. Appel said emphatically:

"Medical care is available to every man, woman and child in the United States regardless of his or her ability to pay for it.

"That care is not now denied, nor will it be denied." ◄

Tested... and proved...

ORAL therapy in diaper rash!



Convenient... simply open a capsule and add the contents to the baby's daily formula, or to fruit juice or water. No lotions... no rinses... no ointments... just oral therapy.

Send for samples and literature.

S. F. DURST & CO., INC.
Philadelphia 20, Pa.

Effective therapy! Thousands of pediatricians and general practitioners prescribe Pedameth for ammonia dermatitis—and they continue to prescribe it. Clinical tests have proved its effectiveness. Pedameth is safe because it contains only dl-methionine (0.2 Gm.) one of the essential amino acids. When Pedameth is administered, the pH of the urine is lowered and an as-yet-unknown antibacterial agent appears in the urine. Pedameth works . . . it's the safe, effective, convenient answer to ammoniacal diaper rash.

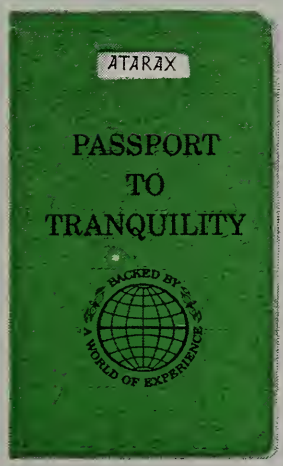
Prescribe

PEDAMETH®

(dl-methionine DURST)

A GUIDE TO

THE REALMS OF THERAPY BEST ATTAINED WITH



ATARAX®

(brand of hydroxyzine)

World-wide record of effectiveness—over 200 laboratory and clinical papers from 14 countries.
Widest latitude of safety and flexibility—no serious adverse clinical reaction ever documented.
Chemically distinct among tranquilizers—not a phenothiazine or a meprobamate.
Added frontiers of usefulness—antihistaminic; mildly antiarrhythmic; does not stimulate gastric secretion.

Special Advantages	Supportive Clinical Observation	...and for additional evidence
IN CHILDREN unusually safe; tasty syrup, 10 mg. tablet	"... Atarax appeared to reduce anxiety and restlessness, improve sleep patterns and make the child more amenable to the development of new patterns of behavior...." Freedman, A. M.: Pediat. Clin. North America **5**:573 (Aug.) 1958.	Bayart, J.: Acta paediat. belg. **10**:164, 1956. Ayd, F. J., Jr.: California Med. **87**:75 (Aug.) 1957. Nathan, L. A., and Andelman, M. B.: Illinois M. J. **112**:171 (Oct.) 1957.
IN ELDERLY PATIENTS well tolerated by debilitated patients	"... seems to be the agent of choice in patients suffering from removal disorientation, confusion, conversion hysteria and other psychoneurotic conditions occurring in old age." Smigel, J. O., et al.: J. Am. Geriatrics Soc. **7**:61 (Jan.) 1959.	Settel, E.: Am. Pract. & Digest Treat. **8**:1584 (Oct.) 1957. Negri, F.: Minerva med. **48**:607 (Feb. 21) 1957. Shalowitz, M.: Geriatrics **11**:312 (July) 1956.
IN ALLERGIC PATIENTS useful adjunctive therapy for asthma and dermatosis; particularly effective in urticaria	"All [asthmatic] patients reported greater calmness and were able to rest and sleep better ... and led a more normal life.... In chronic and acute urticaria, however, hydroxyzine was effective as the sole medicament." Santos, I. M., and Unger, L.: Presented at 14th Annual Congress, American College of Allergists, Atlantic City, New Jersey, April 23-25, 1958.	Eisenberg, B. C.: J.A.M.A. **169**:14 (Jan. 3) 1959. Coirault, R., et al.: Presse méd. **64**:2239 (Dec. 26) 1956. Robinson, H. M., Jr., et al.: South. M. J. **50**:1282 (Oct.) 1957.
IN HYPEREMOTIVE ADULTS does not impair mental acuity	"... especially well-suited for ambulatory neurotics who must work, drive a car, or operate machinery." Ayd, F. J., Jr.: New York J. Med. **57**:1742 (May 15) 1957.	Garber, R. C., Jr.: J. Florida M. A. **45**:549 (Nov.) 1958. Menger, H. C.: New York J. Med. **58**:1684 (May 15) 1958. Farah, L.: Internat. Rec. Med. **169**:379 (June) 1956.

SUPPLIED: Tablets, 10 mg., 25 mg., 100 mg.; bottles of 100. Syrup (10 mg. per tsp.), pint bottles. Parenteral Solution: 25 mg./cc. in 10 cc. multiple-dose vials; 50 mg./cc. in 2 cc. ampules.

ROERIG Rx

New York 17, N. Y.
Division, Chas. Pfizer & Co., Inc.
Science for the World's Well-Being



LOOKS AT MEDICINE

A special editorial page feature from the March 31 *Indianapolis News*, presenting various views on the Forand bill and/or old-age medical benefits, is reprinted *in toto* for the information of the medical profession. The *Journal* is indebted to *The News* for permission to reprint the full feature, and to *The Indianapolis Star* and Charles Werner for permission to reproduce the editorial cartoon.

'Should Government Give Medical Care to Aged?'

AS THE NEWS SEES IT

Contempt For The Aged

America's aged, between now and the adjournment of Congress, will have to line up patiently and take their medicine: repeated injections of vote-happy irresponsibility, administered by both political parties.

The Eisenhower administration has done well to reject the demagogic scheme of Representative Aime Forand, which would make the aged wards of the federal government. It is disturbing, however, to note that the administration now feels itself called on to muster up some kind of alternative plan, so that the Democrats will not have a monoply on tax-supported affections for old people.

Nothing could be more truly contemptuous of the elderly than this blatant admission that their medical problems are a pawn to be used for political advantage—and that their votes are up for grabs by whatever party can deliver the most handouts.

The vote-buying contest also is contemptuous of the American people as a whole. It presupposes that they are simpletons who cannot see what is happening to their money. Legislation of this sort simply takes from one group of taxpayers to give to another, and then—when the first group gets restive — reverses the process. Moreover, like all other federal aid proposals, it would take money from the states and—after standard deductions for overhead, red tape, and bungling—return it to them.

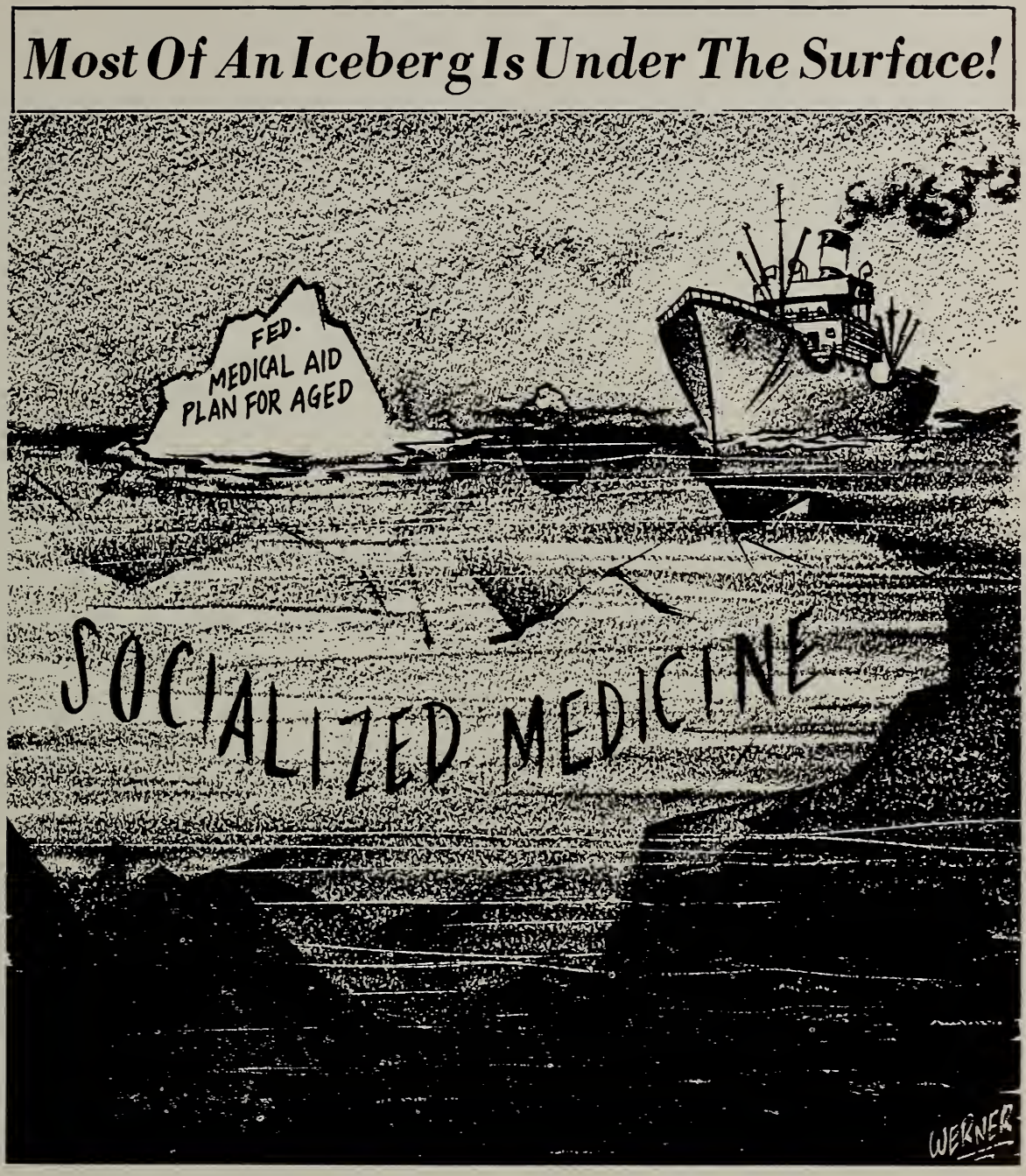
Apart from its fiscal trickery, the legislation is a needless imposition on the taxpayers. By the end 1960, 60% of Americans 65 and over who want health insurance coverage will have it, through participation in private programs. By 1970, an estimated 90% will have coverage. Obviously, the need for alternative sources of health insurance is diminishing rapidly, rather than increasing.

Finally, federal health legislation, however devised, seeks to put on a production-line basis one of the most delicate of professional relationships—that between doctor and patient.

As the English experiment has demonstrated, it would make participation in the program the criterion for treatment, rather than objective evidence of sickness. It would, in a word, substitute the judgment of bureaucrats for the judgment of physicians.

By every standard, the Forand concept is in error. The pending bill and all similar legislation must be defeated.

Continued



Reprinted from *The Indianapolis Star*, March 29, 1960.
Charles Werner, cartoonist.

FORAND BILL SUMMARY

Hospital, Nursing Home, Surgical Care Proposed

By Lou Hiner Jr.
The News Washington Bureau

The federal government has concerned itself over health problems since 1798 when Uncle Sam established a hospital for ailing seamen.

Since that time few issues have provoked as much controversy as the federal government's role in the health of its citizens.

Congress is now weighing the "pros" and "cons" of the so-called Forand bill (H.R. 4700) which would set up a federally-administrated program of health benefits for aged persons.

Following is a summary of the Forand bill:

Proposal—To amend the Social Security Act to provide "insurance" against the cost of hospital, nursing home and surgical services to all those eligible for old-age and survivors benefits.

Benefits—Each eligible person would be insured against the cost of hospital care, including room, drugs, medical care and appliances regularly furnished bed patients. Bills for attending doctor would not be paid. Surgical expenses would be covered.

Nursing home services would be covered if the patient is transferred to such a place from the hospital. The nursing home care could be extended so that up to 120 days of combined care would be permitted in a 12-month period but only 60 days could be hospital care.

Any individual could select the surgeon of his choice. The cost of oral surgery by a dentist in a hospital would be covered.

Administration—The program would be administered by the Department of Health, Education and Welfare. The OASI system would use its existing record-keeping setup to certify eligibility, to issue insurance cards, etc.

The HEW would draw up the regulations and establish an advisory council.

Exclusions—Persons eligible for permanent and disability benefits are not included. The proposal does not apply to costs incurred in federal hospitals, or in tuberculosis or mental institutions, or in other countries.

It will not cover all types of nursing home care or apply to institutions that provide primarily domiciliary care. It does not apply to workmen's compensation cases unless arrangements are made to reimburse the insurance program.

It does not include elective surgery.

Cost of proposed programs—Estimates range from $1,150,000,000 to $3 billion per year.

Financing—It is proposed to increase social security contribution rates of employers and employees by one-fourth each and of the self-employed by three-eighths. The maximum increase for the first group would be $12 a year and for the self-employed $18.

THE VIEW OF LABOR

Aged Recipients Should Not Be Labeled Paupers

By Dallas Sells
President, Indiana State AFL-CIO

The problem of the increasing numbers of our senior citizens over 65 can best be illustrated in the area of health care. Unfortunately, while 11 million persons, age 62 or over, are receiving social security benefits as a matter of right, the average primary benefit is now only $72 per month.

Leaders of opposition to provide health care benefits through social security talk glibly of the opportunities for free care open to the "medically indigent."

Labor feels that individuals should not be forced to become paupers in order to have their health needs met, as is the case with the present welfare standards.

According to the Department of Health, Education and Welfare, not more than two out of five senior citizens have no form of health insurance protection.

Because of the increasing costs of medical care, particularly at an age when individuals can least afford to pay, the AFL-CIO feels that the private plan should be supplemented through some measure similar to the present Forand proposal.

Important social effects would flow from the enactment of such a bill as H.R. 4700.

1. It would ease the financial problems of hospitals by providing payment for much of the care that now they must give to charity cases without charge or at rates far below cost. Even though public-welfare payments to hospitals

have been increased in many areas, they often do not cover actual expenses. Insofar as a hospital now transfers the cost of free care or partly-paid care to paying patients, its rates could correspondingly be reduced.

2. Blue Cross plans would be relieved of a high-cost load and therefore could hold down their rates and compete more effectively with commercial insurance plans. Far from damaging Blue Cross and Blue Shield, enactment of the Forand bill might prove their lifesaver.

3. Insofar as the proposal would make it unnecessary for individuals to turn to public assistance and private charity, it would relieve private welfare organizations and government agencies of a welfare load now financed by taxpayers or donations. Through substituting social insurance for public assistance, it would work in the direction preferred by the Congress.

4. The bill would accelerate action to increase the supply of medical personnel and facilities required to make good care available to everybody. With an assured market for skilled nursing care, for example, the supply of nursing homes would quickly increase.

5. The measure would force greater attention by the medical profession and the community to present lags in quality and kind of care. Commercial insurance plans are not concerned with quality. Today many people are victims of inadequate care which the insurance companies will pay for but which does not restore health or independence.

MAKE IT VOLUNTARY

HEW Chief Is Opposed To Compulsory Coverage

By Arthur Flemming
Secretary of Health, Education and Welfare

There is general agreement that a problem of medical care for the aged does exist.

We do not think that the Forand bill (H.R. 4700) provides a satisfactory solution to the problem.

In approaching this problem I feel that we should keep in mind the developments that have taken place on two fronts.

First of all, there are the very significant steps that the federal government has taken in recent years to help deal with the hazards of old age.

The number of persons who benefit from the Old Age, Survivors and Disability Insurance Program has increased very materially. At the same time there has been a marked increase in the payments to the beneficiaries. Payments under the old age assistance program, including medical services, have been liberalized.

In the second place there are the very significant advances that have been made in recent years in extending the benefits of health insurance to people 65 years of age and over.

We estimate that approximately 42% of the persons in this age group now have some protection against the cost of hospital care. While we do not have precise data, I think it is safe to say that approximately 6,500,000 aged persons currently have some health insurance. Contrast this figure with that for 1952 when it was estimated that only slightly more than 3 million aged persons had any coverage of this kind.

Insurance companies also have been working to make health insurance available to older people. There is considerable variation in what policies cover and in the benefits they provide. It is difficult to generalize on the protection offered to the aged under insurance company policies.

Enactment of H.R. 4700 would have far-reaching and irrevocable consequences. It would establish a course from which there would be no turning back. The opportunity for continued growth in coverage and adequacy of voluntary health insurance for the aged would be stifled before its full potential could be gauged.

In the light of all of the developments I have just identified I want to make it clear that, as an administration, we will oppose any program of compulsory health insurance.

We have been investigating the feasibility of a program that would help accelerate rather than impede the present voluntary approach to this problem. In these studies we have been keeping in mind the following guiding principles:

1. That there should be no compulsion on anyone to participate in any health insurance program.

2. That there should be no action by anyone that would tend to stifle private initiative in the health insurance field. Anything done in this area should build on—and not undermine or re-

place with a federal system—the excellent progress that is now being made by private effort.

3. That we should strive to strengthen and stimulate our existing private system so as to foster additional progress—both in terms of scope of protection and numbers of persons protected.

4. That we should preserve and strengthen the private relationships which now characterize the rendering of health care services.

5. That all aged persons should have the opportunity of particiating in any program that might be developed.

6. That there should be available to the aged —particularly in the low-income groups—protection against the severest burden of health care costs, namely, the financially catastrophic cost of institutional care in connection with long-term and other very expensive illnesses.

Before arriving at a final conclusion whether the federal government can devise within this framework of principles a practical program, it is going to be necessary for us to explore further some complex issues.

THEY PLAY ON COMPASSION

Bill's Supporters Seek To Hoodwink The Public

By E. W. Mericle, M.D.
President, Indiana State Medical Association

President Eisenhower and his administration adopted the wise course in turning thumbs down on the Forand proposal to provide surgical, hospital and nursing home care to recipients of social security.

The taxpayers of this nation have already had $2 million of their money spent to finance a White House Conference on the Problems of the Aged and Aging. This conference will be held in January of 1961. It seems a waste of tax funds for the present session of Congress to pre-empt this conference by attempting to decide on a solution when they are not sure of the problem.

Supporters of the bill have played on the normal American compassion for the aged in their political endeavors and they have grossly attempted to hoodwink the public by misrepresenting the facts.

1. For 120 days a year the Forand legislation purports to give "free" hospital, surgical, nursing home and dental benefits for social security recipients. The facts are:

(a) In that these benefits are for those 65 years and older—a group where extended hospital and nursing home care need is prevalent in illnesses—after 120 days the recipients must be returned to the community for care. Why not let the community include the 120 days also at much less cost to our citizens?

(b) Hospital care is provided ONLY for surgical benefits. Where nonsurgical illnesses exist, the local community facilities must be utilized. Only an approximate 33% are surgical in this group.

(c) Nursing home care is provided only on convalescence from surgical procedures and only in a home administered by a hospital or a medical doctor. There are only a few such nursing homes in the state of Indiana.

(d) It prohibits care for mental illnesses, tuberculosis and other chronic diseases. These, too, must be cared for by the local or state community.

(e) Only those eligible for social security in the over-65 age group are eligible for the benefits. This leaves approximately 25% of that group who are not eligible. Figures show that these 25% of the people are the most needy.

2. Proponents call this "free" medical insurance.

Yet social security taxes already are designed to reach 9% (4½% paid by employee, 4½% by employer) of gross pay of those making up to $4,800 by 1969. The Department of Welfare estimates the Forand bill will cost $1,121,000,000 in the first year. AMA estimates the first year's cost at between $2 billion and $2,387,000,000.

Just what is this "need" for the over-65, medically speaking? Is it large enough for such drastic measures with consequences as have been set out here?

In Indiana today the following situation exists:

Our estimated population of the group in question is 442,000. Of this group, according to

a survey made by the Indiana State Medical Association, the following facts have been tabulated:

112,000 Are veterans of military service.

105,000 Are protected by Blue Cross and Blue Shield.

128,331 Are protected by private insurance carriers.

110,510 Are drawing pensions or retirement from private sources.

364,191 Were drawing monthly social security benefits totaling $22,554,733 per month as of February 28, 1959.

30,875 is the average number receiving medical aid per month from the Indiana State Department of Public Welfare.

Of the total, 8,470 are in nursing homes. The following indicates their economic status:

4,870 Private plus organization.

2,132 Welfare.

854 Welfare plus social security.

614 Trustee plus other sources.

Many state and county leaders are working on community programs for taking care of the aged on a local level; some of which are in operation right here in Indiana and working. The White House Conference on the Problems of the Aged and Aging has been called to study these problems and prevent a headlong rush into carrying out of the plans of proponents of socialized government; but rather to find firm, intelligent, workable answers to the problem.

MATTER OF MONEY

Opponents Use Stall Tactics, Author Charges

By Rep. Aime J. Forand
Democrat of Rhode Island

As people grow old, they need more medical care but usually have less money to meet its rising cost. Most of them cannot get adequate protection through private insurance, and a severe disability may mean financial disaster.

Individual health insurance polices are expensive; they usually exclude a pre-existing condition; they may be refused or cancelled. Group insurance also is unavailable to most retired persons and aged widows since they have no employment connection such as normally is required.

Young widows and children similarly have low incomes and little opportunity to obtain private insurance.

Many hospitals have constant and serious financial difficulties because they have to provide free service to these people. Private charities and public assistance agencies frequently pay for such hospital care or help make up hospital deficits.

It was in August of 1957 that I first proposed providing medical care as a part of the benefits available to the elderly under the social security program.

The proposal would transfer to the self-supporting insurance system a financial burden which now falls on individuals and private charities, and on public assistance financed by taxpayers. Thus it would work in the direction preferred by Congress.

Fifteen million persons would be eligible this year.

I said then, as I have said repeatedly, that if anyone could devise a better system for helping meet the rising medical costs of our retired people, I would gladly support his program and work for its enactment.

During 1958, when my proposal was being considered in committee, the Eisenhower administration took the position that the session would soon be over and nothing could be done without study. In April, 1959, after much prodding, the HEW secretary released a report in which he recognized the need for action in this area.

Today, we once again find the administration resorting to delaying tactics. Once again it requests time for study, consultation and investigation.

I think it is clear that the administration, in bowing to the pressures of the American Medical Association and the insurance companies, is not only listening to the few to the detriment of millions, but studying an approach to the problem that has many infirmities.

I am convinced that the use of the Social Security System represents the only sound and practical way of meeting the health needs of our growing number of retired people. The day will soon come when this workable system will be utilized. ◄

Lifts depression.



You see an improvement within a few days
Thanks to your prompt treatment and the smooth action of Deprol, her depression is relieved and her anxiety and tension calmed – *often in two or three days.* She eats well, sleeps well and soon returns to her normal activities.

as it calms anxiety!

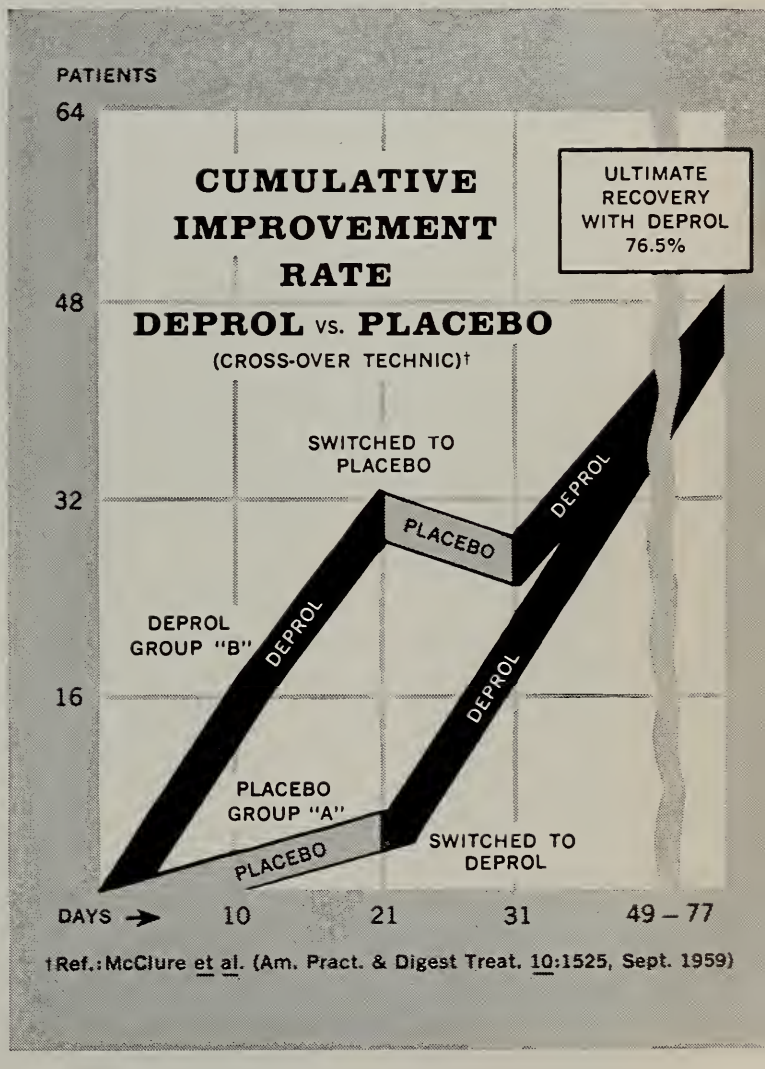
Smooth, balanced action lifts depression as it calms anxiety... rapidly and safely

Balances the mood – no "seesaw" effect of amphetamine-barbiturates and energizers. While amphetamines and energizers may stimulate the patient – *they often aggravate anxiety and tension.* And although amphetamine-barbiturate combinations may counteract excessive stimulation – *they often deepen depression.*

In contrast to such "seesaw" effects, Deprol lifts depression as it calms anxiety – both at the same time.

Acts swiftly – the patient often feels better, sleeps better, within two or three days. Unlike the delayed action of most other antidepressant drugs, which may take two to six weeks to bring results, Deprol relieves the patient quickly – often within two or three days.

Acts safely – no danger of liver damage. Deprol does not produce liver damage, hypotension, psychotic reactions or changes in sexual function – frequently reported with other antidepressant drugs.



†Ref.: McClure et al. (Am. Pract. & Digest Treat. 10:1525, Sept. 1959)

BIBLIOGRAPHY *(11 clinical studies, 764 patients):*

1. Alexander, L. (35 patients): Chematherapy of depression – Use of meprobamate combined with benactyzine (2-diethylaminoethyl benzilate) hydrochloride. J.A.M.A. 166:1019, March 1, 1958. **2.** Bateman, J. C. and Carlton, H. N. (50 patients): Meprobamate and benactyzine hydrochloride (Deprol) as adjunctive therapy for patients with advanced cancer. Antibiotic Med. & Clin. Therapy 6:648, Nov. 1959. **3.** Bell, J. L., Tauber, H., Santy, A. and Pulita, F. (77 patients): Treatment of depressive states in office practice. Dis. Nerv. System 20:263, June 1959. **4.** Breitner, C. (31 patients): On mental depressions. Dis. Nerv. System 20:142, (Section Two), May 1959. **5.** Landman, M. E. (50 patients): Choosing the right drug for the patient. Submitted for publication, 1960. **6.** McClure, C. W., Papas, P. N., Speare, G. S., Palmer, E., Slattery, J. J., Konefal, S. H., Henken, B. S., Waad, C. A. and Ceresia, G. B. (128 patients): Treatment of depression—New technics and therapy. Am. Pract. & Digest Treat. 10:1525, Sept. 1959. **7.** Pennington, V. M. (135 patients): Meprobamate-benactyzine (Deprol) in the treatment of chronic brain syndrome, schizophrenia and senility. J. Am. Geriatrics Soc. 7:656, Aug. 1959. **8.** Rickels, K. and Ewing, J. H. (35 patients): Deprol in depressive conditions. Dis. Nerv. System 20:364, (Section One), Aug. 1959. **9.** Ruchwarger, A. (87 patients): Use of Deprol (meprobamate combined with benactyzine hydrochloride) in the office treatment of depression. M. Ann. District of Columbia 28:438, Aug. 1959. **10.** Settel, E. (52 patients): Treatment of depression in the elderly with a meprobamate-benactyzine hydrochloride combination (Deprol). Antibiotic Med. & Clin. Therapy 7:28, Jan. 1960. **11.** Splitter, S. R. (84 patients): The care of the anxious and the depressed. Submitted for publication, 1959.

Dosage: Usual starting dose is 1 tablet q.i.d. When necessary, this may be gradually increased up to 3 tablets q.i.d.

Composition: 1 mg. 2-diethylaminoethyl benzilate hydrochloride (benactyzine HCl) and 400 mg. meprobamate.

Supplied: Bottles of 50 light-pink, scored tablets. Write for literature and samples.

Deprol®

WALLACE LABORATORIES / *New Brunswick, N. J.*

CD-1519

Continuing Expansion of Blue Shield Programs

One of a series of articles prepared by Blue Cross-Blue Shield.

A review of new benefits made available by Blue Shield in 1959 and the first part of 1960 indicates that our effort to develop new protection has been intensified.

Since January 1959, many new benefits have been made available. These include a number of endorsements for a wide range of in-hospital medical benefits. One series of endorsements (M30A, M120A, and M365) is available with the Standard or Preferred Certificate for 30, 120 and 365 day coverage periods. These endorsements provide payment for medical service in hospitals where such service is not connected with the preparation for or after care of surgical or obstetrical cases.

Payment will be made up to $15.00 for the first day, $10.00 for the second day, $4.00 for each of the next eight days, and $3.00 for each day thereafter on which the physician makes one or more calls. Ninety days must elapse between services. In the treatment of pulmonary tuberculosis, venereal disease and mental or nervous disorders, this benefit will be allowed for a total of 30 days during each successive 12 months.

Other in-hospital medical endorsements (M30S and M120S) have been added during the same period. These provide in-hospital medical payments of either $3.00, $4.00 or $5.00 for a period of 30 or 120 days for medical care of surgical patients by a physician other than the operating surgeon. Thirty days is allowed in the treatment of pulmonary tuberculosis, venereal disease and mental or nervous disorders.

The Preferred Schedule is doing a good job. Combining it with good in-hospital medical and diagnostic programs helps the schedule do an even better job.

One coverage we are pushing at this time includes the Preferred $300.00 Schedule, plus Endorsements M120A and II. This provides surgical allowances up to $300.00 per operation, anesthesia allowances totaling 20 per cent of the surgical allowance, allowances for medical service in the hospital (when not connected with the preparation for or after care of surgical or obstetrical conditions) up to $15.00 for the first day, $10.00 for the second, $4.00 for each of the next eight days, and $3.00 each day thereafter when the surgeon makes one or more calls —not to exceed 120 days.

Payment up to $50.00 per certificate year for diagnostic X-ray and pathological services for a disease or injury is also included (Endorsement II).

One of the newest Blue Shield programs combines the Preferred Series 300, Endorsements M120A, II, plus the recently developed M120-S-5 that provides payment for in-hospital medical care of surgical patients by a physician other than the operating surgeon of up to $5.00 for each day's visit for a total of 120 days.

At the end of 1959 approximately 88% of the Blue Shield membership had been sold some type of in-hospital medical coverage. At that time 22% of all Blue Shield had some type of Blue Shield diagnostic protection.

Blue Shield's general policy is to make available any type of program requested by the public, providing it is actuarially sound, and can be sold. Our specific program for 1960 is to push the use of the Preferred and Special schedules and our medical and diagnostic programs by present and new accounts—and to continue to develop and offer whatever programs are required to match the real health care needs of the people of Indiana.

W. C. Huddlestone
Public Relations Division ◄

Butazolidin®

brand of phenylbutazone

in arthritis and allied disorders

proved by a decade of experience

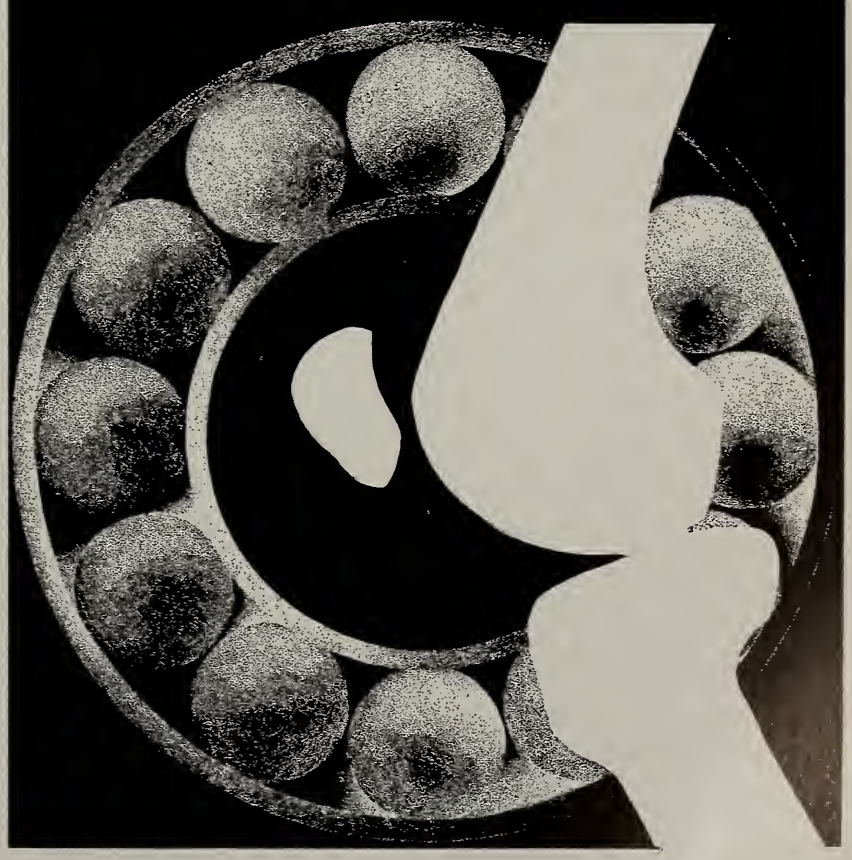
Ten years of experience in countless cases—more than 1700 published reports—have now established the eminence of Butazolidin among the potent non-hormonal antiarthritic agents.

Repeatedly it has been demonstrated that Butazolidin:
Within 24 to 72 hours produces striking relief of pain.
Within 5 to 10 days affords a marked improvement in mobility and a significant subsidence of inflammation with reduction of swelling and absorption of effusion.

Even when administered over months or years Butazolidin does not provoke tolerance nor produce signs of hormonal imbalance.

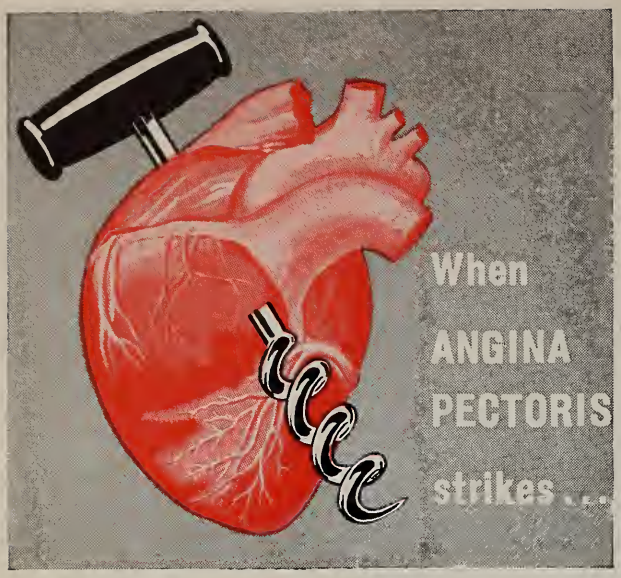
Butazolidin® brand of phenylbutazone: Red-coated tablets of 100 mg.
Butazolidin® Alka: Capsules containing Butazolidin® 100 mg.; dried aluminum hydroxide gel 100 mg.; magnesium trisilicate 150 mg.; homatropine methylbromide 1.25 mg.

Geigy, Ardsley, New York



Geigy

BU 7-60



prescribe

NIPHYLLINE

the unique specific

This exclusive development is neutral in action, and ***specific in prophylaxis and treatment of angina pectoris.*** It is effective orally in about thirty minutes, for periods of 7 to 8 hours . . . and, even when given routinely, does not cause nausea or gastric upset. Niphylline is an efficient vasodilator and diuretic combining the effectiveness of Neothylline (soluble, neutral, stable derivative of theophylline) and pentaerythritol tetranitrate, substantially more effective than mannitol hexanitrate. Thus, the patient receives the benefits of both drugs without any annoying side effects.

Niphylline is safe, and well tolerated . . . exerts strengthening effect on heart muscles, and acts synergistically, remarkably reducing severity and frequency of cardiac attacks.

Indications: Relief and control of angina pectoris, cardiovascular symptoms, asthenia, coronary spasm with myocardial pain, prophylaxis and treatment of left ventricular insufficiency, cardiac dyspnea and oliguresis.

Dosage: One or two tablets, 3 or 4 times daily, or as directed by physician.

Supplied: Bottles of 100 and 1000 tablets.

Each tablet contains: Pentaerythritol tetranitrate, 10 mg., and Neothylline (dihydroxypropyl theophylline), 100 mg.

PM **PAUL MANEY**
LABORATORIES, INC.
Cedar Rapids, Iowa

Wanted

Continued

Harry R. Miller, 4115 Nebraska, Toledo, Ohio, *general surgery.*

Marion Lee Connerley, 2290 Sixth Avenue, San Diego 1, Calif., *thoracic and cardiovascular surgery.*

Lloyd C. France, 7610 Kipling, Detroit 6, Mich., *general surgery and vascular.*

Russell S. Williams, 20th Station Hosp., APO 696, New York, N. Y., *radiology.*

Bernard L. Berman, 1246½ Brockton, Los Angeles, Calif., *dermatology.*

S. R. Joseph, 1107 Porter Street, Columbia, Mo., *general surgery.*

W. J. Lehman, 7344 A. North Winchester Avenue, Chicago 26, Ill., *orthopedics.*

Victor W. Kershul, 1128 W. Washington Street, Ann Arbor, Mich., *psychiatry.*

Edgar W. Killian, 5637 S. Rockwell Street, Chicago 29, Ill., *otolaryngology.*

Locations

Delaware County—EATON—population 1,800. Located close to Muncie where hospital facilities are available. One physician in the community and he is leaving July 1960. A fully equipped, air conditioned office available. Contact Dr. Robert J. Lutz, 113 East North Street, Eaton, Ind., for details.

Johnson County—FRANKLIN—population 10,000. Located 18 miles south of Indianapolis on U. S. 31. The fully equipped office of the late Dr. Harry Murphy is available. County seat town with a new hospital. Contact Mrs. Harry Murphy, 150 N. Main Street, Franklin, Ind., for details.

St. Joseph County—MISHAWAKA—population 33,000. Located in the northern part of the state. The practice of the late Dr. B. J. Wyland, 116 West Third Street, Mishawaka, is available. Dr. Wyland practiced in Mishawaka many years. Contact Miss Pauline Dakin, R.N., for details at 116 West Third Street, Mishawaka, Ind. ◄



". . . and just feel that you can depend on me for a pinch . . . err . . . in a pinch!"

The Journal of the INDIANA STATE MEDICAL ASSOCIATION

Supervised by THE COUNCIL

Volume 53 — May 1960 — Number 5

Indianapolis attorney calls for factual, unbiased information in simple terms from physicians testifying in court litigations.

Duties of the Medical Expert in Court

JAMES V. DONADIO, LL.B.
Indianapolis

MEMBERS OF THE medical profession have achieved an increased importance in the courtroom. Litigated cases concerning personal injuries have grown in numbers and importance under the conditions of modern life. Doctors are necessary witnesses in developing the evidence concerning personal injuries. Doctors, with the lawyers, have a real responsibility in such cases.

In assessing such responsibility, it will be well to remind ourselves of the purpose of a lawsuit. Fundamentally, it is a method evolved by organized society for the purpose of administering justice among citizens according to rules of law recognized as just and equitable. Our courts are the most important part of our civilized government. They protect our property; they protect our means of happiness; and they protect our very lives. Whenever we step into a courtroom, we should be mindful of its high purpose, and our demeanor should be in keeping with its function.

Too often, we lose sight of these important fundamentals. Lawyers are too prone to forget their duties as officers of the court and resort to the tactics of the prize fight or wrestling match, expecting the judge or arbitrator to do nothing but act as a referee between the contestants. The trial of a lawsuit is not primarily a battle of wits; it is a seeking after truth so that justice can be done. While the lawyer owes a duty to his client to see that the facts favorable to his cause are presented and that the court properly understands the law applicable to the case, he has a higher duty to the court to see that the facts are truthfully presented and that the hearing officer and jury are not misled.

Address presented before the Oct., 1959 meeting of the Indiana Bone and Joint Club.

A Doctor's Duty Exacting

The duty of the doctor when called as a witness is equally exacting. Indeed, the duty of the doctor as a witness is peculiar. He is called upon to testify not only as to the medical facts within his knowledge from observation, but also as to his opinion as an expert concerning the effect and significance of such facts. As an expert, he is expected to help the court, arbitrator and jury interpret and understand the medical facts developed by the testimony so that they may reach a proper and correct conclusion from such facts. As such expert witness, the doctor is not an advocate, zealous to help one side win; rather he should be as a judge, carefully and impartially weighing the facts and giving his conscientious opinion concerning their effect or consequences.

Whenever the medical witness abandons the impartial attitude of the expert and assumes the position of a partisan, he not only stultifies himself but loses his value as an expert.

With the foregoing general principles in mind, I should like to present for your reflection and consideration a few observations which to me are essential for the proper presentation of medical evidence.

Should Always Confer

The doctor and the attorney should always confer relative to the common problems presented in a particular case. Such conferences should be arranged in advance of a court or other hearing at the mutual convenience of each, in full appreciation that, to each profession, time is of the utmost importance. No physician and no attorney should be required to spend unnecessary time in arranging or attending such a conference. The attorney who knows and understands the progress of his client's case, the conflict, if any, of its medical aspects, and the probability of settlement or trial should determine the necessity of such conference. The physician should feel obligated to point out anything which he believes will be helpful in presenting the patient's case as well as the weaknesses in the opposing medical theories or testimony.

It is unfair to the patient, client, the physician and the cause of justice to present a medical witness who has not first conferred with the attorney and who, therefore, may lack a full appreciation of the significance to the case of the particular evidence he is being asked to give. It is equally obvious that the attorney is less able to present the full interests of his client where he has not had the advantage of full conferences with the physician in advance of presenting the case.

In the conference, full attention should be given to:

(a) The complete history received by the physician both as to the occurrence giving rise to the litigation and the specific complaints registered by the litigant.

(b) The objective, abnormal and normal, findings during the treatment and examinations.

(c) The subjective complaints and full discussion as to their plausibility.

(d) Pain and suffering connected with the particular problem.

(e) X-ray, laboratory and other mechanical examination aids.

(f) The permanency or handicap in the future of the malady.

You may be called upon to testify as (a) the attending physician, (b) as a voluntary expert, or (c) as a subpoenaed expert. In either category, remember always that you are a witness under oath. Never assume the role of the advocate. If appearing as an attending physician, remember that your patient is represented by an attorney who serves as the advocate. Don't ever become hostile. Remember that you are on the witness stand as a provider of the facts. Show respect and consideration for the court, the jury and the attorneys, for doing so will gain the respect and admiration of the court, jury and attorneys for you and thus make your presentation most effective.

If you believe that an attorney is omitting an important point in the course of presenting the case or that he is either misunderstanding given testimony or misunderstanding the importance of certain medical testimony which is being offered by either side, you should tell the attorney so before you're excused as a witness.

Physician Is "Expert"

Respecting expert testimony, most attorneys understand, and you should understand, that in a very real sense and one recognized by Indiana law, every physician is relatively "expert" in the field of medical testimony. The thoroughness and high quality of your training entitles you to this status as does your unlimited license.

There is, however, another degree of expertness recognized alike by courts and both professions which comes with specialized training and experience in a particular branch of medical science—in this group, the science of administering to diseases and injuries of the bones, joints, tendons and their allied tissues. It is in this latter sense that the term medical expert is more commonly understood and used.

As an expert witness, you may or may not have treated the patient. You may or may not have examined the patient. The testimony of an expert must in part depend then on the facts of his relationship to the particular patient. The testimony of an expert if he has not treated the patient cannot be expected to be the same as if he had treated the patient in the nakedness of his distress. Expert testimony will be still more limited if the physician, even though an acknowledged expert, has never examined the patient but has been limited to x-rays, observations, the reports of other physicians or to hypothetical questions.

In presenting such a witness, the expert should not permit himself to be obliged to offer opinion evidence which exceeds the factual relationship of such expert to the patient or which exceeds the facts contained within hypothetical questions put to him as the basis for his opinion. In other words, he should be just as willing to make answers on cross-examination on facts stated in questions different than those posed by the counsel calling him, thus avoiding any charge that he is taking sides.

Subpoenas No Reflection

There are situations in which the attorney subpoenas the medical expert either because a physician has been uncooperative or the attorney has thought him so, or the physician has said, for example, that he does not wish to testify or that he has no opinion. Moreover, even where none of the foregoing reasons exist, the attorney may wish to subpoena such medical expert for purely psychological reasons. The service of such subpoena should in no way be taken as a reflection on the doctor.

If subpoenaed as a medical expert, the physician cannot reasonably be held to special study, review of the authorities and medical literature, or to other specialized preparation in such circumstances. No medical expert can be compelled to form an opinion, although he may be required to state the substance of his observations, if he observed the patient. If he does not have a professionally adequate basis for an opinion as to a particular litigant whom he did not observe, he cannot be compelled to offer an opinion before a court or administrative body. If he has an opinion, he is obliged to state it.

It is hard to say or write in words the proper limits of medical testimony. My observations would be that, if a physician has treated a patient on whose behalf he is offering testimony, he must offer the facts of his diagnosis, his treatment and his prognosis honestly and simply. He should not indulge in speculation unless the case unavoidedly requires such indulgence and, in such situation, I would suggest that he should clearly label his own testimony as speculative, or his best estimate, or his best judgment.

No Justification in Evidence Suppression

Under no circumstances is a medical witness justified in suppressing medical evidence or in taking sides as such. First, as has been suggested, such an attitude goes to the very credibility and usefulness of the testimony. Second, it is an unwarranted usurpation of part of the attorney's function.

If the physician is testifying as an expert, he should offer no opinion beyond the facts of the case or which is not otherwise in the court record or which goes beyond his personal knowledge or runs counter to his professional training and judgment. The doctor's professional judgment and conscience should mark the limits of his testimony, including his opinion.

Finally, I would make this observation about how the doctor should talk when on the witness stand.

Technical Language Misleading

A medical witness testifying before an administrative body, such as an Industrial Board member, may ordinarily use technical language with relative freedom and confidence. The reasons for this are that such bodies become relatively expert in the understanding of his medical vocabulary. This is true, in varying measure, of judges. It is not true, however, of a jury. It is possible for medical testimony to be so worded technically that its meaning is entirely lost upon a jury or is so completely misunderstood that the jury finds differently than it would if it knew the true import of the testimony.

When this situation occurs, it may be the responsibility of either or both the physician and the attorney to make his professional testimony clear, both for the record and for physicians and attorneys on the other side. My suggestion is that a medical witness should first express his findings and opinion in medical terms and then by proper questioning from the attorney should translate those terms as accurately as possible into language intelligible to the court, attorneys and the jury, having in mind the locality where the case is being tried. The doctor should also put into intelligible language the effect of the particular injuries. The latter is frequently easier than the technical statement of a diagnosis or of the treatment accorded.

Remember always that simplicity of expression is the finest attribute of a medical witness, as well, in fact, as of other witnesses. Remember always that your testimony is not intended to impress or edify but to explain. If it does not explain and does not clarify the issues of a particular case, your testimony has failed in the sense that it was not useful to the determination of the case and to the litigants. ◄

Unused Polio Vaccine Supply Increases

Supplies of unused polio vaccine have reached a high of 26.4 million doses although over 90 million Americans still need to be vaccinated, Dr. Leroy E. Burney, Surgeon General of the Public Health Service, reported recently.

"Every year, for the past four years, there has been a surplus of vaccine in the spring and winter followed by a shortage in the summer when the occurrence of polio cases reminds people they should get vaccinated," Dr. Burney said:

"This problem can be solved only if the public understands the following facts:

"1. The vaccine is most effective if used *before* polio is prevalent; the sooner you get vaccinated the greater will be your protection against polio this season.

"2. The vaccine manufacturing process takes about four months; if demand for vaccine is low now, supplies are likely to be low in the summer, since the present supply may be outdated by then.

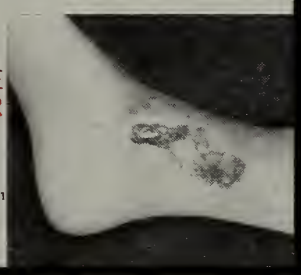
"3. It is the third shot, due seven or more months after the first two that gives the greatest protection. A fourth shot a year after the third adds even greater protection."





FORCE INJURY
severe bruises ... swelling ... cleared by fifth day[2]





VARICOSE ULCER
15 years duration ... resolved with VARIDASE[1]





INFLAMMATORY DERMATOSIS
rapidly spreading rhus dermatitis healed within a week[1]





INFECTED LACERATION
marked reversal in 3 days... returned to school... closure advanced[1]





THROMBOPHLEBITIS
back on his feet in a week after recurrent episode[1]





REFRACTORY CELLULITIS
normal routine resumed after 4 days of VARIDASE[1]

The Journal

of the INDIANA STATE MEDICAL ASSOCIATION

Devoted to the interests of the medical profession of Indiana

Editor: Frank B. Ramsey, M.D., 1802 North Illinois Street, Indianapolis 2, Indiana

Associate Editors: A. W. Cavins, M.D., 221 South Sixth Street, Terre Haute, Indiana; Lall G. Montgomery, M.D., Ball Memorial Hospital, Muncie, Indiana; David A. Bickel, M.D., 515 Odd Fellows Building, South Bend, Indiana; Stephen L. Johnson, M.D., 521 Sycamore Street, Evansville, Indiana.

Editorial Board:	Term Expires
George M. Johnson, M.D., Richmond	Dec. 31, 1960
Irvin W. Wilkens, M.D., Indianapolis	Dec. 31, 1960
Harold D. Lynch, M.D., Evansville	Dec. 31, 1961
Jene R. Bennett, South Bend	Dec. 31, 1961
Samuel R. Mercer M.D., Fort Wayne	Dec. 31, 1962
Franklin F. Premuda, M.D., Hammond	Dec. 31, 1962

Necrologist: James B. Maple, M.D., 117 West Washington Street, Sullivan, Indiana.

Assistant Editor: Corki Wilson

Editorial Assistant: Sara M. Snyder

Business Manager: James A. Waggener

1019 Hume Mansur Building, Indianapolis 4, Indiana

Practical Politics and Doctors

MEDICINE IS AGAIN faced with a threat from Washington. The Forand bill is a dangerous threat to medical care and the Nation's economy. Much has been and will be written on these subjects. The following statements are a suggestion concerning how the physicians may counteract the influences attempting to make the Forand bill a law.

In the past, we doctors have voted, urged our patients to vote for candidates friendly to our ideas, and our wives have frequently transported voters to the polls. We write letters to our congressmen and senators telling them what we believe and what we want. The January 11, 1960 issue of *AMA News* copied an editorial from the *New England Journal of Medicine*. The point of this editorial was that elected representatives frequently comment that "Doctors want me to do this and that, but where were they at election time?"

We are naive patriots and citizens who have overlooked the practical economics of political life. We criticize "influence peddlers"; we want men of integrity to hold political office. Even Mr. Nixon's television interview evoked our sympathy, but not our understanding. Each citizen has an obligation to not only vote, but to financially support political candidates of his choice. Running for political office is a risky financial venture, a luxury which many noble citizens can not afford. There was a movement in the nation to subscribe campaign funds for the major political parties; this has not had the success needed.

A broad base of financial support from people who are not seeking patronage is necessary to permit elected representatives to have freedom to act in the best interests of all the people. Physicians do not have the time to be active in precinct political organization work, but they do have the capacity to write checks. This year congressmen are running for election. You can show your favorite where you stood at election time by material support which he needs and will appreciate. It takes money to buy newspaper ads and to appear on radio and TV. Whether you

sell potatoes or furniture or political ideas and candidates, it costs to advertise.

The author has had an interesting and educational experience in this field in the past few months as local co-chairman of the Matt Welsh for Governor Fund Drive. In our community, Matt Welsh has made political contributions "respectable" and persons of both political faiths have supported our favorite son. Conservatives are predominant in both parties here in Knox County and as Dr. Fount Richardson (President, American Academy General Practice), recently said, "The Forand bill fight is not a one-party affair. We have two Democrats on the doctors' side in my state of Arkansas."

The point is we physicians should participate in our representative form of government by not only voting for the candidates of our choice, but should put our money where our mouths are if we expect to be heard in the Halls of Congress.

E. T. Edwards, M.D.

Growth, Sales and Profits in Drug Industry

MANY GOOD ARGUMENTS have been stopped when someone started to quote hard facts. The Pharmaceutical Manufacturers Association was addressed during its annual meeting last month by an economist, Dr. Jules Backman, research professor of economics at New York University.

Dr. Backman pointed out that the drug industry is expanding rapidly. Today it is providing new jobs three times faster than all other manufacturing, and it is growing in dollar volume twice as fast as the national economy. Employment in the manufacture of medicine is up 20% since 1947. All other manufacturing shows a 5.7% increase in the same period.

Also during the same period (1947 to 1959), wholesale prices in the industry declined by 6% while the price index for all commodities was rising 18.9%.

Profits of the pharmaceutical manufacturers were analyzed by the economist. He named greater risk exposure, rapid product innovation and obsolescence, more intensive promotion and understatement of net worth as factors which are characteristic of the industry. He urged manufacturers to disseminate information regarding sales, costs and labor benefits, and to publicize the extent to which public ownership of stock benefits the public in a financial way.

He declared that the Kefauver investigation had in some aspects been beneficial in that it had provided an opportunity for the public to understand the care and effort required to produce first quality drugs, the cost of searching out new drugs and the great amount of good which has accrued as a result of more potent and specific preparations.

From AMA:

The Needy and the Near-Needy Physician

IN CONTEMPORARY times, when much thought has been or should be given by physicians to the proposals advanced in the Forand resolution, let us not overlook the physician who may be in need of financial aid. The application of the federal proposal is confined to citizens over 65 years of age. The title of this editorial implies no temporal restriction. A physician in need of provisional or long-term aid may be a recent graduate of medical school stricken with poliomyelitis or a physician no longer able to practice because of age or chronic illness.

The medical profession in some states has grappled with the problem squarely and has responded with a plan of action. States with the largest physician population have accepted their responsibilities for a long period of time.

The California Medical Association underwrites a nonprofit corporation which provides benefits for needy physicians and their families. The fund is supported by a contribution of one dollar a year from the dues of each active member of the association. In the southern part of the state the Los Angeles County Physicians Aid

Association was incorporated in 1940. This association provides either direct financial aid or domiciliary care, depending on the circumstances.

The state medical society in Illinois established a benevolence fund in the same year. Direct monetary aid is provided. There is no specifically designated physicians' home.

The Massachusets Medical Benevolent Society was organized 1857 with the provision for direct aid to indigent physicians and their widows.

In New York state, the Physicians Mutual Aid Association was incorporated in 1868 with a purpose similar to that of the Massachusetts society. A proposal for a physicians' home was given a trial in the 1920's but abandoned in favor of direct monetary aid.

This information has been gleaned from a brochure on the subject which was prepared by Beverly C. Smith of New York City. The contents were assembled after an inquiry to the executive secretaries of the constituent medical societies throughout the country. C. Gordon Heyd, past president of the American Medical Association, is the president of the New York organization. The brochure supplies helpful documentary data for one interested in this matter, a subject reviewed by the House of Delegates at their recent session in Dallas.

The resolution submitted by a delegate of the Indiana State Medical Society requests that "The American Medical Association take appropriate steps to investigate the need, the desirability, and the feasibility of establishing a suitable facility in a suitable climate as an abode for aged and aging physicians and for those who have retired from the active practice of medicine." The Reference Committee acted favorably on this resolution, which was supported by the House of Delegates.

It is believed that this measure is one approach to a problem that will be applicable to a small percentage of physicians only, but it is pertinent until such time as a voluntary physicians' annuity program is approved. Furthermore, maximum benefits of a group retirement annuity plan for physicians will be possible only if legislation similar to HR-10, 86th Congress, as approved by the House of Representatives in March, 1959, and now pending before the Senate Finance Commitee, is passed.

Through one device or a combination the physician in financial need must be reassured just as he has comforted countless patients during his days of professional activity.

Reprinted from the *Journal* of the AMA, Vol. 172, No. 5, Jan. 30, 1960.

Journal Offers $5 Each for Anecdotes

A new department of *The Journal* is being organized for the publication of accounts of personal experiences of Indiana physicians. The practice of medicine is interwoven and frequently involved with the drama of life. In a lifetime of practice doctors are in contact with many episodes of amusing, thrilling, ridiculous or dramatic import. Members of the association are invited to submit manuscripts for this purpose. Author's names need not be published, initials may be used. The narrations may be short, but should be limited to 1200 words. *The Journal* will pay $5.00 for each one published.

109th Annual AMA Meeting
Forum by 2,000 Top Medical Men

CHICAGO—The 109th annual meeting of the American Medical Association will be a forum presented by some of the nation's top scientific brains.

Approximately 2,000 physicians, all outstanding in their fields, will participate in presenting the scientific program of the meeting to be held in Miami Beach, June 13-17.

There will be two general scientific meetings in the grand ballroom of the Fontainebleau Hotel, and other lectures, symposiums and panel discussions in the Fontainebleau, Eden Roc Hotel and in the new, air-conditioned Miami Beach Exhibition Hall. Sessions on dermatology, being held jointly with the Society for Investigative Dermatology, will be in the di Lido Hotel.

The opening general scientific meeting, Monday, June 13, will begin with the Joseph Goldberger Lecture on Clinical Nutrition. Dr. Carl A. Lincke, chairman of the AMA Council on Scientific Assembly, will preside at this meeting.

The lecture will be followed by a symposium on nutrition, including an address by Grace A. Goldsmith, professor of medicine, Tulane University School of Medicine, New Orleans, on "Highlights on the Cholesterol—Fats, Diets and the Atherosclerosis Problem."

The second general meeting will be a symposium on "Evaluation and Preparation of Patients for Anesthesia and Surgery," Tuesday morning, June 14, to which the sections on anesthesiology, diseases of the chest, general practice, internal medicine, pediatrics, pathology and physiology and surgery have contributed. Participating will be Meyer Saklad, Providence, R.I.; Thomas Rardin, Columbus, Ohio; Eugene Turrell, Milwaukee, Wis.; John S. LaDue, New York City; Arlie R. Mansberger, Jr., Baltimore; George Meneeley, Nashville, Tenn.; Robert M. Smith, Boston, and C. Rollins Hanlon, St. Louis, Mo.

Section Programs

What's new in surgery will be explored during a symposium and panel discussion on Wednesday morning. The program was developed from suggestions obtained from a survey of the heads of departments of surgery in the nation's medical schools.



The symposium will be on "Recent Advances in Treatment of the Cancer Patient," with an introduction to the problem, including methods of decreasing spread of cancer cells during operations, presented by Warren H. Cole, Chicago. Dr. Cole also will serve as moderator of the panel on "Current Status of the Treatment of Advanced Cancer of the Thyroid and Breast."

Arthur M. Master, New York City, will speak on "Effort, Occupation (including physicians) in Coronary Occlusion" during a symposium on medical chest emergencies and John F. Briggs, St. Paul, Minn., will discuss "Pulmonary Embolism."

John H. Moyer, Philadelphia, will moderate a symposium on "Edema—Its Physiology and Use of Newer Diuretics in Its Treatment." Irving S. Wright, New York, will moderate a sym-

posium on "Pathogenesis and Treatment of Thrombo-embolic Phenomena." Daniel C. Moore, Seattle, Wash., will take part in a session on "Newer Trends in Diagnosis and Treatment" discussing "Oxygen—The Rational Therapy for Systemic Toxic Reactions from Local Anesthetic Drugs."

There will be panel discussions on "Tumors of the Trachea and Bronchial Tree," with Paul H. Holinger, Chicago, moderator, and one on "Disseminated Diseases of the Chest," with Harold O. Peterson, Minneapolis, moderator.

Highlights of other section meetings include:

Nervous and Mental Diseases—E. S. Gurdjian, Detroit, "Critique of Occlusive Disease of the Carotid Artery and the Stroke Syndrome" and Leo H. Bartemeier, Baltimore, "Comments on the Relations Between Psychiatrists and Other Physicians."

Obstetrics and Gynecology—Stirling G. Pillsbury, Long Beach, Calif., "31,595 Deliveries with One Maternal Death" and Jerome M. Kummer, Santa Monica, Calif., "An Answer for Criminal Abortion."

Internal Medicine—"Symposium on Hypocholesteremic Drugs," Walter L. Palmer, Chicago, "The Billings Lecture: Causality in Peptic Ulcer" and Rudolph H. Kampmeier, Nashville, Tenn., "Collagen Diseases—Some Unanswered Questions."

Laryngology, Otology, and Rhinology—George A. Sisson, Syracuse, N.Y., "Problems and Complications in Head and Neck Surgery" and C. M. Kos, Iowa City, Iowa, "Five-Year Results of Stapes Mobilization and Current Results with Vein Plug Stapedeoplasty."

Preventive Medicine—Jan H. Tillisch, Rochester, Minn., "Medical Aspects of Safety in the Air" and Robert B. Stonehill, San Antonio, Texas, "Air Travel and the Cardiopulmonary Patient," a film presentation.

Orthopedic Surgery—Sidney Keats, Newark, N.J., "Surgery of the Extremities in the Treatment of Cerebral Palsy" and H. R. McCarroll, St. Louis, Mo., "The Management of Complicated Ununited Fractures of the Tibia and Fibula."

Pediatrics—Leonard S. Sommer, Miami, moderator, "Symposium on Congenital Heart Disease—Present-day Status from Viewpoint of Practitioner of Medicine."

The section on miscellaneous topics will feature a half-day session on the "Management of the Older Patient." Participants include Philip Thorek, Chicago.

Exhibits Number 290

About 290 exhibits will be on display in the Miami Beach Exhibition Hall, representing the most outstanding selected from 540 applications.

A new special exhibit on body fluid disturbances, offering a complete course in body fluids, will be presented in its entirety on two days. Different aspects will begin at specific times to permit physicians to attend only those parts in which they are particularly interested.

A special exhibit on fractures will include booths on fractures of the ankle, hip, wrist, tibia and fibula, children's fractures and fractures resulting from falls on the outstretched hand. About 50 prominent orthopedic surgeons will take part in the demonstrations at this exhibit.

Specials on pulmonary function and fresh tissue pathology also will be highlighted in the scientific exhibition area.

An outstanding program of motion pictures and television, which will be coordinated with the rest of the scientific program, will be presented also in the Miami Beach Exhibition Hall.

Pharmaceutical Manufacturers Speak Out

Dr. Austin Smith, president of the Pharmaceutical Manufacturers Association, told Senate investigators recently that Americans "would be paying a billion dollars a year more for drugs if the price of medicine in the past few years had gone up only as much as the total cost of living."

President's Page

Recently it was my privilege to go with the members of the executive committee to attend the dinner for the Honorable Charles Halleck. While we were in Washington, opportunity was available for us to have conferences with various congressmen from Indiana. Our chief concern and reason for visiting was to inform these people as to the position the State Medical Association was taking in regard to the Forand-type legislation. Dr. Wendell Covalt and I visited four congressmen.



The first congressman we interviewed was a sincere fellow who I feel certain will give every consideration to doing what he honestly believes is the correct thing to do. He showed us some information, in the form of letters, which he had received from his constituents. We saw, perhaps, 25 of these letters and they were about 50-50 for, and against, legislation. We noted at the time that already there was beginning a deluge of postcards, the source of which we do not know, in favor of this legislation. It was our feeling that these were coming from some organized effort.

Our second call was made on a gentleman who has been in Congress for many years. He received us quite graciously and told us that a few years ago the doctors in his community had actually utilized every effort to defeat him for Congress. He said that none of these people had come to see him about his stand in regard to socialized medicine and further stated that he never had been for it and never would be for it—he doesn't care for the principle in any way whatever. This man was particularly disturbed by the fact that doctors had worked against him without even talking to him.

The third gentleman, another new congressman, started questioning us about the income of doctors and mentioned the fact that there were a few millionaires in medicine from his district. He was quickly put right on this question and a heated discussion followed which lasted for a few minutes. At the end of the time I believe all three of us had a better understanding of the situation. This man is not for the Forand-type legislation if any other effort can be made to take care of the aging population. At the end of the interview, I believe this congressman had a better understanding of what medicine's position is and why we are against this type legislation.

The fourth gentleman we were permitted to see was a young, energetic, brilliant person whose ability to utilize an offense for a defense was apparent from the very first. He informed us, quite coldly, that the problem of the aging person was a problem for medicine and if medicine doesn't come up with some answer to this problem it will be necessary for the Federal government to intervene. In spite of every tactic he would not be maneuvered into a position in which the legislator had to take responsibility for this consideration. He asked for concrete examples of what medicine is doing to help in the aging population situation as regards matters of health. It was pointed out to him that certain features of the unhappiness of the

aging population were not under the control of medicine or really under the control of health. This man was asked what he would do in regard to caring for the loneliness of these people and the other factors of their lives. This he made no answer to because he had no answer to the problem.

A few salient facts were gained from this experience: 1) We apparently are not keeping our legislators informed adequately as to our feelings about various phases of legislation. Another obvious factor is that we are not meeting these people, and knowing them, prior to their elections in such a manner that our influence can be best utilized. 2) If we are to stay interested in the political climate of our country it is necessary that we adopt a practical attitude toward legislation. I recently talked to Dr. Louis Orr, President of the American Medical Association, about this problem. He too is quite concerned about it—fearing that the legislators in Washington are not getting medicine's message. All in all, I learned that one letter, written in a logical manner with certain facts to back up a request, gets much more consideration that a host of cards mailed to a legislator in which all the sender has to do is sign his name.

The legislators are interested in doing the best job they can for the public they represent. I believe they are all honest and sincere people but they cannot be expected to understand our problems unless we make them clear and bring them to their attention. For that reason, any doctor who can, should write to his congressman and to his senator informing him in concise, and logical manner of his viewpoint. This type information is desired and wanted. Our representatives, I believe, will honestly do what is best for everyone if they are properly informed. It is up to us to see that they are informed.

Another factor that is obvious to one visiting in Washington is that these representatives remember those who have been helpful to them in elections. There certainly are enough physicians in Indiana who could give some time to the political efforts of their friends to aid in the election of the proper people to the various legislative bodies. It has been suggested that financial aid be given to legislators in their campaigns in order that special consideration may not be demanded by others.

It is obvious that medicine must come up with some plan to aid in the difficult problem of our aging population. We can no longer be against things because they affect us. It is our duty to contribute our opinions in the molding of public opinion to the betterment of society generally. I feel it is high time that we take the lead in matters of health in our nation because I believe we are the best equipped group to handle it.

Earle W Agnew M.D.

ROSTER OF MEMBERS



Indiana State Medical Association

—

Woman's Auxiliary

May 1960

Price $3.00

Published by
THE JOURNAL
1019 Hume Mansur Building
Indianapolis, Indiana


LAKE
PORTER
LAPORTE
SAINT JOSEPH
ELKHART
LAGRANGE
STEUBEN
10
STARKE
MARSHALL
13
KOS-CIUSKO
NOBLE
DeKALB
12
ALLEN
WHIT-LEY
JASPER
PULASKI
FULTON
NEW-TON
WABASH
HUNTING-TON
WELLS
ADAMS
CASS
MIAMI
11
WHITE
BENTON
CARROLL
HOWARD
GRANT
BLACK-FORD
JAY
8
TIPPE-CANOE
9
CLINTON
TIPTON
DELAWARE
RANDOLPH
WARREN
FOUNT-AIN
MONTGOM-ERY
BOONE
HAMIL-TON
MADI-SON
HENRY
WAYNE
VERMILLION
PARKE
5
PUTNAM
HEN-DRICKS
MARION
7
HANCOCK
6
RUSH
FAY-ETTE
UNION
VIGO
CLAY
MORGAN
JOHN-SON
SHELBY
FRANKLIN
OWEN
BROWN
BARTHOL-OMEW
DECATUR
4
SULLI-VAN
GREENE
MONROE
RIPLEY
DEAR-BORN
JENNINGS
JACKSON
OHIO
KNOX
2
DAVIESS
MARTIN
LAWRENCE
JEFFERSON
SWITZER-LAND
SCOTT
WASHING-TON
ORANGE
CLARK
3
PIKE
GIBSON
1
DUBOIS
CRAWFORD
FLOYD
HARRI-SON
WARRICK
PERRY
POSEY
VANDE-BURGH
SPENCER
COUNCILOR DISTRICTS of the INDIANA STATE MEDICAL ASSOCIATION

Membership Roster

INDIANA STATE MEDICAL ASSOCIATION

Following is a list of paid-up members of the Indiana State Medical Association as of April 15, 1960.

The letter (S) following a name indicates that the physician is a senior member of his local society and of the Indiana State Medical Association. The letter (H) following a name indicates that the physician is an honorary member of his local society and the Indiana State Medical Association.

Names of members who have died during the year do not appear in this list.

If any errors are found in this list, please report them to THE JOURNAL, 1019 Hume Mansur Building, Indianapolis 4, Indiana. The cooperation of members is urgently requested.

ALPHABETICAL LIST OF MEMBERS

Name	City	County
	A	
Aagesen, Walter J.	Anderson	Madison
Abel, Robert	Wakarusa	Elkhart
Abell, Charles F.	Marion	Grant
Able, Walter	Brownsburg	Hendricks
Abramson, Allan L.	Gary	Lake
Abreu, Benedict E.	Indianapolis	Marion
Acher, Robert P.	Greensburg	Decatur
Acker, Robert B. (S)	South Bend	St. Joseph
Acre, Robert R.	Evansville	Vanderburgh
Adair, Samuel	Jeffersonville	Clark
Adair, William K. (S)	Crothersville	Jackson
Adams, Daniel S. (S)	Indianapolis	Marion
Adams, Julia L.	Muncie	Delaware-Blackford
Adams, E. Wade	Fort Wayne	Allen
Adams, Max R.	Flora	Carroll
Adams, William B.	Muncie	Delaware-Blackford
Adamski, Michael S.	Logansport	Cass
Addleman, Robert H.	Indianapolis	Marion
Ade, Charles H.	Lafayette	Tippecanoe
Ade, Mary Keller	Lafayette	Tippecanoe
Adkins, Harold C.	Indianapolis	Marion
Adler, David L.	Columbus	Bartholomew-Brown
Adler, Raymond N.	Evansville	Vanderburgh
Adney, Frank B.	Richmond	Wayne-Union
Advincula, Luis	Pendleton	Madison
Adye, Wallace M.	Evansville	Vanderburgh
Ahlbrand, Roland C.	Fort Wayne	Allen
Aiken, Arthur F.	Fort Wayne	Allen
Aiken, Milo M.	Plainfield	Hendricks
Aiken, Nevin E.	Fort Wayne	Allen
Ake, Loren	Richmond	Wayne-Union
Albertson, Frank P.	Indianapolis	Marion
Albrecht, Willard H.	Gary	Lake
Alcorn, Merritt O.	Madison	Jefferson-Switzerland
Alden, John O.	Hartford, Conn.	Shelby
Alderfer, Henry	Marion	Grant
Aldred, Allen W.	Lawrenceburg	Dearborn-Ohio
Aldrich, Harry D.	Indianapolis	Marion
Aldrich, Howard	Indianapolis	Marion
Alexander, Ezra D.	Indianapolis	Marion
Alexander, John E.	Evansville	Vanderburgh
Alexander, Stephen J.	Crawfordsville	Montgomery
Alfano, Paul A.	Gary	Lake
Alford, James A.	Hamilton	Steuben
Allegretti, Michael L.	Hammond	Lake
Allen, Hubert E. (S)	Richmond	Wayne-Union
Allen, L. Howard	Bedford	Lawrence
Allen, Orris T. (S)	Terre Haute	Vigo
Allen, Robert K.	Indianapolis	Marion
Allen, Robert T.	Richmond	Wayne-Union
Almquist, Carl O.	Gary	Lake
Altier, William H.	Fowler	Benton
Alvey, Charles R.	Muncie	Delaware-Blackford
Alvis, Edmond O.	Indianapolis	Marion
Alward, John H.	Kokomo	Howard
Ambrose, Jesse C.	Noblesville	Hamilton
Ambrozaitis, Kazys	Gary	Lake
Amico, Pasquale J.	Crown Point	Lake
Amini, Sohrab	Huntingburg	Dubois
Amos, Robert L.	New Castle	Henry
Amstutz, Henry C.	Goshen	Elkhart
Amy, William E. (S)	Corydon	Harrison-Crawford
Anderson, James W.	Indianapolis	Marion
Anderson, John B.	Vincennes	Knox
Anderson, John T.	Indianapolis	Marion
Anderson, Milton H.	Evansville	Vanderburgh
Anderson, Richard M.	Vincennes	Knox
Anderson, Walter C.	Terre Haute	Vigo
Anderson, Wendell C.	Indianapolis	Marion
Andrews, Hugh K.	Franklin	Johnson
Angel, Virgil E.	East Chicago	Lake
Angeles, Uldarico A.	Gary	Lake
Ansbacher, Stefan (H)	Marion	Grant
Anshutz, William M.	Indianapolis	Marion
Antes, Earl H.	Evansville	Vanderburgh
Antreasian, Berj	Indianapolis	Marion
Appel, Richard H.	Indianapolis	Marion
Apple, Eddie R.	Salem	Washington
Applegate, Albert E.	Frankfort	Clinton
Arata, Justin E.	Fort Wayne	Allen
Arata, Lucian A.	Shelbyville	Shelby
Arbeiter, Herbert I.	Munster	Lake
Arbogast, John L.	Indianapolis	Marion
Arbogast, Paul B.	Vincennes	Knox
Arbuckle, William E. (S)	Indianapolis	Marion
Arendell, Robert E.	Evansville	Vanderburgh
Arford, John E.	Warsaw	Kosciusko
Arisman, Ralph K.	South Bend	St. Joseph
Arlook, Theodore D.	Elkhart	Elkhart
Armalavage, Leon J.	Gary	Lake
Armer, Robert M.	Indianapolis	Marion
Armington, Charles L.	Anderson	Madison
Armington, Robert L.	Anderson	Madison
Armstrong, Thomas D.	Michigan City	La Porte
Arney, Amos	Michigan City	La Porte
Arnold, Aaron L.	Indianapolis	Marion
Arnold, Robert D.	Indianapolis	Marion
Aronson, Sidney S.	Indianapolis	Marion

Name	City	County
Arrowsmith, James L.	Hammond	Lake
Arthur, Nora M. (S)	Washington	Daviess-Martin
Artis, Myrle E.	Kokomo	Howard
Artz, Richard W.	Angola	Steuben
Ash, Harold H.	W. Lafayette	Tippecanoe
Asher, Ernest O. (S)	New Augusta	Marion
Asher, James W.	New Augusta	Marion
Atchison, Kenneth C. (S)	Rockport	Spencer
Atienza, Rizalino T.	Gary	Lake
Atkins, Clarence C.	Rushville	Rush
Atwood, William H.	Elkhart	Elkhart
Ault, Carl H.	Kokomo	Howard
Ault, Roy	Terre Haute	Vigo
Aust, Charles H.	Indianapolis	Marion
Austin, Charles E.	Anderson	Madison
Austin, Eugene W.	Evansville	Vanderburgh
Austin, Maynard A. (S)	Evansville	Vanderburgh
Austin, Richard P.	Bedford	Lawrence
Avery, George O.	Indianapolis	Marion
Ayres, Kenneth D.	Anderson	Madison
Ayres, Wendell W.	Marion	Grant

B

Babb, Forrest J.	Stockwell	Tippecanoe
Bacastow, Merle S.	Indianapolis	Marion
Bacevich, Andrew J.	East Chicago	Lake
Bachmann, Arnold J.	Indianapolis	Marion
Backer, George P.	LaPorte	LaPorte
Backer, Henry G.	Ferdinand	Dubois
Backer, Mary B.	LaPorte	La Porte
Backs, Alton J.	South Bend	St. Joseph
Backs, Mark F.	Willow Grove, Pa.	St. Joseph
Badders, Ara C.	Portland	Jay
Bahler, Dean R.	Leesburg	Kosciusko
Bahr, Robert E.	Fort Wayne	Allen
Bailey, Douglas A.	Marion	Grant
Bailey, Earl W.	Logansport	Cass
Bailey, Edwin B.	Linton	Greene
Bailey, Lawrence S.	Zionsville	Boone
Bailey, Orville T.	Chicago, Ill.	Marion
Bailey, Paul P.	Fort Wayne	Allen
Baird, Melvin S.	Indianapolis	Marion
Baitinger, Herbert M.	Gary	Lake
Bakemeier, Otto H.	Indianapolis	Marion
Bakemeier, Robert E.	Indianapolis	Marion
Baker, Avey M.	New Albany	Floyd
Baker, Eldon E.	Delphi	Carroll
Baker, Guy D. (S)	Crandall	Harrison-Crawford
Baker, Herman M. (S)	Evansville	Vanderburgh
Baker, John R.	Lafayette	Tippecanoe
Baker, Leslie M.	Aurora	Dearborn-Ohio
Baker, Mason R.	Evansville	Vanderburgh
Baker, Milan D.	Culver	Marshall
Baker, Warren	Michigan City	La Porte
Bakos, Edward R.	Hammond	Lake
Balch, James F	Indianapolis	Marion
Balcom, Francis H.	New Castle	Henry
Baldridge, William O.	Terre Haute	Vigo
Baldwin, John H. (S)	Jeffersonville	Clark
Balingit, Bienvenido L.	East Chicago	Lake
Balkema, Catherine M.	Lafayette	Tippecanoe
Ball, Clay A. (S)	Muncie	Delaware-Blackford
Ball, John R.	Fort Wayne	Allen
Ball, Joseph E.	Indianapolis	Marion
Ball, Margaret J.	Fort Wayne	Allen
Ball, Phillip	Muncie	Delaware-Blackford
Ballard, Charles A. (S)	Logansport	Cass
Ballenger, William E.	Richmond	Wayne-Union
Balsbaugh, George	North Manchester	Wabash
Baltes, Joseph H.	Fort Wayne	Allen
Banister, Revel H. (S)	Indianapolis	Marion
Bankoff, Milton L.	Michigan City	La Porte
Banks, Horace M.	Indianapolis	Marion
Bannon, William G.	Terre Haute	Vigo
Baptisti, Arthur, Jr.	Indianapolis	Marion
Baran, Charles	South Bend	St. Joseph
Barch, John W.	Fort Wayne	Allen
Barclay, Irvin C.	Evansville	Vanderburgh
Bard, Frank B.	Crothersville	Jackson
Barden, Tom P.	Indianapolis	Marion
Barnes, Helen B.	Greenwood	Johnson
Barnett, Ralph E.	Peru	Miami
Barnhart, Willard T.	Evansville	Vanderburgh
Barone, Carmelo V.	Mishawaka	St. Joseph
Barrett, Thomas L.	Vincennes	Knox
Barron, Elmer A.	East Chicago	Lake
Barrow, John H.	Dale	Spencer
Barry, Maurice J. (S)	Indianapolis	Marion
Bartholomew, Mary L.	Goshen	Elkhart
Bartle, James Leo	Indianapolis	Marion
Bartlett, Donald T.	Vincennes	Knox
Bartley, Max D.	Indianapolis	Marion
Barton, Reginald R.	Gary	Lake
Barton, Robert	Angola	Steuben
Barton, Willoughby M.	Centerville	Wayne-Union
Bartsch, Harvey L.	South Bend	St. Joseph
Bash, Wallace E.	Fort Wayne	Allen
Baskett, Russell J.	Jonesboro	Grant
Bassett, Margaret	Thorntown	Boone
Bassler, Carl R. (S)	Niles, Mich.	St. Joseph
Bastnagel, William F.	Indianapoils	Marion
Batman, Gordon W.	Indianapolis	Marion
Batt, David J.	Muncie	Delaware-Blackford
Battersby, J. Stanley	Indianapolis	Marion
Batties, Paul A.	Indianapolis	Marion
Bauer, Thomas B.	Indianapolis	Marion
Baughn, William L.	Anderson	Madison
Baum, John R.	Warsaw	Kosciusko
Baumeister, Herbert E.	Indianapolis	Marion
Baxter, Harry R.	Seymour	Jackson
Baxter, John P.	Indianapolis	Marion
Baxter, Neal E.	Bloomington	Owen-Monroe
Baxter, Samuel M.	New Albany	Floyd
Bayley, William E.	Lafayette	Tippecanoe
Baylor, Edward M.	Evansville	Vanderburgh
Baynes, Frank L.	Wolcott	White
Beach, Robert R.	Indianapolis	Marion
Beam, Vernon B.	East Chicago	Lake
Beamer, Parker R.	Indianapolis	Marion
Beams, Ralph H.	Fort Wayne	Allen
Bean, Joseph S.	Logansport	Cass
Beardsley, Frank A.	Frankfort	Clinton
Beaven, John B.	Jasper	Dubois
Beaver, Ernest R.	Rensselaer	Jasper-Newton
Beaver, Howard W.	Indianapolis	Marion
Beaver, Norman E.	Berne	Adams
Bechtold, Samuel E.	South Bend	St. Joseph
Beck, David C.	Monticello	White
Beck, Evart M.	Indianapolis	Marion
Beck, Herma A. (S)	Lebanon	Boone
Beck, Robert E.	Evansville	Vanderburgh
Beck, Thomas A.	Swayzee	Grant
Becker, Harry G.	Indianapolis	Marion
Becker, Philip H.	Crown Point	Lake
Becker, Samuel W.	Whiting	Lake
Beckes, Ellsworth W.	Vincennes	Knox
Beconovich, Robert	Hammond	Lake
Bedwell, Marion H.	Sullivan	Sullivan
Beeler, Franklin K.	Anderson	Madison
Beeler, John W.	Indianapolis	Marion
Beeler, Raymond C. (S)	Indianapolis	Marion
Beeson, Wilbur	Greenfield	Hancock
Begley, Joseph W., Jr.	Evansville	Vanderburgh

Name	City	County
Beggs, Lowell F.	Columbus	Bartholomew-Brown
Behn, Walter M., Jr.	Kokomo	Howard
Behn, Walter M.	Gary	Lake
Behnke, Roy H.	Indianapolis	Marion
Beierlein, Karl M.	Fort Wayne	Allen
Beilke, Clifford A.	East Chicago	Lake
Belding, Ray T.	Kokomo	Howard
Bell, Horace D.	South Bend	St. Joseph
Belshaw, George	Indianapolis	Marion
Belt, James H.	Indianapolis	Marion
Benages, Anthony G.	Terre Haute	Vigo
Benchik, Frank A.	East Chicago	Lake
Bender, Cecil K.	Goshen	Elkhart
Bender, Martin J.	Evansville	Vanderburgh
Bender, Robert L.	Elkhart	Elkhart
Bendler, Carl H.	Gary	Lake
Benedict, Charles D.	LaGrange	LaGrange
Benedict, Paul F.	Indianapolis	Marion
Benham, Lawrence E.	Bedford	Lawrence
Benken, Lawrence D.	Muncie	Delaware-Blackford
Bennett, Abner P.	Evansville	Vanderburgh
Bennett, Ivan F.	Indianapolis	Marion
Bennett, J. B.	Warren	Huntington
Bennett, Jene R.	South Bend	St. Joseph
Benninghoff, Daniel R. (S)	Fort Wayne	Allen
Benson, James E.	Elkhart	Elkhart
Benz, Jesse (S)	Marengo	Harrison-Crawford
Benz, Owen F.	Wanatah	La Porte
Bergal, Milton B.	Gary	Lake
Bergan, Joseph A.	Michigan City	La Porte
Bergendahl, Emil H.	Fort Wayne	Allen
Berger, Morley	Beech Grove	Marion
Berghoff, James R.	Fort Wayne	Allen
Berghoff, Raymond J.	Fort Wayne	Allen
Bergwall, Warren L.	Muncie	Delaware-Blackford
Berke, Robert D.	South Bend	St. Joseph
Berkshire, Shaffer B.	North Vernon	Jennings
Berkson, Myron E.	Michigan City	La Porte
Berman, Edward J.	Indianapolis	Marion
Berman, Jacob K.	Indianapolis	Marion
Bernard, Marvin R.	Gary	Lake
Bernoske, Daniel G.	Crown Point	Lake
Best, Robert C.	Whiting	Lake
Bethea, Dennis A. (S)	Hammond	Lake
Bethea, Robert O.	Farmersburg	Sullivan
Beutler, Theodore V.	Fort Wayne	Allen
Beverland, Malon E. (S)	Indianapolis	Marion
Biasini, Benedict A.	South Bend	St. Joseph
Bibler, Henry E.	Muncie	Delaware-Blackford
Bibler, Lester D.	Indianapolis	Marion
Bichacoff, Billie D.	Bozeman, Mont.	Allen
Bickel, David A.	South Bend	St. Joseph
Bidney, Evelyn B.	Bloomington	Owen-Monroe
Bigler, Frederick W.	Goshen	Elkhart
Bill, Robert O.	Indianapolis	Marion
Billings, Elmer R.	Elkhart	Elkhart
Bills, R. James	Gary	Lake
Bills, Robert N.	Gary	Lake
Bird, Charles R. (S)	Indianapolis	Marion
Birdzell, John P.	Crown Point	Lake
Birmingham, Peter J. (S)	South Bend	St. Joseph
Birum, Patricia	Union City	Randolph
Bizer, Mier	Jeffersonville	Clark
Bisgyer, Jay L.	Gary	Lake
Bishop, Charles A.	South Bend	St. Joseph
Bishop, Harry A.	Frankton	Madison
Bishop, Robert E.	Bluffton	Wells
Bissonnette, Roger P.	Evansville	Vanderburgh
Bivin, James H.	Mooresville	Morgan
Bixler, Donald P.	Anderson	Madison
Bixler, Louis C.	South Bend	St. Joseph
Bjorklund, C. Ray	Hobart	Lake
Black, Boyd K.	Vincennes	Knox
Black, Edgar K.	Circleville, O.	Wabash
Black, Henry R.	Indianapolis	Marion
Black, James	Brownsburg	Hendricks
Black, Joe M.	Seymour	Jackson
Blackburn, Erwin	South Bend	St. Joseph
Blackford, Florence	Indianapolis	Marion
Blackford, Ralph E.	Indianapolis	Marion
Blackwell, Donald S.	Indianapolis	Marion
Blake, Albert L.	Indianapolis	Marion
Blassaras, Chris	Anderson	Madison
Blatt, A. Ebner	Indianapolis	Marion
Blazey, Arthur G.	Washington	Daviess-Martin
Bledsoe, James G.	New Castle	Henry
Blessinger, Louis H.	Corydon	Harrison-Crawford
Blessinger, Paul J.	Jasper	Dubois
Blichert, Peter A.	Fort Wayne	Allen
Blix, Fred M.	Ladoga	Montgomery
Bloemker, Edward F.	Indianapolis	Marion
Bloom, Asa W.	Marion	Grant
Bloom, George R.	Elkhart	Elkhart
Bloomer, Richard S.	Rockville	Parke-Vermillion
Blosser, Blaine A. (S)	Fremont	Steuben
Blosser, Howard V. (S)	Fort Wayne	Allen
Blossom, Paul W.	Richmond	Wayne-Union
Blum, Leon L.	Terre Haute	Vigo
Boardman, Carl (S)	Gary	Lake
Bobb, Kenneth E.	Seymour	Jackson
Bobowski, Stan J.	San Francisco, Calif.	Marion
Bodnar, Leslie M.	South Bend	St. Joseph
Bogardus, Carl R.	Austin	Scott
Boggs, Eugene F.	Indianapolis	Marion
Bogmenko, Leon T.	Pendleton	Madison
Bohner, Caryle B.	Hidalgo, Mexico	Marion
Bolin, John T. (S)	Mountain Home, Arkansas	Lake
Bolin, Robert C.	Lafayette	Tippecanoe
Boling, Grover C., Jr.	Indianapolis	Marion
Bolman, Ralph M.	Fort Wayne	Allen
Bombar, Leslie E.	Hammond	Lake
Bonaventura, Angelo P.	East Chicago	Lake
Bond, George S. (S)	Indianapolis	Marion
Bond, Virginia	Indianapolis	Marion
Bond, Walter C.	Clay City	Clay
Bond, William H.	Indianapolis	Marion
Boneta, Thomas L.	Scottsburg	Scott
Bonsett, Charles A.	Indianapolis	Marion
Booher, Norman R.	Indianapolis	Marion
Booher, Olga Bonke	Indianapolis	Marion
Booker, Harold E.	Indianapolis	Marion
Boone, Max L.	Peru	Miami
Boone, Robert D.	Evansville	Vanderburgh
Boonstra, Charles E.	Bluffton	Wells
Booth, Boynton H.	Indianapolis	Marion
Booth, Franklin M.	South Bend	St. Joseph
Booze, James	Indianapolis	Marion
Bopp, Henry, Jr.	Terre Haute	Vigo
Bopp, James	Terre Haute	Vigo
Borak, Walter J.	Gary	Lake
Borders, Theodore R.	Fort Wayne	Allen
Boren, Paul	Poseyville	Posey
Boren, Samuel W. (S)	Poseyville	Posey
Borenstein, Herschel	Gary	Lake
Borland, Raymond M.	Bloomington	Owen-Monroe
Borough, Lester D.	South Bend	St. Joseph
Bosch, Ralph	Seymour	Jackson

Name	City	County
Bosler, Howard A.	Waterford Mills, mail Goshen	Elkhart
Bossard, John W.	Fort Wayne	Allen
Boswell, Robert W. C.	Evansville	Vanderburgh
Botkin, Charles (S)	Muncie	Delaware-Blackford
Botkin, Clyde G.	Muncie	Delaware-Blackford
Botkin, Thomas	Muncie	Delaware-Blackford
Boughman, Joseph D.	Kokomo	Howard
Bowdoin, George E.	Elkhart	Elkhart
Bowen, Otis R.	Bremen	Marshall
Bowers, Charles R.	Anderson	Madison
Bowers, Copeland C.	Kokomo	Howard
Bowers, Gah T.	Fort Wayne	Allen
Bowers, Garvey B.	Kokomo	Howard
Bowers, George W.	Indianapolis	Marion
Bowers, John A.	Kokomo	Howard
Bowers, Jesse W. (S)	Fort Wayne	Allen
Bowman, Charles M.	Albion	Noble
Bowman, Geo. W. (S)	Indianapolis	Marion
Bowser, Philip G.	Goshen	Elkhart
Boyd, Charles S.	East Chicago	Lake
Boyd, H. Clark	Terre Haute	Vigo
Boyd, Stella N.	Evansville	Vanderburgh
Boyer, Floyd A.	Indianapolis	Marion
Boyer, Grace B.	Marion	Grant
Boyer, Philip A.	Indianapolis	Marion
Boyle, Carroll	Poseyville	Posey
Boys, Frank F.	East Chicago	Lake
Boze, Robert L.	Berne	Adams
Bradley, Charles F.	Hobart	Lake
Bradley, Louis F.	Bluffton	Wells
Bradley, Stephen C. (S)	Terre Haute	Vigo
Brady, Kingdon	Morocco	Jasper-Newton
Brady, Samuel G.	Gary	Lake
Brady, Thomas A.	Indianapolis	Marion
Brakel, Frank J.	Evansville	Vanderburgh
Brandman, Harry	Gary	Lake
Brandt, William E.	Fort Wayne	Allen
Brauchla, Carl H. (S)	Anderson	Madison
Brauer, Abraham A.	East Chicago	Lake
Braun, Benjamin D.	Chicago, Ill.	Lake
Braunlin, Robert F.	Marion	Grant
Brayton, John R., Jr.	Key West, Fla.	Marion
Brayton, John R.	Indianapolis	Marion
Brayton, Lee	Indianapolis	Marion
Brazelton, Osborne T. (S)	San Diego, Calif.	Gibson
Brechtl, Harvey J.	South Bend	St. Joseph
Breedlove, Dane	Ft. Defiance, Ariz.	Grant
Breneman, William L.	Lowry AFB, Denver, Colo.	Marion
Brenner, Andrew M.	Winchester	Randolph
Bretz, John M.	Huntingburg	Dubois
Brewer, Robert A.	A.P.O. 114, New York, N. Y.	Wells
Brickley, Harry D. (S)	Bluffton	Wells
Brickley, Richard A.	Indianapolis	Marion
Bridges, Alvin	Anderson	Madison
Bridges, William L.	Fort Wayne	Allen
Bridwell, Edgar	Bedford	Lawrence
Briggs, Robert W.	Indianapolis	Marion
Brillhart, James R.	Indianapolis	Marion
Brincko, John	Gary	Lake
Bringas, Irineo B.	Gary	Lake
Brink, Calvin C. (S)	Gary	Lake
Bristol, Henry M. S.	Terre Haute	Vigo
Britt, Robert	Evansville	Vanderburgh
Britton, Welbon D.	Montezuma	Parke-Vermillion
Brock, Earl E. (S)	Anderson	Madison
Brockman, Wilfred	Corydon	Harrison-Crawford
Brockmole, Arnold W.	Evansville	Vanderburgh
Brodie, Donald W.	Indianapolis	Marion
Bromley, Luman W.	Fort Wayne	Allen
Bronson, Paul J.	Terre Haute	Vigo
Brooks, Fred R., Jr.	Indianapolis	Marion
Brooks, Harry L.	Michigan City	La Porte
Broomes, Edward L. C.	East Chicago	Lake
Broshears, Kenneth P.	Linton	Greene
Brosius, Robert H. W.	Fort Wayne	Allen
Brown, Archie E.	Indianapolis	Marion
Brown, David B.	Gary	Lake
Brown, David E.	Indianapolis	Marion
Brown, Dewitt W.	Indianapolis	Marion
Brown, Earl R. Jr.	Kokomo	Howard
Brown, Frances T.	Indianapolis	Marion
Brown, Frank M.	Indianapolis	Marion
Brown, Frederic W.	Fort Wayne	Allen
Brown, George E.	Greenwood	Johnson
Brown, George W.	Evansville	Vanderburgh
Brown, Gordon T.	Indianapolis	Marion
Brown, James C.	Valparaiso	Porter
Brown, James M.	Anderson	Madison
Brown, Jesse F.	Gary	Lake
Brown, John S.	Carlisle	Sullivan
Brown, Kenneth H.	New Albany	Floyd
Brown, Leland G.	Muncie	Delaware-Blackford
Brown, Leo R.	Gary	Lake
Brown, Marcel S.	Spencer	Owen-Monroe
Brown, Richard J.	Richmond	Wayne-Union
Brown, Robert M.	Marion	Grant
Brown, Robert R.	Terre Haute	Vigo
Brown, Stewart D.	Albany	Delaware-Blackford
Brown, Thomas C.	Indianapolis	Marion
Brown, Thomas M.	Muncie	Delaware-Blackford
Brown, Wendell E.	Indianapolis	Marion
Browning, James S.	Indianapolis	Marion
Browning, William M.	Indianapolis	Marion
Brownley, Emma J.	Indianapolis	Marion
Brubaker, Harold S.	Huntington	Huntington
Brubaker, Ora G. (S)	North Manchester	Wabash
Brubeck, Robert E.	Martinsville	Morgan
Bruce, Reginald A.	Indianapolis	Marion
Brueckman, F. Robert	Indianapolis	Marion
Bruegge, Theodore J.	Kokomo	Howard
Bruetsch, Walter L.	Indianapolis	Marion
Bruner, Ralph W.	Jeffersonville	Clark
Bryan, Franklin A.	Fort Wayne	Allen
Bryan, Robert E.	Kendallville	Noble
Bryan, Robert J.	South Bend	St. Joseph
Bryan, Stanton L.	Evansville	Vanderburgh
Bryant, Edward G.	East Chicago	Lake
Buchanan, Wallace D.	South Bend	St. Joseph
Buche, Franklin P. (S)	Richmond	Wayne-Union
Buchholz, Ransom R.	Georgetown, Texas	Vanderburgh
Buckingham, Richard E.	Bloomington	Owen-Monroe
Buckles, David L.	Anderson	Madison
Buchman, Marshall H.	New Albany	Floyd
Buckner, George D.	Fort Wayne	Allen
Buckner, Joy F.	Bluffton	Wells
Buechler, William F.	Elwood	Madison
Buechner, Frederick W.	South Bend	St. Joseph

Name	City	County
Buehler, George M.	Jeffersonville	Clark
Buehner, Donald F.	Evansville	Vanderburgh
Bugh, Charles W.	Fairbanks, Alaska	Marion
Buhrmester, Harry C.	Lafayette	Tippecanoe
Bullard, Mattie J.	Gary	Lake
Bullers, Robert C.	Franklin	Johnson
Bullington, George E.	Franklin	Johnson
Bunde, Carl A.	Indianapolis	Marion
Bunker, Ladoska Z.	North Manchester	Wabash
Burcham, James B.	Gary	Lake
Burdette, Harold F.	Indianapolis	Marion
Burger, Robert A.	Gary	Lake
Burger, Thomas C.	Evansville	Vanderburgh
Burghard, Rolla D.	Indianapolis	Marion
Burk, James M.	Decatur	Adams
Burket, Cecil R.	Bremen	Marshall
Burkhardt, Boyd A.	Tipton	Tipton
Burkle, John C. (S)	Lafayette	Tippecanoe
Burkle, Robert J.	Indianapolis	Marion
Burks, Jess E.	Crawfordsville	Montgomery
Burman, Leonard	Los Angeles, Calif.	Marion
Burnett, Arthur B.	New Castle	Henry
Burnett, Paul C.	Logansport	Cass
Burnikel, Ray H.	Evansville	Vanderburgh
Burns, John T.	Lafayette	Tippecanoe
Burns, Paul E.	Montpelier	Delaware-Blackford
Burress, Clyde R.	Evansville	Vanderburgh
Burris, Floyd L.	Michigan City	La Porte
Burrous, E. Lee	Peru	Miami
Burton, Philip B.	Fort Bragg, N. C.	Marion
Burwell, Stanley W.	Muncie	Delaware-Blackford
Bush, Charles E.	Kirklin	Clinton
Bush, Hargis R.	Cannelton	Perry
Buslee, Roger M.	South Bend	St. Joseph
Bussard, Clifford F. (S)	South Bend	St. Joseph
Bussard, Frank	South Bend	St. Joseph
Butler, Joe B.	Crothersville	Jackson
Butler, John O.	Indianapolis	Marion
Butler, Robert M.	Indianapolis	Marion
Butterfield, Robert M.	Muncie	Delaware-Blackford
Butts, Milton A.	South Bend	St. Joseph
Butz, Ralph O.	Muncie	Delaware-Blackford
Byrd, Ryland P.	Jeffersonville	Clark
Byrn, Howard W. (S)	New Albany	Floyd
Byrne, Louis E.	Roachdale	Putnam
Byrne, Robert J.	Bicknell	Knox

C

Cacia, John J.	Evansville	Vanderburgh
Caffrey, James F.	Logansport	Cass
Cagle, Bob R.	New Palestine	Hancock
Cahn, Hugo M.	Indianapolis	Marion
CaJacob, Melville E.	Terre Haute	Vigo
Caldwell, Marilyn R.	Indianapolis	Marion
Caldwell, Milton V.	Terre Haute	Vigo
Caldwell, William C. (S)	Evansville	Vanderburgh
Call, Earle B. (S)	Knightstown	Henry
Call, Herbert F.	Indianapolis	Marion
Call, William H.	Ann Arbor, Mich.	Marion
Callaghan, Winship C.	Greensburg	Decatur
Callahan, Richard H.	East Chicago	Lake
Calli, Louis	North Vernon	Jennings
Calvert, John H., Jr.	Indianapolis	Marion
Calvert, Raymond R.	Lafayette	Tippecanoe
Cameron, Don F.	Angola	Steuben
Cameron, Mary H.	Angola	Steuben
Campagna, Ettor A.	East Chicago	Lake
Campbell, H. Edwin, Jr.	Indianapolis	Marion
Campbell, John A.	Indianapolis	Marion
Campbell, Patrick B.	Elkhart	Elkhart
Campbell, Robert L.	Indianapolis	Marion
Campbell, Sam W.	Noblesville	Hamilton
Campbell, William T.	Bedford	Lawrence
Canaday, Clifford E. (S)	Memphis, Tenn.	Henry
Canaday, James W. (S)	Indianapolis	Marion
Canganelli, Vincent G.	Lafayette	Tippecanoe
Cannon, Daniel H.	New Albany	Floyd
Cantwell, Edgar R.	Indianapolis	Marion
Capestany, Max A.	Indianapolis	Marion
Caplin, Irvin	Indianapolis	Marion
Caplin, Samuel S.	Westville	LaPorte
Carberry, George A.	Gary	Lake
Carbone, Joseph A.	Gary	Lake
Carey, J. Albert	Gary	Lake
Carey, Willis W. (S)	Kendallville	Noble
Carlo, Ernest R.	Fort Wayne	Allen
Carlson, Edward A. (S)	Peru	Miami
Carlson, Norman R.	Michigan City	La Porte
Carlson, Ralph F.	Evansville	Vanderburgh
Carlyle, Ivan E. (S)	Michigantown	Clinton
Carmody, Raymond F.	Gary	Lake
Carneal, Thomas E. (S)	Winamac	Pulaski
Carney, Joel T.	Jeffersonville	Clark
Carney, John C.	Monticello	White
Carpenter, James B.	Lafayette	Tippecanoe
Carpenter, Ramesh S.	Garrett	DeKalb
Carpentier, Harry F.	Princeton	Gibson
Carpentier, James R.	La Porte	La Porte
Carr, Joseph H.	Henryville	Clark
Carrel, Francis E.	Frankfort	Clinton
Carroll, Bertha Rose	W. Lafayette	Tippecanoe
Carroll, John C.	Decatur	Adams
Carroll, Mary E.	Crown Point	Lake
Carson, Wayne	Indianapolis	Marion
Carter, F. R. Nicholas	South Bend	St. Joseph
Carter, Fred S.	La Porte	La Porte
Carter, Jean V.	Tipton	Tipton
Carter, John O.	Hobart	Lake
Carter, Oren E.	Indianapolis	Marion
Carter, William D.	Walkerton	St. Joseph
Cartwright, Emor L. (S)	Fort Wayne	Allen
Cartwright, Jack D.	La Porte	La Porte
Casey, Stanley M.	Huntington	Huntington
Cassady, James V.	South Bend	St. Joseph
Cassady, John R.	South Bend	St. Joseph
Cattell, Lee M.	Kokomo	Howard
Cavins, Alexander W.	Terre Haute	Vigo
Caylor, Charles H.	Bluffton	Wells
Caylor, Harold D.	Bluffton	Wells
Caylor, Truman E.	Bluffton	Wells
Chael, Thomas C.	Hammond	Lake
Challman, William B.	Mt. Vernon	Posey
Chambers, Alan R.	Fort Wayne	Allen
Chambers, Carol R.	Union City	Randolph
Chambers, Leroy B.	Union City	Randolph
Chambers, Pauline D.	Greenwood	Johnson
Chamblee, Roland W.	South Bend	St. Joseph
Chandler, Leon H.	Goshen	Elkhart
Chappel, Alfred T.	Franklin	Johnson
Charles, Henry L.	Hagerstown	Wayne-Union
Chase, James A.	Ligonier	Noble
Chattin, Herbert O.	Vincennes	Knox
Chattin, Robert E.	Loogootee	Daviess-Martin
Chattin, William R.	Indianapolis	Marion
Chattin, Vance J.	Washington	Daviess-Martin
Chen, Ko K.	Indianapolis	Marion
Cheng, Sylvia F.	Logansport	Cass

Name	City	County
Cheydleur, Eleanor P.	Evansville	Vanderburgh
Chernish, Stanley M.	Indianapolis	Marion
Chevalier, Robert A.	Indianapolis	Marion
Chevigny, Julius J.	Gary	Lake
Chidlaw, Benj. W. (S)	Hammond	Lake
Childress, Richard H.	Indianapolis	Marion
Childress, Robert C.	Indianapolis	Marion
Childs, Alpha G. W. (S)	Madison	Jefferson-Switzerland
Childs, Wallace E.	Madison	Jefferson-Switzerland
Chivington, Paul V.	Indianapolis	Marion
Christiansen, Philip A.	Indianapolis	Marion
Christie, Marvin	Beech Grove	Marion
Christie, Robert W.	Muncie	Delaware-Blackford
Christophel, Verna	Mishawaka	St. Joseph
Chroniak, Walter	Indianapolis	Marion
Chu, Johnson C. S.	Logansport	Cass
Chube, David D.	Gary	Lake
Clancy, James F.	Hammond	Lake
Clark, Cecil P.	Indianapolis	Marion
Clark, George A.	Birmingham, Michigan	Marion
Clark, Ivan A.	Paoli	Orange
Clark, Jack P.	Syracuse	Kosciusko
Clark, Lawson J.	Indianapolis	Marion
Clark, Marion E.	Cambridge City	Wayne-Union
Clark, Stanley A. (S)	South Bend	St. Joseph
Clark, Thomas W.	Evansville	Vanderburgh
Clark, William B., Jr.	Jeffersonville	Clark
Clark, William H.	South Bend	St. Joseph
Clark, William R.	Fort Wayne	Allen
Clarke, Elton R.	Kokomo	Howard
Clarkson, Clarence G.	Liberty	Wayne-Union
Classen, Pete R. C.	Elkhart	Elkhart
Clay, Eleanor	Columbus	Bartholomew-Brown
Claybourn, Norman L.	East Chicago	Lake
Cleveland, John B.	Michigan City	La Porte
Clevenger, Joseph H.	Muncie	Delaware-Blackford
Clevinger, William G.	Indianapolis	Marion
Cline, Kenneth L.	Wyatt	St. Joseph
Close, Gerald A.	Indianapolis	Marion
Close, W. Donald	Indianapolis	Marion
Clouse, Paul A.	Evansville	Vanderburgh
Clunie, William A.	Huntington	Huntington
Coade, George E.	Indianapolis	Marion
Coates, Jacqueline	Indianapolis	Marion
Cobb, Clarence M.	Logansport	Cass
Coble, Frank H.	Richmond	Wayne-Union
Coble, Ralph R. (S)	Indianapolis	Marion
Cochran, Harry A., Jr.	Fort Wayne	Allen
Cochran, John F.	Bloomington	Owen-Monroe
Cochran, Robert B.	Muncie	Delaware-Blackford
Cockrum, William M.	Evansville	Vanderburgh
Coddens, Avery L.	Earl Park	Benton
Coddington, Robert C.	Indianapolis	Marion
Coffel, Melvin H.	Vincennes	Knox
Coggeshall, Warren E.	Indianapolis	Marion
Cohen, Irving	Plainfield	Hendricks
Cohn, Alvin F.	Indianapolis	Marion
Cole, Ira	Lafayette	Tippecanoe
Cole, William L.	Evansville	Vanderburgh
Coleman, Floyd B.	Waterloo	DeKalb
Coleman, Henry G.	Salem	Washington
Coleman, Joseph E.	Evansville	Vanderburgh
Colip, George D.	South Bend	St. Joseph
Collins, Hubert L.	Indianapolis	Marion
Collins, Robert C.	Indianapolis	Marion
Colvin, Robert C.	Newburgh	Warrick
Colosey, Frederick J.	South Bend	St. Joseph
Combs, Herman T.	Evansville	Vanderburgh
Combs, John H.	Evansville	Vanderburgh
Combs, Loyal W.	W. Lafayette	Tippecanoe
Combs, Pearl B. (S)	Evansville	Vanderburgh
Combs, Stuart R.	Terre Haute	Vigo
Comeau, William J.	Marion	Grant
Comer, Kenneth E.	Mooresville	Morgan
Compton, George	Tipton	Tipton
Compton, Walter A.	Elkhart	Elkhart
Condit, David H.	South Bend	St. Joseph
Conforti, Victor P.	Terre Haute	Vigo
Congleton, G. C. (S)	Terre Haute	Vigo
Conklin, James O.	Terre Haute	Vigo
Conklin, Raymond L.	South Bend	St. Joseph
Conley, John E.	Fort Wayne	Allen
Conley, Joseph L. (S)	Indianapolis	Marion
Conley, Thomas M.	Kokomo	Howard
Connell, Paul S.	Plymouth	Marshall
Connell, Vactor O.	Bourbon	Marshall
Connelly, Richard D.	Fort Wayne	Allen
Connoy, Andrew F.	Westfield	Hamilton
Connoy, Leo F.	Westfield	Hamilton
Conrad, Henry W.	Lawrenceburg	Dearborn-Ohio
Conway, Chester C.	Indianapolis	Marion
Conway, Glenn	Indianapolis	Marion
Conway, Thomas J.	Terre Haute	Vigo
Cook, Charles E.	North Manchester	Wabash
Cook, Gordon C.	South Bend	St. Joseph
Cook, Norman R.	Richmond	Wayne-Union
Cook, Robert G.	Bluffton	Wells
Cooksey, Thomas L. (S)	Crawfordsville	Montgomery
Cooney, Charles J.	Fort Wayne	Allen
Coons, John D.	Lebanon	Boone
Coons, Ritchie	Lebanon	Boone
Cooper, B. Trent	Roanoke	Huntington
Cooper, Harry L. (S)	South Bend	St. Joseph
Cooper, John	Muncie	Delaware-Blackford
Cooper, Leo K.	Gary	Lake
Cooper, Waller W.	Evansville	Vanderburgh
Cope, Stanton E.	Huntington	Huntington
Corcoran, Patrick J. V.	Evansville	Vanderburgh
Cormican, Herbert L.	Elkhart	Elkhart
Cornacchione, Matthew	Indianapolis	Marion
Cornell, Robert A.	Crawfordsville	Montgomery
Corpe, Kenneth F.	Rushville	Rush
Corrao, Gaetano	Gary	Lake
Corsentino, Bart	Vincennes	Knox
Cortese, James V.	Indianapolis	Marion
Cortese, Thomas A.	Indianapolis	Marion
Costello, Albert J.	Hammond	Lake
Cotter, Edward R.	Hammond	Lake
Cottrell, Robert F.	Fort Wayne	Allen
Coughenour, J. Robert	Indianapolis	Marion
Countryman, Frank W.	Indianapolis	Marion
Coursey, James O.	Plymouth	Marshall
Covalt, Wendell E.	Muncie	Delaware-Blackford
Covell, Harry M.	Auburn	DeKalb
Covey, Thomas J.	Valparaiso	Porter
Cox, Clifford E. (S)	Indianapolis	Marion
Cox, Leon T.	Richmond	Wayne-Union
Coyner, Alfred B.	Lafayette	Tippecanoe
Craft, Kenneth L.	Indianapolis	Marion
Craig, Alexander F.	New Castle	Henry
Craig, Harry L.	Indianapolis	Marion
Craig, Reuben	Kokomo	Howard
Craig, Reuben A.	Kokomo	Howard
Craig, Richard M.	Fort Wayne	Allen
Craig, Robert A.	Syracuse	Kosciusko
Crain, James W.	Williamsport	Fountain-Warren

Name	City	County
Crampton, Chas. C. (S)	Delphi	Carroll
Crandall, Lathan A.	Elkhart	Elkhart
Crawford, James H.	Evansville	Vanderburgh
Crawford, John A.	Indianapolis	Marion
Crawford, Theodore R.	Kokomo	Howard
Creek, Jean A.	Bloomington	Owen-Monroe
Crevello, Albert J.	Evansville	Vanderburgh
Crimm, Paul D.	Evansville	Vanderburgh
Cring, George V. (S)	Portland	Jay
Cripe, Earl P.	Bremen	Marshall
Cripe, William	Portland	Jay
Crist, John R.	Mt. Vernon	Posey
Crockett, Franklin S. (H)	West Lafayette	Tippecanoe
Crockett, Wayne A.	Terre Haute	Vigo
Cron, William J.	Warsaw	Kosciusko
Cronin, H. Joseph	Portland	Jay
Cross, David G.	Indianapolis	Marion
Crowder, James H.	Sullivan	Sullivan
Crowley, Joseph B.	South Bend	St. Joseph
Crudden, Charles H.	Evansville	Vanderburgh
Crum, Marion M.	Angola	Steuben
Culbertson, Carl S.	South Bend	St. Joseph
Culbertson, Clyde G.	Indianapolis	Marion
Cullen, Paul K.	Indianapolis	Marion
Cullen, Paul K., Jr.	Rochester, Minn.	Marion
Cullnane, Chris W.	Evansville	Vanderburgh
Culloden, William G.	Indianapolis	Marion
Culmer, Walter N. (S)	Indianapolis	Marion
Culp, John E.	Fort Wayne	Allen
Cunningham, Gene C.	Indianapolis	Marion
Cunningham, Robert D.	Marion	Grant
Cure, Charles W.	Indianapolis	Marion
Cure, Elmer T.	Muncie	Delaware-Blackford
Currie, Robert W.	Indianapolis	Marion
Curry, R. Louis	Indianapolis	Marion
Curtner, Myron L. (S)	Vincennes	Knox
Custer, Edward W.	South Bend	St. Joseph
Cuthbert, Marvin P.	Indianapolis	Marion
Cutshaw, James A.	Monroeville	Allen
Cymbala, Bohdan	Evansville	Vanderburgh
Czenkusch, Helen G.	Indianapolis	Marion

D

Daggy, B. T.	Richmond	Wayne-Union
Daggy, James R.	Richmond	Wayne-Union
Dahling, Clemens W.	New Haven	Allen
Dailey, James E.	Watseka, Ill.	Marion
Dainko, Alfred J.	East Chicago	Lake
Dale, Maxwell H.	Connersville	Fayette-Franklin
Daley, Edward H.	Indianapolis	Marion
Dallas, Fred R.	Indianapolis	Marion
Dallas, Mary E.	Indianapolis	Marion
Dalton, John E.	Indianapolis	Marion
Dalton, William W.	Indianapolis	Marion
Dalton, Wilson L.	Shelbyville	Shelby
Daly, Joseph M.	Indianapolis	Marion
Dancer, Charles R. (S)	Fort Wayne	Allen
Daniel, John C.	Indianapolis	Marion
Daniel, Robert A.	Gary	Lake
Danieleski, Ladislaus J.	Gary	Lake
Daniels, George R. (S)	Marion	Grant
Dann, Morton W.	Indianapolis	Marion
Dannacher, William D.	Wabash	Wabash
Dare, Lee A.	Jeffersonville	Clark
Darling, Dorothy	Gary	Lake
Datzman, Basil J.	La Porte	La Porte
Datzman, Richard C.	Fort Wayne	Allen
Daugherty, Fred N.	Crawfordsville	Montgomery
Daugherty, Silas C.	Evansville	Vanderburgh
Daugherty, William L.	Hutsonville, Ill.	Sullivan
Daves, William L.	Evansville	Vanderburgh
Davidoff, Manuel A.	Ossian	Wells
Davidson, Dale A.	Indianapolis	Marion
Davidson, Harold H.	Evansville	Vanderburgh
Davidson, N. Cort	Indianapolis	Marion
Davies, Robert	New Castle	Henry
Davis, Alice Hall (S)	Hammond	Lake
Davis, Carl M.	Valparaiso	Porter
Davis, Edgar C.	Muncie	Delaware-Blackford
Davis, Howard B.	Lafayette	Tippecanoe
Davis, John A.	Flat Rock	Shelby
Davis John A.	Indianapolis	Marion
Davis, John C. (S)	Logansport	Cass
Davis, Joseph B.	Marion	Grant
Davis, Lloyd H. (S)	Madison	Jefferson-Switzerland
Davis, Margaret M.	Indianapolis	Marion
Davis, Marvin R.	Columbus	Bartholomew-Brown
Davis, Merle J.	Terre Haute	Vigo
Davis, Merrill S.	Marion	Grant
Davis, Neal	Gary	Lake
Davis, Parvin M.	New Albany	Floyd
Davis, Richard	Marion	Grant
Davis, Sam J.	Indianapolis	Marion
Davis, Thomas N. III	Hammond	Lake
Davis, William H.	New Market	Montgomery
Day, William D. C.	Seymour	Jackson
Deal, Eleanor H.	Speedway City	Marion
Dean, Donald I.	Rushville	Rush
Dearmin, Robert M.	Indianapolis	Marion
DeArmond, Murray	Indianapolis	Marion
De Bois, Elon	Gary	Lake
Decker, Harvey	Terre Haute	Vigo
Deems, Myers B.	Evansville	Vanderburgh
Deever, John W.	Indianapolis	Marion
DeFries, John J.	New Paris	Elkhart
DeGrazia, Eugene J.	Valparaiso	Porter
Deitch, Robert D.	Indianapolis	Marion
DeMotte, C. Bowen	Indianapolis	Marion
DeNaut, James F.	Knox	Starke
Denham, Robert H.	South Bend	St. Joseph
Dennison, Alfred D., Jr.	Indianapolis	Marion
Denny, E. Rankin	Terre Haute	Vigo
Denny, Forrest L.	Indianapolis	Marion
Denny, James W.	Indianapolis	Marion
Denny, Melvin H.	Rushville	Rush
Denton, Larkin D.	Greentown	Howard
Denzer, Edward K.	Evansville	Vanderburg
Denzer, William O.	Evansville	Vanderburgh
Deppe, Charles F.	Franklin	Johnson
DeRenne, William L.	Newport	Parke-Vermillion
Derhammer, George L.	Brookston	White
DesJean, Paul A.	Indianapolis	Marion
Dester, Herbert E.	Greencastle	Putnam
DeTar, George B. (S)	Winslow	Pike
Detrick, Herbert W. (S)	Sarasota, Fla.	Lake
Dettloff, Frederick	Greencastle	Putnam
Deur, Julius	Lafayette	Tippecanoe
Deutsch, William	Muncie	Delaware-Blackford
DeVoe, Kenneth	South Bend	St. Joseph
DeWees, Dwight L.	Indianapolis	Marion
Dhein, Donald T.	Crown Point	Lake
Diamond, Leo L.	Marion	Grant
Dian, August J.	Gary	Lake
Dickerson, W. Martin	Monticello	White
Dickey, William M.	Bay Pines, Fla.	Marion
Dickson, Carolyn L.	Indianapolis	Marion

Name	City	County
Dickson, Dale D.	Greensburg	Decatur
Dieckman, Herbert S.	Evansville	Vanderburgh
Diefendorf, Charles F. (S)	Evansville	Vanderburgh
Dielman, Franklin C. (S)	Fulton	Fulton
Dierdorf, Fred W.	APO 125, New York, N.Y.	Marion
Dierolf, Edward J.	Gary	Lake
Dieter, William J.	Fort Wayne	Allen
Dietl, Ernest L.	South Bend	St. Joseph
Dietz, Richard A.	Greensburg	Decatur
Dill, Charles W.	Beech Grove	Marion
Dill, Myron K.	Indianapolis	Marion
Dillman, Carl E.	Corydon	Harrison-Crawford
Dilts, Robert L.	Indianapolis	Marion
Dimmett, Robert P.	Metairie, La.	Warrick
Dingle, Paul E.	Richmond	Wayne-Union
Dininger, William S.	Winchester	Randolph
Dintaman, Paul G.	Indianapolis	Marion
Dirks, Kenneth R.	F.P.O., New York, N. Y.	Marion
Dittmer, Jack E.	Valparaiso	Porter
Dittmer, Thomas L.	Valparaiso	Porter
Ditton, Irvin W. (S)	Fort Wayne	Allen
Dixon, Fritz R.	Houston, Texas	Marion
Dixon, Rex W.	Anderson	Madison
Dluzansky, James J.	Indianapolis	Marion
Dodd, Robert D.	South Bend	St. Joseph
Dodd, Roberts K.	Evansville	Vanderburgh
Dodds, James U.	Hartford City	Delaware-Blackford
Dodds, Wemple	Crawfordsville	Montgomery
Doenges, James L.	Anderson	Madison
Doherty, Raymond J.	Crown Point	Lake
Dolezal, Bernard J.	South Bend	St. Joseph
Dollens, Claude (S)	Oolitic	Lawrence
Dome, Hardin S. (S)	Tell City	Perry
Donahue, Claude M.	Carmel	Hamilton
Donahue, Francis E.	Dublin	Wayne-Union
Donahue, George R.	Lafayette	Tippecanoe
Donahue, James M.	Indianapolis	Marion
Donaldson, Frank C.	Anderson	Madison
Donato, Albert M.	Indianapolis	Marion
Donchess, Joseph C.	Gary	Lake
Doneff, Ronald H.	Indianapolis	Marion
Donnelly, Everett F.	Indianapolis	Marion
Doran, J. Hal	Indianapolis	Marion
Dorman, Willis L.	Indianapolis	Marion
Dormire, Robert D.	Warsaw	Koscuisko
Dorrance, Thomas O.	Bluffton	Wells
Dosado, Elpidio B.	Gary	Lake
Doss, Jerome F.	Indianapolis	Marion
Doty, James R., Jr.	Indianapolis	Marion
Doughty, Samuel R., Jr.	Indianapolis	Marion
Douglas, William T.	Montpelier	Delaware-Blackford
Dovey, Edward G.	Elkhart	Elkhart
Dowd, Joseph A.	Indianapolis	Marion
Dowell, Emil H.	Rockville	Parke-Vermillion
Downer, Luther H.	Evansville	Vanderburgh
Drake, Dale W.	Evansville	Vanderburgh
Drake, James R.	Anderson	Madison
Drake, John C.	Anderson	Madison
Drake, Marion C.	Elwood	Madison
Draper, Merlin H. (S)	St. Petersburg, Fla.	Allen
Drennen, Robert V.	Anderson	Madison
Drew, Arthur L., Jr.	Indianapolis	Marion
Dreyer, Ralph W.	Richmond	Wayne-Union
Drummy, W. W.	Terre Haute	Vigo
Dryden, Gale E.	Indianapolis	Marion
Dublin, Madeline P.	Francesville	Pulaski
DuBois, Charles C. (S)	Warsaw	Kosciusko
DuBois, Ramon B.	Lafayette	Tippecanoe
Dudding, Joseph E.	Hope	Bartholomew-Brown
Dudgeon, Charles A.	Hartford City	Delaware-Blackford
Duemling, Arnold H.	Fort Wayne	Allen
Dugan, William M.	Indianapolis	Marion
Dukes, Betty	Dugger	Sullivan
Dukes, David A.	Tell City	Perry
Dukes, David J.	Corydon	Harrison-Crawford
Dukes, Frederic M. (S)	Dugger	Sullivan
Dukes, Joe E.	Dugger	Sullivan
Dulin, Basil B.	Anderson	Madison
Dunbar, Fred	Marion	Grant
Duncan, John S.	Gary	Lake
Duncan, Raymond	Bedford	Lawrence
Duncan, Stuart J.	Indianapolis	Marion
Dunham, Henry H.	Evansville	Vanderburgh
Dunlap, D. Logan	South Bend	St. Joseph
Dunn, Ferrell W. (S)	Muncie	Delaware-Blackford
Dunning, Thomas W.	Muncie	Delaware-Blackford
Dunstone, Harry C.	Fort Wayne	Allen
Dupes, Lowell E.	Indianapolis	Marion
Dupler, Lee F. W.	Indianapolis	Marion
Durham, Lowell J.	La Porte	La Porte
Durkee, Melvin S.	Evansville	Vanderburgh
Dusard, Joseph C.	Bedford	Lawrence
DuSold, Donald D.	Crown Point	Lake
Dutchess, C. Toney	Galveston	Cass
Dyar, Edwin W.	Indianapolis	Marion
Dycus, Walter A.	Evansville	Vanderburgh
Dye, William E.	Oakland City	Gibson
Dyer, George W.	Terre Haute	Vigo
Dyer, Wallace K.	Evansville	Vanderburgh
Dyke, Richard W.	Indianapolis	Marion
Dyken, Mark L.	New Castle	Henry
Dykhuizen, Theodore A.	Frankfort	Clinton

E

Eades, R. Charles	South Bend	St. Joseph
Eades, Ralph C.	Valparaiso	Porter
Earl, Max M.	Kokomo	Howard
Earp, Evanson B.	Indianapolis	Marion
Easter, James N.	Butlerville	Jennings
Eastman, Joseph R., Jr.	Indianapolis	Marion
Eaton, Edwin R.	Indianapolis	Marion
Eaton, Lyman D.	Indianapolis	Marion
Eaton, Marion J.	Lafayette	Tippecanoe
Ebbinghouse, Tom	Richmond	Wayne-Union
Ebert, J. Wayne	Indianapolis	Marion
Eberwein, John H. (S)	Indianapolis	Marion
Ebin, Judah L.	South Bend	St. Joseph
Eby, Ida L. (S)	Warren	Huntington
Echsner, Herman J.	Columbus	Bartholomew-Brown
Eckerle, John E.	New Albany	Floyd
Eckert, Russell A.	Logansport	Cass
Edmonds, Kendrick	Bedford	Lawrence
Edwards, Bernard E.	South Bend	St. Joseph
Edwards, Edward T., Jr.	Vincennes	Knox
Edwards, Henry G.	Terre Haute	Vigo
Edwards, William F.	New Albany	Floyd
Egan, Sherman	South Bend	St. Joseph
Egbert, Herbert L.	Indianapolis	Marion
Eggers, Ernest L. (S)	Hammond	Lake
Eggers, Henry W.	Hammond	Lake
Eggers, Richard	Crawfordsville	Montgomery
Egnatz, Nicholas	Hammond	Lake
Ehrich, William S. (S)	Evansville	Vanderburgh

Name	City	County
Eicher, Palmer O.	Indianapolis	Marion
Eikenberry, Hugh W.	Indianapolis	Marion
Eisaman, Jack L.	Bluffton	Wells
Eisenberg, David A.	Martinsville	Morgan
Eisterhold, John A.	Evansville	Vanderburgh
Eldridge, Gail E.	Indianapolis	Marion
Elkins, James P.	Indianapolis	Marion
Elledge, Ray	Hammond	Lake
Ellett, John, Jr.	Coatesville	Hendricks
Elliott, John C. (S)	Guilford	Dearborn-Ohio
Elliott, Lloyd A. (S)	Elkhart	Elkhart
Elliott, Paul W.	Lafayette	Tippecanoe
Elliott, Ralph A.	Gary	Lake
Elliott, Thomas A.	Elkhart	Elkhart
Ellis, Davis W.	Rushville	Rush
Ellis, George M.	Connersville	Fayette-Franklin
Ellis, Lyman H.	Lizton	Hendricks
Ellis, Seth W.	Anderson	Madison
Ellis, William N.	Indianapolis	Marion
Ellison, Alfred	La Jolla, Calif.	St. Joseph
Elshout, Clem H.	La Porte	La Porte
Elsten, Aubrey W.	Anderson	Madison
Elston, Lynn W.	Fort Wayne	Allen
Elston, Ralph W.	Fort Wayne	Allen
Elstun, Wesley B.	Hammond	Lake
Elward, Carl J.	Wabash	Wabash
Emenhiser, Donald C.	New Haven	Allen
Emenhiser, John L.	Fort Wayne	Allen
Emery, Charles B.	Bedford	Lawrence
Emhardt, John T.	Indianapolis	Marion
Emhardt, John W. A. (S)	Indianapolis	Marion
Emme, Richard W.	Harlan	Allen
Endicott, Wayne	Greenfield	Hancock
Engel, Edward L.	Evansville	Vanderburgh
Engeler, James E.	Lafayette	Tippecanoe
Engle, Russell B.	Winchester	Randolph
Engleman, Harry K. (S)	Georgetown	Floyd
English, Hubert M.	Gary	Lake
English, John P.	South Bend	St. Joseph
Ensey, Philip L.	Richmond	Wayne-Union
Ensminger, Leonard A. (S)	Indianapolis	Marion
Entner, Charles L.	Connersville	Fayette-Franklin
Episcopo, Arsenius R.	Salem	Washington
Erdel, Milton W.	Frankfort	Clinton
Erehart, Archie D.	Anderson	Madison
Erehart, Mark G.	Huntington	Huntington
Ericksen, Lester G.	South Bend	St. Joseph
Erickson, Gustaf W.	South Bend	St. Joseph
Ericson, Harold L.	Windfall	Tipton
Erwin, W. Robert	La Porte	La Porte
Eshelman, Henry R.	Monterey	Pulaski
Eskew, Kenneth W.	Sullivan	Sullivan
Espino, Jose C.	Munster	Lake
Espy, Theodore R.	Gary	Lake
Estes, Ambrose C.	Bloomington	Owen-Monroe
Evans, Frederick H.	Indianapolis	Marion
Evans, Frederick J.	Clinton	Parke-Vermillion
Evans, Paul V.	Indianapolis	Marion
Everly, Ralph V.	Indianapolis	Marion
Eviston, John B.	Huntington	Huntington
Ewing, Nathaniel D.	Vincennes	Knox

F

Fadell, Matthew J.	Gary	Lake
Fadul, Armand	Gary	Lake
Fagaly, William J.	Lawrenceburg	Dearborn-Ohio
Failey, Robert B.	Indianapolis	Marion
Fair, Herbert D. (S)	Muncie	Delaware-Blackford
Faith, Ira L.	Evansville	Vanderburgh
Fargher, Francis M.	Michigan City	La Porte
Fargher, Robert A.	La Porte	La Porte
Farner, James E.	Mishawaka	St. Joseph
Farnsworth, Samuel A.	La Porte	La Porte
Farquhar, John S., Jr.	Hammond	Lake
Farr, James C.	Paragon	Morgan
Farrell, John J., Jr.	Greenfield	Hancock
Farrell, Joseph T.	Indianapolis	Marion
Farris, John J.	Washington	Daviess-Martin
Faul, Henry J.	Evansville	Vanderburgh
Faulkner, Donald J.	Hobart	Lake
Fausset, C. Basil	Indianapolis	Marion
Faust, Howard M. Jr.	Anderson	Madison
Faw, Melvin L.	Evansville	Vanderburgh
Feferman, Martin E.	South Bend	St. Joseph
Feinn, Harry S.	La Porte	La Porte
Feldman, Max	South Bend	St. Joseph
Fell, Robert M.	Rosedale	Parke-Vermillion
Fenneman, Robert J.	Evansville	Vanderburgh
Ferguson, Arthur N.	Fort Wayne	Allen
Ferguson, Donald H.	Anderson	Madison
Ferguson, William B.	Lafayette	Tippecanoe
Ferrara, Donald W.	Peru	Miami
Ferrara, Joseph F.	Franklin	Johnson
Ferrara, Samuel J.	Peru	Miami
Ferrell, Mars B.	Fortville	Hancock
Ferry, Francis A.	Indianapolis	Marion
Ferry, John L.	Whiting	Lake
Ferry, Paul W.	Kokomo	Howard
Fessler, Gordon S.	Rising Sun	Dearborn-Ohio
Fichman, Abraham M.	Fort Wayne	Allen
Fickas, Dallas	Evansville	Vanderburgh
Fiedler, Howard W.	Indianapolis	Marion
Fields, Donald C.	Lafayette	Tippecanoe
Fields, Donald L.	Indianapolis	Marion
Filipek, Walter J.	South Bend	St. Joseph
Fine, Nathaniel J.	Indianapolis	Marion
Finfrock, James D.	Fayetteville, Ark.	Marion
Finneran, Joseph C.	Indianapolis	Marion
Fipp, August L.	Rome City	Noble
Firestein, Ben Z.	South Bend	St. Joseph
Firestein, Ray	South Bend	St. Joseph
Fisch, Charles	Indianapolis	Marion
Fischer, Albert A.	Indianapolis	Marion
Fischer, Burnell	Hammond	Lake
Fischer, Carlton N.	La Porte	La Porte
Fischer, Warren E.	Anderson	Madison
Fish, Clyde M. (S)	Deerfield, Fla.	St. Joseph
Fish, Edson C.	South Bend	St. Joseph
Fisher, Frank C.	Indianapolis	Marion
Fisher, Frank L.	Crawfordsville	Montgomery
Fisher, Gerald E.	Ippy French Equatorial Africa	Marion
Fisher, Henry	Marion	Grant
Fisher, John E.	Attica	Fountain-Warren
Fisher, John E.	Newcastle	Henry
Fisher, Lawrence F.	South Bend	St. Joseph
Fisher, Walter S.	Columbus	Bartholomew-Brown
Fisher, William C.	Evansville	Vanderburgh
Fitz Gerald, Maurice D.	Evansville	Vanderburgh
Fitzgerald, Brice E.	Logansport	Cass
Fitzgerald, William J.	Indianapolis	Marion
Fitzpatrick, H. W. (S)	Elwood	Madison
Fitzpatrick, James S.	Portland	Jay
Fitzpatrick, William J.	Hammond	Lake
Flack, Russell A.	Lafayette	Tippecanoe
Flaherty, Robert A.	Fort Wayne	Allen

Name	City	County
Flanagan, Estle P. (S)	Walton	Cass
Flanagan, Paul M.	Indianapolis	Marion
Flanders, Robert J.	Indianapolis	Marion
Flanigan, Meredith B.	Indianapolis	Marion
Flannigan, Harley F.	LaGrange	LaGrange
Fleetwood, Raymond A.	Nappanee	Elkhart
Fleischer, Jacob C.	East Chicago	Lake
Fleischl, Herbert	Indianapolis	Marion
Fleming, Claude F. (S)	Elkhart	Elkhart
Fletcher, Charles F. (S)	Sunman	Ripley
Flick, John J.	Indianapolis	Marion
Flora, Fred W.	Frankfort	Clinton
Flora, Joseph O.	Indianapolis	Marion
Fogel, Ernest	Logansport	Cass
Folck, John K.	Princeton	Gibson
Folkening, Norval C.	Indianapolis	Marion
Foltz, Lloyd E.	Brownsburg	Hendricks
Fong, Theodore C. C.	Madison	Jefferson-Switzerland
Forbes, Robert S.	Indianapolis	Marion
Forbes, Violet Crabbe	Wolcott	White
Foreman, Walter A.	Brookville	Fayette-Franklin
Forry, Frank (S)	Indianapolis	Marion
Forsee, Norman E.	Jeffersonville	Clark
Fortuna, Frank W.	Indianapolis	Marion
Fosbrink, Ephriam L.	Syracuse	Kosciusko
Fosgate, Harold	Indianapolis	Marion
Foster, Douglas L.	Hammond	Lake
Foster, Lee N.	Indianapolis	Marion
Foster, Ray D.	Indianapolis	Marion
Foster, Ray T.	Newcastle	Henry
Foster, Robert	Franklin	Johnson
Fountaine, Thomas J.	Bedford	Lawrence
Foust, Betty Jean	Collingswood, N.J.	Marion
Fouts, Dallas B.	Indianapolis	Marion
Fouts, Paul J.	Indianapolis	Marion
Fowler, Richard R.	Bloomington	Owen-Monroe
Fox, C. Philip	Washington	Daviess-Martin
Fox, Jack	Hammond	Lake
Fox, Richard	Greenwood	Johnson
Foy, Hayward W.	Fort Wayne	Allen
Frable, Frank L. Jr.	Lawrenceburg	Dearborn-Ohio
Fralich, Joseph C.	Milwaukee, Wis.	Marion
Frank, Herbert	South Bend	St. Joseph
Frank, John R. (S)	Valparaiso	Porter
Frank, Lyall, Jr.	South Bend	St. Joseph
Frank, Lyall L.	South Bend	St. Joseph
Franke, Gordon R.	Fort Wayne	Allen
Frankhouser, Charles M. A.	Fort Wayne	Allen
Franklin, Philip L.	Gary	Lake
Franklin, William L.	Indianapolis	Marion
Frankowski, Clementine	Whiting	Lake
Frantz, Mount E.	Bryan A.F.B., Texas	Hendricks
Frasch, Mahlon G.	Lafayette	Tippecanoe
Frash, De Von W.	South Bend	St. Joseph
Freeborn, Warren S.	Oaklandon	Marion
Freeby, C. William	Decatur	Adams
Freed, Carl A.	Indianapolis	Marion
Freed, John E., Jr.	Terre Haute	Vigo
Freed, John E. (S)	Terre Haute	Vigo
Freeland, Bill	Batesville	Ripley
Freeman, Jerry A.	Indianapolis	Marion
Freeman, Leslie W.	Indianapolis	Marion
Freeman, Max E.	Indianapolis	Marion
French, Richard N.	Indianapolis	Marion
Fretz, Richard C.	Kokomo	Howard
Frey, Harley B.	Lafayette	Tippecanoe
Frey, William B.	South Bend	St. Joseph
Friedman, Isadore E.	Hammond	Lake
Friedman, Morris S.	South Bend	St. Joseph
Frith, Louis G.	South Bend	St. Joseph
Fromhold, Willis A.	Indianapolis	Marion
Frost, Robert J.	Michigan City	La Porte
Fry, Robert D.	Indianapolis	Marion
Fujawa, Matthew J.	Mishawaka	St. Joseph
Fukumoto, Richard I.	Gary	Lake
Fullam, Richard G.	Fort Wayne	Allen
Fullerton, Robert L.	Monticello	White
Fulton, William H.	Charlotte, N. C.	Marion
Fultz, Roy L.	Salem	Washington
Funk, John W.	Muncie	Delaware-Blackford
Funkhouser, Elmer (S)	Indianapolis	Marion
Fuson, Wenfred J.	Greencastle	Putnam
Futterknecht, James O.	Elkhart	Elkhart

G

Gabe, William E.	Orinda, Calif.	Marion
Gabovitch, Edward R.	Indianapolis	Marion
Gachaw, Gabra S.	Indianapolis	Marion
Gaddy, Euclid T.	Indianapolis	Marion
Gaddy, Nelson D.	Indianapolis	Marion
Gaffney, Raymond	South Bend	St. Joseph
Gailey, Ivan	Chrisney	Spencer
Galante, Vincent J.	Gary	Lake
Galbreath, Jesse P. (S)	Burnettsville	White
Galliher, Marjorie J.	Muncie	Delaware-Blackford
Gallinatti, John J.	Gary	Lake
Gambill, J. Randolph	Madison	Jefferson-Switzerland
Gambill, William D.	Indianapolis	Marion
Gammell, Lindley L.	Edinburg	Johnson
Gammieri, Robert L.	Indianapolis	Marion
Gannon, George W. (S)	Gary	Lake
Ganser, Ralph V.	South Bend	St. Joseph
Ganser, Richard A.	Mishawaka	St. Joseph
Gante, Henry W. (S)	Anderson	Madison
Ganz, Max	Marion	Grant
Garber, J. Neill	Indianapolis	Marion
Garceau, George J.	Indianapolis	Marion
Gard, Daniel A.	Indianapolis	Marion
Gardiner, H. Glenn	East Chicago	Lake
Gardiner, Sprague H.	Indianapolis	Marion
Gardner, Austin L.	Indianapolis	Marion
Gardner, Buckman	Indianapolis	Marion
Gardner, Melvin D.	Michigan City	La Porte
Gardner, Russell A.	Michigan City	La Porte
Garfield, Martin D.	Indianapolis	Marion
Garland, Edgar A.	Evansville	Vanderburgh
Garling, Luvern C.	Muncie	Delaware-Blackford
Garner, W. Stanley	Indianapolis	Marion
Garner, William H.	New Albany	Floyd
Garner, William H., Jr.	New Albany	Floyd
Garrett, John D. (S)	Indianapolis	Marion
Garrett, Robert A.	Indianapolis	Marion
Garrison, James L.	Cumberland	Marion
Garrison, Leon J.	Gas City	Grant
Garton, Harry W.	Fort Wayne	Allen
Garvin, Donald B.	Brazil	Clay
Gastineau, David C.	Fort Wayne	Allen
Gatch, Willis D. (S)	Indianapolis	Marion
Gates, George E.	South Bend	St. Joseph
Gattman, George B.	Elkhart	Elkhart
Gatzimos, Christos D.	Logansport	Cass
Gaul, L. Edward	Evansville	Vanderburgh
Gaunt, Everett W.	Alexandria	Madison
Geckler, Charles E.	Muncie	Delaware-Blackford
Gehres, Robert W.	Shelbyville	Shelby
Geick, Raymond G.	Fort Branch	Gibson
Geider, Roy A.	Indianapolis	Marion
Geiger, Dillon D.	Bloomington	Owen-Monroe

Name	City	County
Geisinger, Lewis N. (S)	Auburn	De Kalb
Geisler, Hans E.	South Bend	St. Joseph
Genovese, Pasquale	Indianapolis	Marion
Genna, Mary E. Miller	Indianapolis	Marion
Gentile, John P.	New Albany	Floyd
George, Charles L.	Indianapolis	Marion
Gerding, William J.	Fort Wayne	Allen
Geronimo, Manuel M.	East Chicago	Lake
Geronimo, Rita R. V.	East Chicago	Lake
Gerrish, Donald A.	Terre Haute	Vigo
Gerrish, Wakefield D. (S)	Clinton	Parke-Vermillion
Gery, Richard E.	Lafayette	Tippecanoe
Getty, William H.	Evansville	Vanderburgh
Gevirtz, Milton B.	Hammond	Lake
Geyer, Joseph	New Albany	Floyd
Gibbs, Charles (S)	Greenfield	Hancock
Gibbs, Joseph W.	Martinsville	Morgan
Gibson, Alois E.	Indianapolis	Marion
Gibson, Greta Maxine	Indianapolis	Marion
Gick, Herman H. (S)	Indianapolis	Marion
Gifford, Fred E.	Indianapolis	Marion
Gilbert, Ivan	Terre Haute	Vigo
Gilbert, Robert G.	Tell City	Perry
Gilkison, John S. (S)	Shoals	Daviess-Martin
Gill, Dee D.	Greenfield	Hancock
Gill, John R.	Denver, Colo.	Lake
Gillespie, Charles F.	Indianapolis	Marion
Gillespie, Garland R.	Brownstown	Jackson
Gillespie, Jacob E.	Indianapolis	Marion
Gillim, Parvin D.	Indianapolis	Marion
Gillum, Eugene M.	Portland	Jay
Gilman, Marcus M.	South Bend	St. Joseph
Gilmore, Robert W.	Michigan City	La Porte
Gilmore, Russell A.	Michigan City	La Porte
Gingerick, Charles M.	Liberty Center	Wells
Ginsberg, Stewart T.	Indianapolis	Marion
Giorgio, Douglas J.	Evansville	Vanderburgh
Girod, Arthur H.	Decatur	Adams
Girod, Donald A.	Dunkirk	Jay
Gish, Howard M.	Brookston	White
Gitlin, Max M.	Bluffton	Wells
Gitlin, William A.	Bluffton	Wells
Glackman, John C., Jr.	Rockport	Spencer
Gladstone, Naf H.	Fort Wayne	Allen
Glassey, Stephen H.	Fort Wayne	Allen
Glendening, John L. (S)	Indianapolis	Marion
Glendening, Richard L.	Logansport	Cass
Glenn, Fred C. (S)	Tell City	Perry
Glock, Homer E. (S)	Fort Wayne	Allen
Glock, Maurice E.	Fort Wayne	Allen
Glock, Wayne R.	Fort Wayne	Allen
Glosson, Jack R.	Clay City	Clay
Glover, William J.	Gary	Lake
Gobbel, Novy E. (S)	English	Harrison-Crawford
Godwin, Donald W.	Indianapolis	Marion
Goebel, Carl W.	Fort Wayne	Allen
Godersky, George E.	South Bend	St. Joseph
Goethals, Charles J.	Mishawaka	St. Joseph
Goldberg, Harold B.	Gary	Lake
Goldenberg, Norman S.	Indianapolis	Marion
Golding, Robert F.	Gary	Lake
Goldman, Samuel	Indianapolis	Marion
Goldsmith, David A.	Marion	Grant
Goldstone, Adolph	Gary	Lake
Goldstone, Joseph	Gary	Lake
Goldstone, Sidney R.	Gary	Lake
Golper, Marvin N.	Kokomo	Howard
Good, Richard P.	Kokomo	Howard
Goodman, Eli S.	Charlestown	Clark
Goodman, Hubert T.	Terre Haute	Vigo
Goodrum, William R.	Cayuga	Parke-Vermillion
Gootee, Francis H.	Loogootee	Daviess-Martin
Gootee, Thomas H.	Jasper	Dubois
Gordon, Joseph L.	Wheeler	Porter
Gormley, Joseph J.	Indianapolis	Marion
Gosman, James H.	Indianapolis	Marion
Gossard, Meredith B.	Tipton	Tipton
Gossom, Donn R.	Terre Haute	Vigo
Gould, John C.	Fort Wayne	Allen
Govorchin, Alexander	East Chicago	Lake
Gow, Robert C.	Evansville	Vanderburgh
Graber, Virgil R.	Elkhart	Elkhart
Graessle, Harold P.	Seymour	Jackson
Graf, Jerome A.	Bloomfield	Greene
Graf, John P.	South Bend	St. Joseph
Graham, Edward W.	Indianapolis	Marion
Graham, George M.	Fort Wayne	Allen
Graham, James C.	Fort Wayne	Allen
Graham, John D.	Indianapolis	Marion
Graham, William E.	Indianapolis	Marion
Grant, Benjamin F.	Gary	Lake
Grant, M. Arthur	Fairmount	Grant
Grant, Phyllis	New Castle	Henry
Gratz, Ray J.	Indianapolis	Marion
Graves, Noel S.	Vevay	Jefferson-Switzerland
Graves, Orville M.	Princeton	Gibson
Gray, Clyde C. (S)	Cloverdale	Putnam
Gray, Daniel E.	Crown Point	Lake
Gray, Leon	Martinsville	Morgan
Gray, Paul M.	Huntington	Huntington
Grayston, Wallace S. (S)	Huntington	Huntington
Green, Carl L.	Vincennes	Knox
Green, Frank H.	Rushville	Rush
Green, George F.	South Bend	St. Joseph
Green, John H. (S)	North Vernon	Jennings
Green, Leonard J.	Valparaiso	Porter
Green, Morris	Indianapolis	Marion
Green, Norval E.	South Bend	St. Joseph
Green, Oscar	Indianapolis	Marion
Greene, Frederick G. (S)	Bloomingdale	Parke-Vermillion
Greene, Morgan E.	Indianapolis	Marion
Greene, Robert W.	Rensselaer	Jasper-Newton
Greene, William R.	Henryville	Clark
Greenlee, Robert L.	Fort Wayne	Allen
Greer, William	Bedford	Lawrence
Gregg, Albert F.	Connersville	Fayette-Franklin
Gregg, Edwin E.	Thorntown	Boone
Gregoline, Amadeo F.	Gary	Lake
Gregory, Robert L.	Indianapolis	Marion
Greiber, Marvin F.	Muncie	Delaware-Blackford
Greisen, Jack G.	Whiting	Lake
Greist, John H.	Indianapolis	Marion
Greist, Walter D.	Fort Wayne	Allen
Griem, Sylvia F.	Gary	Lake
Griep, Arthur H.	Evansville	Vanderburgh
Griffin, Charles G.	Valparaiso	Porter
Griffin, Joseph P.	Chesterton	Porter
Griffin, Leslie W.	Indianapolis	Marion
Griffis, Vierl C. (S)	Richmond	Wayne-Union
Griffith, Harold R.	Fort Wayne	Allen
Griffith, James W.	Sheridan	Hamilton
Griffith, Richard S.	Indianapolis	Marion
Griffith, Ross E.	Indianapolis	Marion
Grigsby, Hardin B.	Lebanon	Boone
Grillo, Donald	South Bend	St. Joseph
Grimes, Hubert N.	Indianapolis	Marion
Grindrod, John M.	Terre Haute	Vigo
Gripe, Richard P.	Lafayette	Tippecanoe
Grisell, Ted L.	Indianapolis	Marion

Name	City	County
Grosso, William G.	East Chicago	Lake
Grorud, Alton C.	South Bend	St. Joseph
Grotts, Bruce F.	Michigan City	La Porte
Grove, James H.	South Bend	St. Joseph
Gruber, Charles M.	Indianapolis	Marion
Guckien, Joseph L.	Evansville	Vanderburgh
Gustafson, Carl J.	Marion	Grant
Gustafson, Milton	Muncie	Delaware-Blackford
Gustaitis, John W.	Whiting	Lake
Guthrie, James R.	Richmond	Wayne-Union
Guthrie, William H.	Cameroun, W. Africa	Jennings
Gutierrez, Peter E.	Crown Point	Lake
Gutstein, Richard R. (S)	Kendallville	Noble
Guttman, John B.	Wakarusa	Elkhart
Gwin, Merle D. (S)	Miami Beach, Fla.	Jasper-Newton

H

Haas, Charles F.	Lafayette	Tippecanoe
Habegger, Elmer D.	Indianapolis	Marion
Habich, Carl (S)	Indianapolis	Marion
Hackett, Walter G.	Fort Wayne	Allen
Hade, Frederick L. (S)	Bridgeport	Marion
Hadey, James H.	Gary	Lake
Hadley, David	Indianapolis	Marion
Hadley, Harvey (S)	Richmond	Wayne-Union
Haffner, Herman G.	Fort Wayne	Allen
Haggard, David B.	Plainfield	Hendricks
Haggard, Edmund B.	Indianapolis	Marion
Hagie, Frank E.	Richmond	Wayne-Union
Haley, Alvin J.	Fort Wayne	Allen
Haley, Paul E.	South Bend	St. Joseph
Halfast, Richard W.	Kokomo	Howard
Hall, Bernard R.	Logansport	Cass
Hall, Donald L.	Petersburg	Pike
Hall, Frank M.	Indianapolis	Marion
Hall, Jack H.	Indianapolis	Marion
Hall, James M.	South Bend	St. Joseph
Hall, Orville A.	Muncie	Delaware-Blackford
Hall, Robert S.	Muncie	Delaware-Blackford
Hall, Thomas C.	Chesterton	Porter
Hall, William R.	Indianapolis	Marion
Halleck, Harold J.	Winamac	Pulaski
Haller, Richard C.	Indianapolis	Marion
Haller, Robert L.	Kempton	Tipton
Haller, Thomas C.	Crawfordsville	Montgomery
Hamer, Homer G. (S)	Indianapolis	Marion
Hamilton, Antha A.	Vevay	Jefferson-Switzerland
Hamilton, Charles O.	South Bend	St. Joseph
Hamilton, Emory D.	Fort Wayne	Allen
Hamilton, James R.	Mitchell	Lawrence
Hamilton, M. Luther (S)	Newberry	Greene
Hamilton, Orville G.	Bluffton	Wells
Hamilton, Thomas	Columbia City	Whitley
Hammel, Howard T.	Bedford	Lawrence
Hammer, Jay W.	Middletown	Henry
Hammersley, George K.	Frankfort	Clinton
Hammond, James B.	Indianapolis	Marion
Hammond, Keith	Paoli	Orange
Hammond, R. Case	Evansville	Vanderburgh
Hampshire, Donald R.	Indianapolis	Marion
Hampton, James N.	Argos	Marshall
Hancock, John G.	Indianapolis	Marion
Haney, William	Madison	Jefferson-Switzerland
Hanley, Harriet F.	South Bend	St. Joseph
Hann, Eldon C.	Indianapolis	Marion
Hanna, Thomas A.	Indianapolis	Marion
Hannah, Jack W.	Elkhart	Elkhart
Hanneken, Vincent J.	Wabash	Wabash
Hansell, Robert M.	Indianapolis	Marion
Hanson, Martin F.	Elwood	Madison
Harcourt, Allan K.	Indianapolis	Marion
Harcourt, Robert S.	Indianapolis	Marion
Harden, Murray E.	Lafayette	Tippecanoe
Hardin, Wayne E.	Ossian	Wells
Harding, James H.	Williamsport	Fountain-Warren
Harding, M. Richard	Indianapolis	Marion
Harding, Myron S.	Indianapolis	Marion
Hardtke, Eldred F.	Bloomington	Owen-Monroe
Hardy, John J. (S)	North Liberty	St. Joseph
Hare, Daniel M.	Evansville	Vanderburgh
Hare, Earl H.	Indianapolis	Marion
Hare, Francis W., Jr.	Madison	Jefferson-Switzerland
Hare, Laura	Indianapolis	Marion
Harger, Robert W.	Indianapolis	Marion
Harkcom, Harry E.	St. Paul	Decatur
Harkness, Robert G.	Terre Haute	Vigo
Harless, Clarence M.	Chesterton	Porter
Harless, Fred	Monroeville	Allen
Harlin, William L.	Evansville	Vanderburgh
Harmon, Carl J.	Richmond	Wayne-Union
Harmon, Wayne	Lynn	Randolph
Harned, Ben K.	Evansville	Vanderburgh
Harold, Albert H. (S)	Indianapolis	Marion
Harold, Norris E. (S)	Indianapolis	Marion
Harper, James W.	East Chicago	Lake
Harrington, James F.	Logansport	Cass
Harris, Carl B.	Indianapolis	Marion
Harris, Paul N.	Indianapolis	Marion
Harris, Robert F.	Noblesville	Hamilton
Harris, Robert W.	New Albany	Floyd
Harrison, Benjamin L.	New Castle	Henry
Harshman, James A.	Indianapolis	Marion
Harshman, Louis P.	Fort Wayne	Allen
Harstad, Casper	Rockville	Parke-Vermillion
Hart, L. Paul	Evansville	Vanderburgh
Hart, Robert B.	Columbus	Bartholomew-Brown
Hart, William D.	Anderson	Madison
Harter, Eli B.	Lafayette	Tippecanoe
Hartley, Clarence A., Jr.	Evansville	Vanderburgh
Hartman, John J.	Angola	Steuben
Hartsough, Ralph I.	Remington	Jasper-Newton
Hartwick, John P.	South Bend	St. Joseph
Hartz, F. Minton	Evansville	Vanderburgh
Harvey, Harry C.	Fort Wayne	Allen
Harvey, Ralph J.	Zionsville	Boone
Harvey, Verne K., Jr.	Indianapolis	Marion
Harvey, Verne K. Sr.	Indianapolis	Marion
Hasewinkel, Carroll W.	Carmel	Hamilton
Hasewinkle, August M.	Fort Wayne	Allen
Hash, John S.	Noblesville	Hamilton
Hashemi, Hossein	Warsaw	Kosciusko
Haslem, Ezra R.	Terre Haute	Vigo
Haslem, John R.	Terre Haute	Vigo
Haslinger, Clarence J.	Indianapolis	Marion
Hass, Caroline E.	W. Lafayette	Tippecanoe
Hass, Thomas W.	W. Lafayette	Tippecanoe
Hastings, Warren C.	Fort Wayne	Allen
Hatfield, Jack J.	Indianapolis	Marion
Hatfield, Nicholas W.	Indianapolis	Marion
Hattendorf, Anton P.	Fort Wayne	Allen
Haugseth, Ellsworth K.	South Bend	St. Joseph
Hauss, Augustus P. (S)	New Albany	Floyd
Havens, A. Lyle	Jeffersonville	Clark
Havens, Thomas R.	Jeffersonville	Clark
Havens, Oscar	Cicero	Hamilton
Havens, Russell E.	Fort Wayne	Allen

Name	City	County
Havice, Jay F.	Lake Lure, N. C.	Allen
Hawes, James K. (S)	Columbus	Bartholomew-Brown
Hawes, Marvin E.	Columbus	Bartholomew-Brown
Hawk, Edgar A.	Evansville	Vanderburgh
Hawk, James H.	Indianapolis	Marion
Hawkins, Glen E.	South Bend	St. Joseph
Hawkins, Richard D.	Bedford	Lawrence
Hawtof, David B.	Indianapolis	Marion
Hay, Gene R.	Indianapolis	Marion
Hayes, Frank W.	East Chicago	Lake
Hayes, J. D., Jr.	Gary	Lake
Hayes, Jesse D.	East Chicago	Lake
Hayes, Theodore R.	Muncie	Delaware-Blackford
Haymond, George M.	Indianapolis	Marion
Haymond, Joseph L.	Indianapolis	Marion
Haynes, John T.	Indianapolis	Marion
Hays, Everett L.	Indianapolis	Marion
Haywood, John G.	Noblesville	Hamilton
Hazinski, Robert T.	Griffith	Lake
Headley, Lloyd M.	Lebanon	Boone
Healey, Robert J.	Indianapolis	Marion
Heard, Albert	Evansville	Vanderburgh
Heaton, Elton	Huntingburg	Dubois
Heck, Martin C.	Jasper	Dubois
Hedde, Eugene L.	Logansport	Cass
Hedgcock, Robert A.	Frankfort	Clinton
Hedrick, James T.	Gary	Lake
Hedrick, Philip W.	Indianapolis	Marion
Heilman, William C., Jr.	New Castle	Henry
Heilman, W. C., Sr. (S)	New Castle	Henry
Heimburger, Robert F.	Indianapolis	Marion
Heinrich, Weston A.	Evansville	Vanderburgh
Heinrichs, Harry H. (S)	Indianapolis	Marion
Held, George A.	Jasper	Dubois
Heller, Nelson L. (S)	Dunkirk	Jay
Helmen, Charles H.	Indianapolis	Marion
Helmen, Harry W. (S)	South Bend	St. Joseph
Helmer, Fredric A.	Fort Wayne	Allen
Helmer, John F.	South Bend	St. Joseph
Heminway, Norman L.	Elkhart	Elkhart
Hendershot, Eugene L.	Evansville	Vanderburgh
Henderson, Francis G.	Indianapolis	Marion
Henderson, Norman C.	Michigan City	La Porte
Henderson, Ramon A.	Muncie	Delaware-Blackford
Henderson, Robert N.	Brookston	White
Henderson, Roscoe C.	Indianapolis	Marion
Henderson, William P.	Indianapolis	Marion
Hendricks, Fred A.	Indianapolis	Marion
Hendricks, John W.	Indianapolis	Marion
Hendrix, Charles E.	Vincennes	Knox
Henley, Glenn (S)	Fairmount	Grant
Henn, R. Anthony	Greenfield	Hancock
Henry, Alvin L.	Columbus	Bartholomew-Brown
Henry, Howard J.	Knox	Starke
Henry, Russell S.	Indianapolis	Marion
Hensler, Benton M.	Anderson	Madison
Hepburn, C. K.	Indianapolis	Marion
Hepner, Herman	Kendallville	Noble
Hepner, Herman S.	Bloomington	Owen-Monroe
Herd, Cloyn R.	Peru	Miami
Herendeen, Elbie V.	Rochester	Fulton
Heritier, C. Jules	Columbia City	Whitley
Hermayer, Stephen	Evansville	Vanderburgh
Hernandez, I. C.	East Chicago	Lake
Herr, John W.	Tell City	Perry
Herrick, Charles L.	Akron	Fulton
Herring, George N.	Richmond	Wayne-Union
Herrmann, Gordon T.	Evansville	Vanderburgh
Herrold, George W.	Lafayette	Tippecanoe
Hershberger, Philip	Fort Wayne	Allen
Hershey, Ernest A. (S)	Churubusco	Whitley
Herzberg, Milton	Clinton	Parke-Vermillion
Herzer, Clarence C.	Evansville	Vanderburgh
Hess, Paul P.	New Albany	Floyd
Hetherington, A. M. (S)	Indianapolis	Marion
Hetherington, John A.	Indianapolis	Marion
Hetman, Mitchell J.	Westville	La Porte
Heubi, John E.	Indianapolis	Marion
Hiatt, Russell L.	Louisville, Ky.	Wayne-Union
Hibbs, William G.	Franklin	Johnson
Hibner, Nolan A.	Monticello	White
Hickam, John B.	Indianapolis	Marion
Hickman, A. Lee	Hammond	Lake
Hickman, Donald	Fort Wayne	Allen
Hickman, Jack W.	Indianapolis	Marion
Hickman, Walter F. (S)	Indianapolis	Marion
Hicks, Murwyn L.	Indianapolis	Marion
Hicks, Wilbur D.	Indianapolis	Marion
Higbee, Paul (S)	Sullivan	Sullivan
Higgins, James L.	Otis AFB, Mass.	Pike
Higgins, John R.	New Albany	Floyd
Higgins, Kenneth E.	Fort Wayne	Allen
High, Ralph L.	Muncie	Delaware-Blackford
Hilbert, John W.	South Bend	St. Joseph
Hildebrand, John O.	South Bend	St. Joseph
Hill, Gladys Marie	Richmond	Wayne-Union
Hill, Harold D.	Richmond	Wayne-Union
Hill, Howard E.	Muncie	Delaware-Blackford
Hill, James K.	Indianapolis	Marion
Hill, Kenneth G.	New Castle	Henry
Hill, Lloyd	Denver	Miami
Hill, Paul G.	Cambridge City	Wayne-Union
Hill, Robert E.	Yorktown	Delaware-Blackford
Hill, Theodore A.	South Bend	St. Joseph
Hill, Wallace C.	South Bend	St. Joseph
Hillenbrand, Charles	Michigan City	La Porte
Hillery, John	Warsaw	Kosciusko
Hillery, Robert L.	Indianapolis	Marion
Hillis, Lowell J.	Logansport	Cass
Hillman, Marion W.	South Bend	St. Joseph
Hillman, Wm. H. (S)	South Bend	St. Joseph
Himebaugh, Gilbert J.	Evansville	Vanderburgh
Himler, James M.	Indianapolis	Marion
Hinchman, Clarence P.	Geneva	Adams
Hinchman, Jean F.	Parker	Randolph
Hines, Archie V.	Auburn	De Kalb
Hines, Don C.	Indianapolis	Marion
Hines, John H.	Auburn	De Kalb
Hingeley, John E.	Butlerville	Jennings
Hippensteel, Harland	Auburn	De Kalb
Hipskind, Richard E.	Fort Wayne	Allen
Hirsch, Herman L.	Mt. Vernon	Posey
Hisrich, Lloyd W.	Batesville	Ripley
Hobbs, Arthur A.	Evansville	Vanderburgh
Hochhalter, Marian	Logansport	Cass
Hodges, Fletcher (S)	Indianapolis	Marion
Hodgin, Phillip T.	Orleans	Orange
Hodurski, Zigfield	Gary	Lake
Hoetzer, Eldore M.	New Haven	Allen
Hoffman, Arthur F.	Fort Wayne	Allen
Hoffman, Doris	Vincennes	Knox
Hoffman, Herman	Indianapolis	Marion
Hoffman, Max N.	Covington	Fountain-Warren

Name	City	County
Hofmann, J. William (S)	Indianapolis	Marion
Hogan, Thomas W.	Terre Haute	Vigo
Hogle, Frank D.	Lafayette	Tippecanoe
Hoit, Leonard	Gary	Lake
Holdeman, Richard W.	South Bend	St. Joseph
Holladay, Lloyd J.	Lafayette	Tippecanoe
Holland, Deward J. (S)	Bloomington	Owen-Monroe
Holland, Philip T.	Bloomington	Owen-Monroe
Hollenberg, Alfred E.	Hagerstown	Wayne-Union
Hollenberg, Edward L.	Winamac	Pulaski
Holloway, William A. (S)	Logansport	Cass
Holman, Jerome E., Sr. (S)	Indianapolis	Marion
Holman, Jerome E., Jr.	Indianapolis	Marion
Holmes, Claude D. (S)	Frankfort	Clinton
Holsinger, Robert E.	Fort Wayne	Allen
Holtzman, Norman N.	South Bend	St. Joseph
Holtzman, Paul W.	Bloomington	Owen-Monroe
Honan, Paul R.	Lebanon	Boone
Hood, Ainslee A.	Indianapolis	Marion
Hooke, Samuel W. (S)	Noblesville	Hamilton
Hoopes, Jane M.	Evansville	Vanderburgh
Hoover, Dewey A.	Terre Haute	Vigo
Hoover, J. Guy	Evansville	Vanderburgh
Hoover, Peter B.	Boonville	Warrick
Hopkins, Joseph R.	Hammond	Lake
Hopkins, Lester H.	Butlerville	Jennings
Hoppenrath, Wesley M.	Elwood	Madison
Hoppenrath, William (S)	Elwood	Madison
Hord, Luther J., Jr.	South Bend	St. Joseph
Horning, Richard R.	Fort Wayne	Allen
Horst, William N.	Crown Point	Lake
Horswell, Richard G.	Bristol	Elkhart
Horwitz, Thomas	Indianapolis	Marion
Hostetler, Carl M.	Goshen	Elkhart
Hostetter, Irwin S.	Muncie	Delaware-Blackford
Houser, D. Stanley	South Bend	St. Joseph
Houser, Wayne W.	Monon	White
Houston, Fred D.	Lawrenceburg	Dearborn-Ohio
Hovda, Richard B.	Evansville	Vanderburgh
Hover, Galen	Marion	Grant
How, John T. (S)	Lakeville	St. Joseph
How, Louis E.	South Bend	St. Joseph
Howard, William F.	Indianapolis	Marion
Howard, Wm. Harry	Hammond	Lake
Howe, Fordyce L.	Fort Wayne	Allen
Howell, Arthur	Indianapolis	Marion
Howell, Joseph D.	Indianapolis	Marion
Howell, Robert D.	Indianapolis	Marion
Hoyt, John M.	Kokomo	Howard
Hoyt, Lester H.	Indianapolis	Marion
Hoyt, Millard L.	Indianapolis	Marion
Hrisomalos, Frank N.	Bloomington	Owen-Monroe
Hubbard, Jesse D.	Indianapolis	Marion
Huber, Carl P.	Indianapolis	Marion
Huckleberry, Irvin E.	Salem	Washington
Huddle, John R.	Indianapolis	Marion
Hudson, Arlington M.	Connersville	Fayette-Franklin
Hudson, Foster J.	Indianapolis	Marion
Huffman, Galen C.	Columbus, O.	Marion
Huffman, Verlin P.	S. Whitley	Whitley
Hughes, Richard R.	Lafayette	Tippecanoe
Huggins, Victor S.	Evansville	Vanderburgh
Hull, Arthur W.	Elkhart	Elkhart
Hull, De Wayne L.	Indianapolis	Marion
Hull, James E.	Lafayette	Tippecanoe
Hull, Ronald H.	Indianapolis	Marion
Hummel, Russel M.	Marion	Grant
Hummons, Francis D.	Indianapolis	Marion
Humphrey, Edward M.	Covington	Fountain-Warren
Humphrey, Paul E.	Terre Haute	Vigo
Humphreys, Joe E.	Vincennes	Knox
Humphreys, John L.	Fort Wayne	Allen
Humphreys, John W.	Crawfordsville	Montgomery
Hunsberger, Walter G.	Lafayette	Tippecanoe
Hunt, Edgar J.	Terre Haute	Vigo
Hunt, Gayle J.	Richmond	Wayne-Union
Hunter, Donn	Greenfield	Hancock
Hunter, Frank P. (S)	Lafayette	Tippecanoe
Hunter, Lowell G.	Lawrenceburg	Dearborn-Ohio
Huoni, John S.	Jeffersonville	Clark
Hurley, Anson G.	Muncie	Delaware-Blackford
Hurley, James W.	Elkhart	Elkhart
Hurley, John R.	Daleville	Delaware-Blackford
Hursey, Virgil G.	Milford	Koscuisko
Hurt, LaVerne B.	Indianapolis	Marion
Hurteau, William W.	Indianapolis	Marion
Huse, William M.	Indianapolis	Marion
Husted, Robert G.	Hammond	Lake
Hutchison, Donald R.	Fountain City	Wayne-Union
Hutto, William H.	Kokomo	Howard
Hyatt, Gilbert T.	Evansville	Vanderburgh
Hyde, Carroll C.	South Bend	St. Joseph
Hynes, Roy T.	Indianapolis	Marion

I

Imhof, Joseph D.	Muncie	Delaware-Blackford
Ingwell, Guy B.	Knox	Starke
Inlow, Herbert H.	Shelbyville	Shelby
Inlow, William D.	Shelbyville	Shelby
Irick, Robert L.	APO 179, New York, N. Y.	Marion
Irish, Wilbur J.	East Chicago	Lake
Irmscher, George W.	Lawrenceburg	Dearborn-Ohio
Irwin, Glenn W., Jr.	Indianapolis	Marion
Irwin, Seth (S)	Anderson	Madison
Iske, Paul G.	Indianapolis	Marion
Isler, Nathaniel C.	Jeffersonville	Clark
Iterman, George E. (S)	New Castle	Henry
Ivy, John H.	Elkhart	Elkhart

J

Jackson, Charles E.	Bluffton	Wells
Jackson, Dean B.	Hartford City	Delaware-Blackford
Jackson, Frederick E. (S)	Indianapolis	Marion
Jackson, James W. (S)	Indianapolis	Marion
Jackson, John F.	Fort Wayne	Allen
Jackson, John K.	Aurora	Dearborn-Ohio
Jacobs, E. Robert	Columbus	Bartholomew-Brown
Jaeger, Alfred S. (S)	Indianapolis	Marion
Jahns, Albin A.	Gary	Lake
James, John M.	Tell City	Perry
James, Nicholas A. (S)	Tell City	Perry
James, Thomas, Jr.	Huntington	Huntington
Jaquith, Orville S. (S)	Indianapolis	Marion
Jarrett, John C.	Marion	Grant
Jarrett, Paul E.	Anderson	Madison
Jay, Arthur N.	Indianapolis	Marion
Jay, James	Indianapolis	Marion
Jeffries, Kenneth I. (S)	Indianapolis	Marion
Jenkins, Robert E.	Indianapolis	Marion
Jennings, F. Lamont	Chicago, Ill.	Marion
Jennings, Frank L. (S)	Indianapolis	Marion

Name	City	County
Jernigan, William R.	Memphis, Tenn.	Vanderburgh
Jett, Clyde W.	Seelyville	Vigo
Jewell, Earl B. (S)	Logansport	Cass
Jewell, George M.	Kokomo	Howard
Jewett, Joe H.	Indianapolis	Marion
Jinnings, Loren E.	Garrett	De Kalb
Jobes, James E.	Indianapolis	Marion
Jobes, Norman E. (S)	Indianapolis	Marion
Johns, David R. (S)	East Chicago	Lake
Johns, Nicholas C.	South Bend	St. Joseph
Johnson, Arnold L.	Gary	Lake
Johnson, Frank P.	Rochester	Fulton
Johnson, Gardner C. (S)	Evansville	Vanderburgh
Johnson, George M.	Richmond	Wayne-Union
Johnson, Harold V.	Evansville	Vanderburgh
Johnson, Herbert S.	Lafayette	Tippecanoe
Johnson, James B.	Greencastle	Putnam
Johnson, Jerome M.	Palmyra	Harrison-Crawford
Johnson, John J.	Warsaw	Koscuisko
Johnson, Lonnie B.	Gary	Lake
Johnson, Lowell R.	Lafayette	Tippecanoe
Johnson, Owen	Peru	Miami
Johnson, Paul D.	Terre Haute	Vigo
Johnson, Paul S. (S)	Richmond	Wayne-Union
Johnson, Robert B.	Rushville	Rush
Johnson, Stephen L.	Evansville	Vanderburgh
Johnson, Thomas W.	Indianapolis	Marion
Johnson, William A. (S)	Perrysville	Parke-Vermillion
Johnson, William A.	North Vernon	Jennings
Johnson, William F. (S)	Clermont	Marion
Johnson, William H.	East Gary	Lake
Johnston, Alan	Martinsville	Morgan
Johnston, Donald D. (S)	Westville	La Porte
Johnston, Richard M.	Fort Wayne	Allen
Johnston, Robert G. (S)	Huntington	Huntington
Jolly, Lewis E.	Madison	Jefferson-Switzerland
Jolly, Wesley P. (S)	Richland	Spencer
Jones, Albert T.	Anderson	Madison
Jones, Allen W.	Indianapolis	Marion
Jones, Charles A.	Franklin	Johnson
Jones, David	Lafayette	Tippecanoe
Jones, David E.	Indianapolis	Marion
Jones, David G.	Anderson	Madison
Jones, David H.	Charlestown	Clark
Jones, Eli S.	Hammond	Lake
Jones, Francis P.	Indianapolis	Marion
Jones, George L.	Wanamaker	Marion
Jones, Gordon C.	Indianapolis	Marion
Jones, J. Carl	Logansport	Cass
Jones, John G. (S)	Vincennes	Knox
Jones, King S.	Michigan City	La Porte
Jones, Lawrence R.	Indianapolis	Marion
Jones, Robert B. (S)	La Porte	La Porte
Jones, Roland W.	Bethesda, Md.	Marion
Jontz, Joe G.	Fort Wayne	Allen
Jordan, Leo E.	Lynn	Randolph
Jordan, Richard A.	Corydon	Harrison-Crawford
Joseph, Rex M.	Indianapolis	Marion
Jowitt, Richard H.	Indianapolis	Marion
Judd, Donald R.	Indianapolis	Marion
Judson, Walter E.	Indianapolis	Marion
Juergens, Richard B.	Fort Wayne	Allen
Jump, Charles A. (S)	Selma	Delaware-Blackford
Jurgensen, Walter T.	Fort Wayne	Allen
Justin, Renate G.	Terre Haute	Vigo

Name	City	County
	K	
Kabel, Robert N.	Terre Haute	Vigo
Kahler, Maurice V.	Indianapolis	Marion
Kahn, Alexander J.	Indianapolis	Marion
Kahn, Howard L.	Indianapolis	Marion
Kaiser, George C.	Indianapolis	Marion
Kaiser, George D.	Whiting	Lake
Kalb, Everett L.	Indianapolis	Marion
Kamen, Jack M.	Gary	Lake
Kamm, Bernard A.	South Bend	St. Joseph
Kammen, Leo	Indianapolis	Marion
Kammen, Robert	Indianapolis	Marion
Kammer, Walter F.	Muncie	Delaware-Blackford
Kantzer, Floyd B.	Garrett	De Kalb
Karberg, Richard J.	Lafayette	Tippecanoe
Karlick, Joseph	Arcadia	Hamilton
Karn, John W.	South Bend	St. Joseph
Karnafel, Eugene T.	Indianapolis	Marion
Karns, John D.	Winamac	Pulaski
Karol, Herbert J.	Fort Wayne	Allen
Karpel, Bernard	Mooresville	Morgan
Kasting, Gerald	Bedford	Lawrence
Katterjohn, James C.	Indianapolis	Marion
Kauffman, Harley M.	Evansville	Vanderburgh
Kauffman, Nelson N.	Indianapolis	Marion
Kaufman, Julian	Fort Wayne	Allen
Kaufman, Lillie S.	Goshen	Elkhart
Kay, Oran E.	Spencer	Owen-Monroe
Keating, John U.	Elkhart	Elkhart
Keck, Carleton A.	Fort Wayne	Allen
Keeling, Forrest E.	Portland	Jay
Keenan, George B.	Indianapolis	Marion
Keenan, Reid L.	Indianapolis	Marion
Keever, Charles H.	Indianapolis	Marion
Keiser, Venice D.	Indianapolis	Marion
Kellar, Philip E.	Hobart	Lake
Keller, Frank G. (S)	N. Manchester	Wabash
Kelly, Don E.	Indianapolis	Marion
Kelly, Frank (S)	Argos	Marshall
Kelly, John B.	Evansville	Vanderburgh
Kelly, John F.	Marion	Grant
Kelly, Walter F. (S)	Indianapolis	Marion
Kelly, Wendell C.	Anderson	Madison
Kelsey, Lawrence E.	Kewanna	Fulton
Kelsey, Robert M.	La Porte	La Porte
Kemp, John T.	Michigan City	La Porte
Kemp, William A.	Connersville	Fayette-Franklin
Kempf, Gerald F.	Rockville	Parke-Vermillion
Kendall, Forest M.	Nappanee	Elkhart
Kendrick, Frank J.	Gary	Lake
Kendrick, William M.	Mooresville	Morgan
Kennedy, Eva N. (S)	Camden	Carroll
Kennedy, Hunter F.	Indianapolis	Marion
Kennedy, Joseph T.	Indianapolis	Marion
Kennedy, Walter U.	New Castle	Henry
Kenney, David B.	Indianapolis	Marion
Kenney, Francis D.	Hammond	Lake
Kenoyer, Wilbur L.	Lackland AFB Texas	Marion
Kent, Richard N.	Fort Wayne	Allen
Kenyon, Charles E.	Cambridge City	Wayne-Union
Kenzler, Jack	Indianapolis	Marion
Kephart, S. Bruce	Bluffton	Wells
Kepler, Robert W.	La Porte	La Porte
Kercheval, John M.	Clinton	Parke-Vermillion

Name	City	County
Kern, Charles B. (S)	Noblesville	Hamilton
Kern, Clarence G.	Lebanon	Boone
Kerr, Charlotte H.	Michigan City	La Porte
Kerr, Donald M.	Bedford	Lawrence
Kerr, Harry R.	Indianapolis	Marion
Kerr, John E.	Michigan City	La Porte
Kerrigan, John F.	Michigan City	La Porte
Kerrigan, William F.	Connersville	Fayette-Franklin
Keseric, N. E.	French Lick Springs	Orange
Kessler, Robert B.	Evansville	Vanderburgh
Ketcham, Jane M. (S)	Indianapolis	Marion
Ketcham, John S.	Rossville	Clinton
Keyes, Robert C.	Fort Wayne	Allen
Khaton, Odessa M.	Gary	Lake
Kidd, James G. (S)	Wood, Wis.	Wabash
Kidder, Orva T.	Fort Wayne	Allen
Kiechle, Frederich L.	Evansville	Vanderburgh
Kiely, John T.	Anderson	Madison
Kilgore, Byron W.	Indianapolis	Marion
Kilmer, Warren L.	Indianapolis	Marion
Kim, Young D.	Beech Grove	Marion
Kimbrough, Robert F.	Fort Wayne	Allen
Kime, Charles E.	Richmond	Wayne-Union
Kime, Edwin N.	Indianapolis	Marion
Kimmel, George E.	Camp LeJeune, N. C.	Miami
Kincaid, Raymond K.	Tipton	Tipton
Kincaid, Robert S.	Evansville	Vanderburgh
Kindell, Hurschell D.	New Richmond	Montgomery
King, Harold	Indianapolis	Marion
King, Jay M.	Logansport	Cass
King, Joseph W.	Anderson	Madison
King, Robert W.	Cedar Lake	Lake
King, William E.	Indianapolis	Marion
Kingsbury, John K. (S)	Indianapolis	Marion
Kinnaman, Howard A.	Crawfordsville	Montgomery
Kinneman, Robert E.	Greenfield	Hancock
Kintner, Burton E.	Elkhart	Elkhart
Kinzel, Robert J. W.	Indianapolis	Marion
Kirby, Ted C.	Greenfield	Hancock
Kirkhoff, Paul J.	Indianapolis	Marion
Kirklin, Oren L.	Indianapolis	Marion
Kirshman, Forrest E.	Muncie	Delaware-Blackford
Kirtley, James M.	Crawfordsville	Montgomery
Kirtley, Robert W.	Danville	Hendricks
Kirtley, William R.	Indianapolis	Marion
Kissel, Wesley A.	Indianapolis	Marion
Kissinger, Knight L.	Angola	Steuben
Kistler, James J.	La Porte	La Porte
Kistner, Arthur W.	Elkhart	Elkhart
Kitterman, Harry E.	Indianapolis	Marion
Klain, Benjamin V.	Indianapolis	Marion
Klamer, Charles H.	Jasper	Dubois
Klatch, Ben Z.	Lafayette	Tippecanoe
Klatte, Eugene C.	Indianapolis	Marion
Kleifgen, William A.	Fort Wayne	Allen
Kleindorfer, Roscoe L.	Evansville	Vanderburgh
Kleinman, Francis J.	Hebron	Porter
Kleopfer, Ronald G.	Indianapolis	Marion
Klepfer, Jefferson	Richmond	Wayne-Union
Klepinger, Harry E.	Lafayette	Tippecanoe
Kline, Charles D.	Vincennes	Knox
Klingler, Maurice O.	Plymouth	Marshall
Klooze, Kenneth W.	Fort Wayne	Allen
Klos, Stanley J.	Hobart	Lake
Kmak, Chester	East Chicago	Lake
Knapp, Arthur L. (S)	South Bend	St. Joseph
Kneidel, John H.	Indianapolis	Marion
Knepple, La Marr R. (S)	Kokomo	Howard
Knight, Lewis W.	Fort Wayne	Allen
Knode, Kenneth T.	South Bend	St. Joseph
Knotts, Halleck S.	Columbus	Bartholomew-Brown
Knotts, Slater	Columbus	Bartholomew-Brown
Knowles, Charles Y.	Indianapolis	Marion
Knowles, Robert P.	Indianapolis	Marion
Ko, Richard	Gaston	Delaware-Blackford
Kobrin, Meyer W.	Gary	Lake
Koch, Edwin F. Jr.	Indianapolis	Marion
Koch, Elmer L.	Danville	Hendricks
Koch, Howard W.	Winchester	Randolph
Koehler, Elmer G.	Elkhart	Elkhart
Koenig, Robert L.	Valparaiso	Porter
Kohlstaedt, Karl C.	Indianapolis	Marion
Kohlstaedt, Kenneth G.	Indianapolis	Marion
Kohne, Gerald J.	Decatur	Adams
Kohne, Robert W.	Lafayette	Tippecanoe
Kolanko, Leon A.	Hammond	Lake
Kolettis, John G.	Gary	Lake
Komoroske, John E.	East Chicago	Lake
Kooiker, John E.	Indianapolis	Marion
Koons, Karl M.	Indianapolis	Marion
Koontz, William A.	Gas City	Grant
Kopanko, Bernard F.	East Chicago	Lake
Kopcha, Joseph E.	Gary	Lake
Kopecky, Robert R.	Indianapolis	Marion
Kopp, Otis A.	Anderson	Madison
Kopp, William R.	Anderson	Madison
Koransky, David S.	Hammond	Lake
Korn, Jerome M.	Gary	Lake
Kornafel, L. H.	Indianapolis	Marion
Koss, K. William	Muncie	Delaware-Blackford
Krabill, Willard S.	Goshen	Elkhart
Kraft, Bennett	Indianapolis	Marion
Kraning, Kenneth K.	Kewanna	Fulton
Krause, Friedrich	Elkhart	Elkhart
Kreitl, Dorothy R.	Richmond	Wayne-Union
Kremers, George A.	Kokomo	Howard
Kresler, Leon E.	Kentland	Jasper-Newton
Kress, James W.	Muncie	Delaware-Blackford
Krieble, William W.	Terre Haute	Vigo
Kriel, William B.	Indianapolis	Marion
Krsek, Archie J.	Hobart	Lake
Krueger, John E.	Fort Wayne	Allen
Krueger, John E.	South Bend	St. Joseph
Krueger, Robert B.	Columbus	Bartholomew-Brown
Kruse, Edward H. (S)	Fort Wayne	Allen
Kruse, Walter E.	Fort Wayne	Allen
Kubik, Francis J.	Michigan City	La Porte
Kubley, James D.	Plymouth	Marshall
Kudele, Louis T.	Whiting	Lake
Kuhn, Arthur J.	Hammond	Lake
Kuhn, Frederick L.	South Bend	St. Joseph
Kuhn, Hedwig S.	Hammond	Lake
Kuhn, Robert W.	Wilkinson	Hancock
Kunkler, Arnold W.	Terre Haute	Vigo
Kunkler, Joseph (S)	Terre Haute	Vigo
Kunkler, William C.	Terre Haute	Vigo
Kuntz, Herman W.	Indianapolis	Marion
Kurlander, Gerald J.	Indianapolis	Marion
Kurtz, Fred B. (S)	Indianapolis	Marion
Kurtz, Philip L.	Indianapolis	Marion
Kurtz, Richard	Chicago, Ill.	Marion
Kurtz, William A.	Tipton	Tipton
Kwitny, Isadore J.	Indianapolis	Marion
Kyle, Michael A.	Gary	Lake

L

LaBier, C. Russell	Terre Haute	Vigo

Name	City	County
LaBier, Clarence R. (S)	Boca Raton, Fla.	Vigo
Lacy, John D., Jr.	Medaryville	Pulaski
Ladig, Donald S.	Fort Wayne	Allen
LaDine, Clarence B.	Indianapolis	Marion
LaDuron, Jules F.	Muncie	Delaware-Blackford
LaFollette, Donald	New Albany	Floyd
LaFollette, Forrest R.	Hammond	Lake
LaFollette, Robert E.	New Albany	Floyd
Lahr, Richard E.	Marion	Grant
Lalonde, Alban H.	Indianapolis	Marion
Lamb, Emmett B.	Indianapolis	Marion
Lamb, J. Leonard	South Bend	St. Joseph
Lamb, Russell W.	Indianapolis	Marion
Lamber, Chet K.	Indianapolis	Marion
Lambert, Ross W.	Camp Pendleton, Calif.	Marion
Lamey, James L.	Anderson	Madison
Lamey, Paul T.	Anderson	Madison
Lampe, Elfred H.	Fort Wayne	Allen
Lancet, Robert O.	Terre Haute	Vigo
Land, Francis L.	Fort Wayne	Allen
Land, Richard N.	Noblesville	Hamilton
Landis, Charles B.	Lafayette	Tippecanoe
Landon, David J.	Union City	Randolph
Landwehr, Alfons	Indianapolis	Marion
Lane, Charlotte E.	Indianapolis	Marion
Lane, William H.	South Bend	St. Joseph
Lang, Joseph E.	South Bend	St. Joseph
Langdon, Harry K. (S)	Indianapolis	Marion
Langohr, John	Columbia City	Whitley
Langrall, Harrison M. Jr.	Marion	Grant
Lanman, John U.	Munster	Lake
Lanning, R. Adrian	Noblesville	Hamilton
Lansford, Kenneth G.	Indianapolis	Marion
Laramore, Ward	Indianapolis	Marion
Larkin, Bernard J. (S)	Indianapolis	Marion
Larmore, Joseph L.	Anderson	Madison
Larmore, Sarah H.	Anderson	Madison
Larrabee, James F.	Munster	Lake
Larrabee, Wm. H. (S)	New Palestine	Hancock
Larson, Goyt O.	La Porte	La Porte
LaSalle, Richard M.	Wabash	Wabash
LaSalle, Robert M. Jr.	Wabash	Wabash
LaSalle, Robert M., Sr.	Wabash	Wabash
Lasich, Anthony R.	Indianapolis	Marion
Laubscher, Clarence	Evansville	Vanderburgh
Laudeman, Walter A.	Elwood	Madison
Lauer, Dorothy B.	Dana	Parke-Vermillion
Lautz, Herbert A.	Hammond	Lake
Lavengood, Russell W.	Marion	Grant
Lawler, George F.	Indianapolis	Marion
Lawrence, Joseph C.	Evansville	Vanderburgh
Laws, Kenneth F.	Lafayette	Tippecanoe
Lawson, Isaac H. (S)	Kendallville	Noble
Laycock, Richard M.	Fort Wayne	Allen
Layman, Douglas C.	Indianapolis	Marion
Lazo, Vicente R.	Gary	Lake
Leahy, Howard J.	Pendleton	Madison
Leak, Robert H.	Boswell	Benton
Leasure, J. Kent	Indianapolis	Marion
Leasure, Kenneth	Elkhart	Elkhart
Leatherman, Harter L.	Indianapolis	Marion
Lebioda, Henry S.	Gary	Lake
Lee, Glen Ward	Richmond	Wayne-Union
Lee, James	Terre Haute	Vigo
Lee, John M. (S)	Rushville	Rush
Lee, Robert Y.	De Motte	Jasper-Newton
Leff, Abe	Indianapolis	Marion
Leffel, James M.	Indianapolis	Marion
Leffler, William T.	Indianapolis	Marion
Lehman, Kenneth M.	Topeka	LaGrange
Lehmberg, Otto F. C.	Columbia City	Whitley
Leibundguth, Henry	Evansville	Vanderburgh
Leich, Charles F.	Evansville	Vanderburgh
Lein, John	Indianapolis	Marion
Leinbach, Earl	Hamlet	Starke
LeMaster, Theodore R.	Indianapolis	Marion
Leming, Ben L.	Fort Wayne	Allen
Lenk, George G.	Fort Wayne	Allen
Lenox, Jack	Lebanon	Boone
Leonard, Henry S. (S)	Indianapolis	Marion
Leroy, Alvin G.	Alexandria	Madison
Leser, Ralph U.	Indianapolis	Marion
Lester, Vern L.	South Bend	St. Joseph
Lett, Emory B.	Loogootee	Daviess-Martin
Levatin, Bernard I.	South Bend	St. Joseph
Levering, Guy P. (S)	Lafayette	Tippecanoe
Levi, Leon	Indianapolis	Marion
Levin, Eli	East Chicago	Lake
Levin, Ralph T.	Indianapolis	Marion
Levkoff, Abner H.	South Bend	St. Joseph
Lewis, George N.	Gary	Lake
Lewis, James F.	Liberty	Wayne-Union
Lewis, Paul S.	Indianapolis	Marion
Lewis, R. Earl	Indianapolis	Marion
Lewis, Robert J.	Lawrence	Marion
Lichtenberg, Melvin	Indianapolis	Marion
Liddell, Charles K.	Michigan City	La Porte
Lidikay, Edward C.	Indianapolis	Marion
Life, Homer L.	New Castle	Henry
Lind, Jaap J.	Mulberry	Clinton
Lindenborg, Paul G.	Indianapolis	Marion
Lindsay, Hamlin B.	Washington	Daviess-Martin
Ling, John F.	Richmond	Wayne-Union
Lingeman, Byron N.	Crawfordsville	Montgomery
Lingeman, Raleigh E.	Indianapolis	Marion
Lingeman, Roger E.	Indianapolis	Marion
Link, Goethe (S)	Indianapolis	Marion
Link, William C.	Bloomington	Owen-Monroe
Lionberger, John R.	South Bend	St. Joseph
Lippoldt, Charles L.	Oldenburg	Ripley
Lipschutz, Harold	Gary	Lake
Lipsey, Alfred J.	Gary	Lake
Liss, Emanuel C.	Forest Hills, N. Y.	St. Joseph
Little, John W. (S)	Indianapolis	Marion
Littlefield, Paul A.	Indianapolis	Marion
Littlefield, Shirley	Indianapolis	Marion
Litzenberger, Sam W.	Anderson	Madison
Lloyd, Frank P.	Indianapolis	Marion
Lloyd, Joe R.	Noblesville	Hamilton
Lloyd, Robert P.	Fort Wayne	Allen
Lochry, Ralph L. (S)	Indianapolis	Marion
Lockhart, Jack M.	Connersville	Fayette-Franklin
Lockhart, Philip R.	South Bend	St. Joseph
Loehr, William M.	Indianapolis	Marion
Loewenstein, Werner L.	Terre Haute	Vigo
Logan, James Z.	Richmond	Wayne-Union
Lohman, Robert M.	Fort Wayne	Allen
Lohoff, Lewis C.	Tell City	Perry
Loh, Hwei Ya (Chang)	Gary	Lake
Loh, Wei-Ping	Gary	Lake
Long, Keith	Hammond	Lake
Long, Max R.	Marion	Grant
Long, Paul L.	Anderson	Madison
Lonngren, Dudley H.	Marion	Grant
Loomis, Charles H.	Richmond	Wayne-Union
Loomis, Norman S.	Indianapolis	Marion
Loop, Frederick A.	Lafayette	Tippecanoe
Lord, Glen C.	Indianapolis	Marion
Lorenty, Thaddeus B.	Gary	Lake
Lorman, James G.	Fort Wayne	Allen
Louden, Robert W.	Indianapolis	Marion

Name	City	County
Loudermilk, Jack L.	Fort Wayne	Allen
Loughlin, Lawrence L	Indianapolis	Marion
Love, George N.	Indianapolis	Marion
Love, Jesshill	Indianapolis	Marion
Love, V. Logan	Marion	Grant
Lovell, Martin H.	Gary	Lake
Lovett, Harvey D.	Whitestown	Boone
Loving, Jury B.	New Goshen	Vigo
Lowery, George E.	New Castle	Henry
Lozow, David	Indianapolis	Marion
Lucas, Clarence A., Jr.	Indianapolis	Marion
Luckett, Coen L.	Terre Haute	Vigo
Luckey, James	Wolf Lake	Noble
Luckey, Robert C.	Wolf Lake	Noble
Luginbill, Howard M.	Berne	Adams
Lukemeyer, George T.	Indianapolis	Marion
Lukemeyer, St. John	Jasper	Dubois
Lundblad, Wilfred M.	Bloomington	Owen-Monroe
Lundeberg, Ralph A.	Griffith	Lake
Lundt, Milo O.	Elkhart	Elkhart
Lunsford, Thomas E.	Indianapolis	Marion
Lurie, Paul R.	Indianapolis	Marion
Luros, J. Theodore	Indianapolis	Marion
Lutes, David L. (S)	Heltonville	Lawrence
Lutz, Georgianna	Gary	Lake
Luzadder, John E.	New Carlisle	St. Joseph
Lybrook, Daniel E. (S)	Young America	Cass
Lybrook, William B.	Indianapolis	Marion
Lyman, Frank L.	Evansville	Vanderburgh
Lynch, Harold D.	Evansville	Vanderburgh
Lynch, Otis R.	Marengo	Harrison-Crawford
Lyon, Florence M.	Portland	Jay
Lyon, William C.	Fort Wayne	Allen
Lyons, L. Mason	Terre Haute	Vigo
Lyons, Robert E.	Bloomington	Owen-Monroe

M

MacCollum, M. Speers	Indianapolis	Marion
MacDougall, John D.	Indianapolis	Marion
MacKenzie, Pierce	Evansville	Vanderburgh
MacLeod, Donald F.	W. Lafayette	Tippecanoe
MacLeod, John K.	South Bend	St. Joseph
Machledt, John H.	Whiteland	Johnson
Mackel, Frederick O.	Fort Wayne	Allen
Mackey, Colonel G.	Logansport	Cass
Mackey, Harry S. (S)	Indianapolis	Marion
Mackey, John E.	Indianapolis	Marion
Macy, George W.	Columbus	Bartholomew-Brown
Madlang, R. M.	East Chicago	Lake
Madden, Robert J.	Indianapolis	Marion
Mader, John H.	Richmond	Wayne-Union
Madston, A. Ricks	Indianapolis	Marion
Magennis, Herbert L. (S)	Indianapolis	Marion
Mahaffey, John E.	Indianapolis	Marion
Mahank, Camiel C.	Mishawaka	St. Joseph
Mahoney, Charles L.	Terre Haute	Vigo
Majsterek, Stanley L.	Gary	Lake
Makovsky, Theodore	Valparaiso	Porter
Malcolm, Russell	Richmond	Wayne-Union
Malone, Leander A.	Terre Haute	Vigo
Malott, Fred R.	Converse	Miami
Malouf, Stephen D.	Peru	Miami
Manalan, Maurice M.	Indianapolis	Marion
Manalo, Francisco M.	Gary	Lake
Manders, Karl L.	Indianapolis	Marion
Mangan, Frank P.	Gary	Lake
Manifold, Harold M.	Bloomington	Owen-Monroe
Manion, Marlow W.	Indianapolis	Marion
Mankin, William J.	Terre Haute	Vigo
Mann, Mortimer	Indianapolis	Marion
Mann, Richard E.	Indianapolis	Marion
Manning, George	Fort Wayne	Allen
Manning, K. Randolph	Indianapolis	Marion
Manship, Stanley	Paoli	Orange
Mansueto, Mario D.	Hammond	Lake
Manzie, Michael W.	Indianapolis	Marion
Maple, James B. (S)	Sullivan	Sullivan
Marchand, Edwin V.	Haubstadt	Gibson
Marchant, Clarence H.	Bloomington	Owen-Monroe
Marcus, Emanuel	Hammond	Lake
Marcus, Morris C.	Gary	Lake
Maris, Lee J.	Attica	Fountain-Warren
Markle, Joseph G.	Hobart	Lake
Markovitch, Marilyn T.	Indianapolis	Marion
Marks, Howard H.	Huntington	Huntington
Marks, Maurice I.	Indianapolis	Marion
Marks, Ora L.	East Chicago	Lake
Marks, Salvo P.	Hammond	Lake
Marquinez, Adoracion	East Chicago	Lake
Marquis, Gordon	South Bend	St. Joseph
Marr, Griffith	Columbus	Bartholomew-Brown
Marsh, Carl M.	Indianapolis	Marion
Marsh, Chester A. (S)	Los Angeles, Calif.	Henry
Marsh, George W.	Lafayette	Tippecanoe
Marsh, Myrle F.	Indianapolis	Marion
Marshall, Albert L., Jr.	Indianapolis	Marion
Marshall, Caesar L.	Fort Wayne	Allen
Marshall, Cavins R. (S)	Indianapolis	Marion
Marshall, George L. (S)	Bourbon	Marshall
Marshall, Lloyd C. (S)	Mt. Summit	Henry
Marshall, Millard R.	Gary	Lake
Marshall, Thos. J. (S)	Charlestown	Clark
Marshall, Thomas R.	Topsfield, Mass.	Marion
Marske, Robert L.	Michigan City	La Porte
Martin, Charles E. (S)	Lynn	Randolph
Martin, Charles F.	Mishawaka	St. Joseph
Martin, Floyd S.	Goshen	Elkhart
Martin, Guy	Seymour	Jackson
Martin, Hugh E.	Indianapolis	Marion
Martin, Loren H.	Indianapolis	Marion
Martin, Paul H.	Elkhart	Elkhart
Martin, Samuel W.	Corydon	Harrison-Crawford
Martinov, William E.	South Bend	St. Joseph
Marty, Sophocles D.	Corpus Christi, Texas	Marion
Martz, Bill L.	Indianapolis	Marion
Martz, Carl D.	Indianapolis	Marion
Marvel, Howard R.	Lafayette	Tippecanoe
Marvel, Robert J.	Indianapolis	Marion
Maschmeyer, Robert H.	Logansport	Cass
Mason, Bernard A.	South Bend	St. Joseph
Mason, Donald G.	Angola	Steuben
Mason, Everett E.	Evansville	Vanderburgh
Mason, Lester M.	Terre Haute	Vigo
Mason, Richard L.	Hammond	Lake
Masters, John M.	Indianapolis	Marion
Masters, Robert J.	Indianapolis	Marion
Massanari, Walter	Millersburg	Elkhart
Mather, Charles R.	Lafayette	Tippecanoe
Mather, Glenn B.	South Bend	St. Joseph
Mather, J. Winford	East Gary	Lake
Mather, Robert L.	Lafayette	Tippecanoe
Mathews, James R.	Evansville	Vanderburgh
Mathewson, Russell C.	Muncie	Delaware-Blackford
Mathys, Alfred (S)	Mauckport	Harrison-Crawford
Matthew, John R.	North Judson	Starke
Matthew, W. Burleigh	Indianapolis	Marion
Matthews, Bernard J.	Indianapolis	Marion

Name	City	County
Matthews, Dennis W. (S)	North Vernon	Jennings
Matthews, William M.	Indianapolis	Marion
Mattmiller, Everette D.	Avilla	Noble
Mattox, Don M.	Terre Haute	Vigo
Maurer, J. Frank	Brazil	Clay
Maurer, Robert M.	Brazil	Clay
Maxam, B. T.	Indianapolis	Marion
Maxson, Roy V.	Evansville	Vanderburgh
May, George A.	Madison	Jefferson-Switzerland
May, Richard M.	Gary	Lake
Mayberry, Alton	Evansville	Vanderburgh
Mayes, Warren E.	Oakland, Calif.	Allen
Mayfield, Clifford H. (S)	Reynolds	White
McAdams, Hugh B.	Lafayette	Tippecanoe
McAdams, Robert	Lafayette	Tippecanoe
McAleese, George B.	Terre Haute	Vigo
McArdle, Edward G.	Fort Wayne	Allen
McAree, Francis E.	Indianapolis	Marion
McArt, Bruce A.	Elkhart	Elkhart
McAtee, Ott B.	Madison	Jefferson-Switzerland
McBride, James S.	Indianapolis	Marion
McBride, Noel S.	Terre Haute	Vigo
McCabe, James E. (S)	W. Lafayette	Tippecanoe
McCalla, Charles X.	Paoli	Orange
McCallister, John W.	Fort Wayne	Allen
McCallum, Donald C.	Indianapolis	Marion
McCallum, Joseph T. C.	Indianapolis	Marion
McCallum, Robert N.	Indianapolis	Marion
McCarthy, Jeremiah A.	Whiting	Lake
McCartney, Donald H.	Indianapolis	Marion
McCarty, Virgil	Princeton	Gibson
McCaskey, Carl H. (S)	Indianapolis	Marion
McClain, Edwin S.	Indianapolis	Marion
McClain, Marvin L.	Scottsburg	Scott
McClelland, Donald C. (S)	Lafayette	Tippecanoe
McClelland, Harry N.	Alexandria	Madison
McClintock, James A.	Muncie	Delaware-Blackford
McClure, Clark	Knox	Starke
McClure, Glenn	Sullivan	Sullivan
McClure, Morris E.	Union City	Randolph
McClure, Stanley E.	Monon	White
McClure, Warren N.	Kokomo	Howard
McConnell, William C.	Sunman	Ripley
McCool, Joseph H.	Evansville	Vanderburgh
McCord, Carl B. (S)	Veedersburg	Fountain-Warren
McCormack, Lloyd L.	Fremont	Steuben
McCormick, Charles O., Jr.	Indianapolis	Marion
McCormick, Hubert D. (S)	Vincennes	Knox
McCormick, Wilbur C.	Brazil	Clay
McCoy, George E.	Muncie	Delaware-Blackford
McCoy, Melvin H.	Evansville	Vanderburgh
McCoy, Roy R.	Fort Wayne	Allen
McCraley, William J.	South Bend	St. Joseph
McCrea, Fred R.	Terre Haute	Vigo
McCullough, Henry G.	Columbus	Bartholomew-Brown
McCullough, James Y.	New Albany	Floyd
McDaniel, Franklin P. (S)	Atlanta	Hamilton
McDonald, Frank C.	New Castle	Henry
McDonald, Joseph D.	Evansville	Vanderburgh
McDonald, Ralph M.	South Bend	St. Joseph
McDonald, Vergil G. (S)	Anderson	Madison
McDowell, Fletcher W.	Muncie	Delaware-Blackford
McDowell, George A.	Fort Wayne	Allen
McDowell, Mordecai M.	Vincennes	Knox
McEachern, Cecil G.	Fort Wayne	Allen
McElroy, James S.	New Castle	Henry
McElroy, Robert S.	Princeton	Gibson
McEwen, James W.	Terre Haute	Vigo
McFadden, James M.	Lafayette	Tippecanoe
McFarland, Corley B.	South Bend	St. Joseph
McGauvran, Theodore	East Chicago	Lake
McGee, Robert R.	New Castle	Henry
McGrath, Michael F.	Indianapolis	Marion
McGue, Frank J.	Michigan City	La Porte
McGuff, Paul E.	Indianapolis	Marion
McGuire, D. F. (S)	East Chicago	Lake
McIlwain, Eleanor E.	Warren	Huntington
McIlwain, Robert E.	Warren	Huntington
McIndoo, Ralph E.	Kokomo	Howard
McIntire, Clarence R.	Bloomington	Owen-Monroe
McIntosh, Wilbert	Riley	Vigo
McIntyre, Charles J. (S)	Indianapolis	Marion
McIntyre, James M.	Indianapolis	Marion
McKee, Harry G.	Rushville	Rush
McKee, Roy G.	New Castle	Henry
McKeeman, Donald H.	Fort Wayne	Allen
McKeeman, Leland S.	Fort Wayne	Allen
McKinley, A. David	Indianapolis	Marion
McKinley, Joseph	Lafayette	Tippecanoe
McKinney, Daniel H.	Lafayette	Tippecanoe
McKittrick, Jack	Washington	Daviess-Martin
McLaren, David E.	Indianapolis	Marion
McLaughlin, Calvin P.	Pendleton	Madison
McLaughlin, Gordon C.	Terre Haute	Vigo
McLaughlin, James R.	Flora	Carroll
McLaughlin, William T.	Menlo Park, Calif.	Marion
McLean, James S.	Munster	Lake
McMahan, Virgil C.	Vincennes	Knox
McMath, Samuel B.	Gary	Lake
McMichael, Frank J. (S)	Hernando, Fla.	Lake
McMillan, Frederick G. (S)	Indianapolis	Marion
McNabb, George B.	Carthage	Rush
McNabb, Richard C.	Carthage	Rush
McNaughton, Lawrence	Washington	Daviess-Martin
McNeely, Matthew J.	Dillsboro	Dearborn-Ohio
McQuiston, Ralph J.	Indianapolis	Marion
McTurnan, Robert W.	Indianapolis	Marion
McVey, Clarence A.	Hammond	Lake
McWilliams, William B.	Liberty	Wayne-Union
Mead, Clarence H. (S)	Bluffton	Wells
Mead, Frank E.	La Porte	La Porte
Meade, Walter W.	Bicknell	Knox
Medcalf, Norman L. (S)	Lamar	Spencer
Megenhardt, Dennis S.	Indianapolis	Marion
Mehne, Richard G.	Brazil	Clay
Meier, Donald W.	Bluffton	Wells
Meikle, Louise J. (S)	W. Lafayette	Tippecanoe
Meiks, Lyman T.	Indianapolis	Marion
Meiser, Robert D.	Huntington	Huntington
Meister, Doris (S)	Anderson	Madison
Melin, John R.	Indianapolis	Marion
Mella, Ramon E.	East Chicago	Lake
Melloh, Ardis F.	Indianapolis	Marion
Mendelson, Stanley M.	Kokomo	Howard
Mendez, Carlos	Elkhart	Elkhart
Mensch, James R.	Oakland, Calif.	Allen
Mentendiek, Maurice H.	Indianapolis	Marion
Mercer, Samuel R.	Fort Wayne	Allen
Meredith, Elwood J.	Richmond	Wayne-Union
Mericle, Earl W.	Indianapolis	Marion
Merrell, Basil M.	Rockville	Parke-Vermillion
Merrell, Paul	Indianapolis	Marion

Name	City	County
Mershon, Jack B.	Indianapolis	Marion
Mertz, Henry O. (S)	Nokomis, Fla.	Marion
Mertz, John H. O.	Indianapolis	Marion
Messer, Frank W.	Kendallville	Noble
Metcalfe, Grant E.	South Bend	St. Joseph
Meulbroek, Harvey	Pittsburgh, Pa.	Marion
Meyer, Hans	Fort Wayne	Allen
Meyer, Herman A.	Fort Wayne	Allen
Meyer, Theodore O.	Fort Wayne	Allen
Meyn, Werner P.	Terre Haute	Vigo
Michael, Isaac E.	Indianapolis	Marion
Michael, Robert L.	Kokomo	Howard
Michaelis, Stephen C.	Fort Wayne	Allen
Michaels, Joseph F. (S)	Edinburg	Johnson
Middleton, Harvey N.	Indianapolis	Marion
Middleton, Ramona J.	Elkhart	Elkhart
Middleton, Thomas O	Bloomington	Owen-Monroe
Mikan, V. Robert	Logansport	Cass
Miklozek, John E.	Terre Haute	Vigo
Milan, Joseph F.	Bloomington	Owen-Monroe
Miller, Arthur H. (S)	Russiaville	Howard
Miller, Dan T. (S)	Fowler	Benton
Miller, Donald C.	Cedar Lake	Lake
Miller, Donald G.	Middlebury	Elkhart
Miller, Edward D.	Fort Wayne	Allen
Miller, Frank H.	Indianapolis	Marion
Miller, Galen R.	Elkhart	Elkhart
Miller, H. Allison	Marion	Grant
Miller, H. Paul	Fort Wayne	Allen
Miller, Harold E.	Seymour	Jackson
Miller, Harold L.	Indianapolis	Marion
Miller, Henderson L. (S)	West Baden Springs	Orange
Miller, Hugh A.	Elkhart	Elkhart
Miller, James C.	Greensburg	Decatur
Miller, Jerry R.	Indianapolis	Marion
Miller, John D.	Indianapolis	Marion
Miller, John M.	Indianapolis	Marion
Miller, John M.	Bloomington	Owen-Monroe
Miller, Joseph A.	Oaklandon	Marion
Miller, Kenneth D.	Woodburn	Allen
Miller, LaVerne B.	Evansville	Vanderburgh
Miller, Mahlon F.	Fort Wayne	Allen
Miller, Maurice	Michigan City	La Porte
Miller, Milton	Evansville	Vanderburgh
Miller, Milo K. (S)	South Bend	St. Joseph
Miller, Orval J.	Fort Wayne	Allen
Miller, Raleigh S.	Indianapolis	Marion
Miller, Ray D.	Martinsville	Morgan
Miller, Richard C.	Shelbyville	Shelby
Miller, Richard H.	Fort Wayne	Allen
Miller, Robert B.	Fort Wayne	Allen
Miller, Robert J.	Evansville	Vanderburgh
Miller, Roland E.	Lafayette	Tippecanoe
Miller, Roscoe E.	Indianapolis	Marion
Miller, Samuel T. (S)	Elkhart	Elkhart
Miller, Virgil C.	Akron	Fulton
Miller, Wayne S.	Huntington	Huntington
Miller, William A.	Hagerstown	Wayne-Union
Miller, William J.	Fort Wayne	Allen
Milleson, Ann L. M.	Terre Haute	Vigo
Million, Rodney R.	Indianapolis	Marion
Millis, Arthur B.	Richmond	Wayne-Union
Mills, Fred E.	Evansville	Vanderburgh
Mills, John F.	Wabash	Wabash
Milne, Walter S.	Michigan City	La Porte
Milos, Robert J.	Gary	Lake
Milroy, Robert A.	Bluffton	Wells
Minczewski, Richard C.	Gary	Lake
Minick, Linus J.	Churubusco	Whitley
Mininger, Edward P.	Elkhart	Elkhart
Mino, Robert A.	Evansville	Vanderburgh
Mintz, Alfred M.	Hammond	Lake
Miofsky, William E.	Indianapolis	Marion
Mirro, John A.	Lowell	Lake
Misch, William	Cedar Lake	Lake
Mishkin, Irving	Elkhart	Elkhart
Mishler, Joe B.	Pierceton	Kosciusko
Mitchell, Edgar T. (S)	Romney	Tippecanoe
Mitchell, Edward O.	Indianapolis	Marion
Mitchell, George H.	Indianapolis	Marion
Mitchell, George L. (S)	Smithville	Owen-Monroe
Mitchell, Georgia B.	Gary	Lake
Mitman, Floyd B.	Huntington	Huntington
Moats, Carl F.	Fort Wayne	Allen
Moats, George E. (S)	Fort Wayne	Allen
Mock, Harry E. Jr.	Franklin	Johnson
Modisett, Jackson W.	Madison	Jefferson-Switzerland
Modisett, Marcella S.	Madison	Jefferson-Switzerland
Modjeski, Joseph R.	Hammond	Lake
Moehlenkamp, Chas. E.	Evansville	Vanderburgh
Moeller, Victor C.	Fort Wayne	Allen
Moenning John E.	Indianapolis	Marion
Moenning, Walter P.	Indianapolis	Marion
Mohler, Floyd W.	Columbus	Bartholomew-Brown
Molengraft, Cornelius J.	Gary	Lake
Molloy, William J. (S)	Muncie	Delaware-Blackford
Monar, Michael	Rockport	Spencer
Moneyhun, James E.	Anderson	Madison
Monroe, F. Bruce	Gary	Lake
Montgomery, Lall G.	Muncie	Delaware-Blackford
Montgomery, Samuel B. (S)	Cynthiana	Posey
Montgomery, William F.	Indianapolis	Marion
Moon, Charles E.	Center Point	Clay
Moore, Donald F.	Indianapolis	Marion
Moore, E. Gregory	Gary	Lake
Moore, Edwin G.	Gary	Lake
Moore, Harold T.	Indianapolis	Marion
Moore, Martha	Madison	Jefferson-Switzerland
Moore, Richard B.	Indianapolis	Marion
Moore, Robert G.	Vincennes	Knox
Moore, Thomas C.	Muncie	Delaware-Blackford
Moore, Will C. (S)	Muncie	Delaware-Blackford
Moore, William G.	Indianapolis	Marion
Moosey, Louis	Union Mills	La Porte
Moran, Mark M. (S)	Portland	Jay
Moran, William	Hope	Bartholomew-Brown
Moravec, Arthur E.	Fort Wayne	Allen
Morchan, Samuel	Indianapolis	Marion
Morgan, Margaret E.	Indianapolis	Marion
Moriarty, John R.	Indianapolis	Marion
Morrical, Russell J.	Logansport	Cass
Morris, Hyman	Gary	Lake
Morris, Jean W.	Muncie	Delaware-Blackford
Morris, Robert A.	Anderson	Madison
Morris, Warren V.	Monticello	White
Morrison, George C.	Portland	Jay
Morrison, George G.	Lawrenceburg	Dearborn-Ohio
Morrison, James T.	Greensburg	Decatur
Morrison, Lewis E.	Indianapolis	Marion
Morrison, William R.	Kokomo	Howard
Morrow, Dean H.	Bethesda, Md.	Marion
Morrow, Robert E.	Indianapolis	Marion
Morrow, Robert J.	Bedford	Lawrence
Mortenson, Leland J.	Fort Wayne	Allen
Morton, David P.	Westville	La Porte
Morton, Joseph L.	Indianapolis	Marion
Morton, Walter P.	Indianapolis	Marion

Name	City	County
Moser, Elmer B. (S)	Windfall	Tipton
Moser, Edward (S)	Woodburn	Allen
Moser, Rollin H.	Indianapolis	Marion
Moses, George E.	Worthington	Greene
Moses, Robert E.	Worthington	Greene
Moss, Bobby L.	Indianapolis	Marion
Moss, Harlan B.	Iowa City, Ia.	Marion
Moss, Herschel C.	Indianapolis	Marion
Moss, Mavor J.	Yorktown	Delaware-Blackford
Moswin, Jack A.	Gary	Lake
Mothersill, Mark H. (S)	Indianapolis	Marion
Mott, Cassell A.	South Bend	St. Joseph
Moulton, Lillian G.	Evansville	Vanderburgh
Mount, Mathias S.	Bloomfield	Greene
Mount, William M.	Crawfordsville	Montgomery
Mountain, Francis B.	Connersville	Fayette-Franklin
Mouser, Robert W.	Indianapolis	Marion
Mudd, Joseph P.	Clarksville	Clark
Muelchi, Adeline F.	Evansville	Vanderburgh
Mullen, James B.	Indianapolis	Marion
Mueller, Edwin C.	LaPorte	LaPorte
Mueller, Hilbert M.	South Bend	St. Joseph
Mueller, Lawrence W.	Fort Wayne	Allen
Mueller, Lillian B. (S)	Indianapolis	Marion
Muhleman, Charles E.	La Porte	La Porte
Muller, Lullus P.	Indianapolis	Marion
Muller, Paul F.	Indianapolis	Marion
Muller, Victor H.	Indianapolis	Marion
Mumford, E. Bishop (S)	Indianapolis	Marion
Murdock, Harvey L.	Fort Wayne	Allen
Murphy, Edward U.	Evansville	Vanderburgh
Murphy, Eugene C.	South Bend	St. Joseph
Murphy, Harold O.	Claypool	Kosciusko
Murphy, Joseph F.	Lansing, Ill.	Lake
Murphy, Josephine F.	South Bend	St. Joseph
Murphy, Maurice G. (S)	Morgantown	Morgan
Murray, Ernest C.	Kokomo	Howard
Murray, James S.	Beverly Hills, Calif.	Marion
Murray, William E.	New Castle	Henry
Musselman, Glen G.	Terre Haute	Vigo
Musser, A. Wendell	Indianapolis	Marion
Myers, Charles W.	Indianapolis	Marion
Myers, Philip R.	South Bend	St. Joseph
Myers, Roy V.	Indianapolis	Marion
Myre, Theodore T.	Evansville	Vanderburgh

N

Nachman, Elias	Bluffton	Wells
Nafe, Cleon A.	Indianapolis	Marion
Nagan, Robert F.	Indianapolis	Marion
Napper, Floyd S.	Scottsburg	Scott
Nash, Justin R.	Albion	Noble
Nason, Robert A.	Garrett	De Kalb
Navin, Hugh K.	Fortville	Hancock
Navarre, Vincent J.	Whiting	Lake
Nay, Ernest O.	Terre Haute	Vigo
Nay, Richard M.	Indianapolis	Marion
Nayyar, Som N.	Indianapolis	Marion
Neal, Leonard W.	Hammond	Lake
Neale, Alfred E.	Anderson	Madison
Need, Louis T.	Indianapolis	Marion
Neely, Alonzo S. (S)	Indianapolis	Marion
Neidballa, Edward G.	Bristol	Elkhart
Neifert, Noel L.	Tell City	Perry
Nelson, Audrey H.	Memphis, Tenn.	Marion
Nelson, Carl A.	West Lebanon	Fountain-Warren
Nelson, Dudley	Chandler	Warrick
Nelson, F. Dale	South Bend	St. Joseph
Nelson, Harold E.	Muncie	Delaware-Blackford
Nelson, John W.	Memphis, Tenn.	Marion
Nelson, Paul L.	Anderson	Madison
Nelson, Raymond E.	South Bend	St. Joseph
Nelson, Walfred A.	Gary	Lake
Nenneker, Henry (S)	Evansville	Vanderburgh
Nesbit, Leonard L.	Anderson	Madison
Nester, Henry G.	Indianapolis	Marion
Netherton, Clyde R. (S)	Chalmers	White
Neudorff, Louis G.	Terre Haute	Vigo
Neukamp, Frank H.	Connersville	Fayette-Franklin
Neumann, Kenneth O.	Lafayette	Tippecanoe
Newby, Eugene	Sheridan	Hamilton
Newcomb, William K.	Royal Center	Cass
Newland, Arthur E.	Bedford	Lawrence
Newman, Alvin E.	Evansville	Vanderburgh
Newsome, C. K.	Evansville	Vanderburgh
Niccum, Warren L.	Columbia City	Whitley
Nicholas, Dennis	Indianapolis	Marion
Nicholl, Willard	Morris Plains, N. J.	Vanderburgh
Nichols, Anne Sackett	Greencastle	Putnam
Nichols, Robert J.	Vincennes	Knox
Nicholson, Ray W.	Evansville	Vanderburgh
Nicosia, John B.	East Chicago	Lake
Nie, Grover M. (S)	Huntington	Huntington
Nie, Louis W.	Indianapolis	Marion
Niedermayer, Alfred J.	Evansville	Vanderburgh
Nigh, Rufus M.	Fairland	Shelby
Nilges, Richard G.	Gary	Lake
Nill, John H.	Fort Wayne	Allen
Nisenbaum, Harold	Evansville	Vanderburgh
Nixon, Byron	Farmland	Randolph
Nixon, Richard R.	A.P.O. 160, San Francisco, Calif.	Lake
Noblitt, James S. (S)	Rockville	Parke-Vermillion
Nodinger, Louis	Hammond	Lake
Noe, William R.	Bedford	Lawrence
Nohl, John M.	Indianapolis	Marion
Nolan, Gerald R.	Fort Wayne	Allen
Nolin, Richard T.	Indianapolis	Marion
Nolt, Ernest V. (S)	Columbia City	Whitley
Nolting, Henry F. (S)	Indianapolis	Marion
Nonte, Leo R.	Evansville	Vanderburgh
Norman, William H.	Indianapolis	Marion
Norris, Allen A. (S)	Elkhart	Elkhart
Norris, Ernest B.	Culver	Marshall
Norris, Howard L.	Indianapolis	Marion
Norris, Mary Alice	Ft. Sheridan, Ill.	Marion
Norris, Marvin G.	Rushville	Rush
Norris, Max S.	Indianapolis	Marion
Norton, Harold J.	Columbus	Bartholomew-Brown
Norton, Horace	Washington	Daviess-Martin
Nourse, Myron H.	Indianapolis	Marion
Novy, Charles A.	Garrett	De Kalb
Nugen, Harold	Auburn	De Kalb
Nugent, Edwin J.	Indianapolis	Marion
Nurnberger, John I.	Indianapolis	Marion
Nutter, Wyndham H.	Rushville	Rush

O

Oak, David D., Sr. (S)	LaCrosse	La Porte
Oak, David D., Jr.	Hanna	La Porte
Oatman, Jack G.	Marion	Grant
O'Brian, Earl J.	Indianapolis	Marion
O'Brian, John F.	Fort Wayne	Allen

Name	City	County
O'Brien, Francis E.	Rensselaer	Jasper-Newton
O'Brien, Raymond J.	Michigan City	La Porte
O'Bryan, Richard B.	Columbus	Bartholomew-Brown
O'Connor, Joseph M.	Muncie	Delaware-Blackford
Ochsner, Harold C.	Indianapolis	Marion
Ockerman, Kenneth R.	Rensselaer	Jasper-Newton
Offutt, Andrew C.	Indianapolis	Marion
Olcott, Charles W.	Aurora	Dearborn-Ohio
Oldag, George E.	Elwood	Madison
Oliphant, Frank W.	Mount Vernon	Posey
Oliphant, Robert W.	Terre Haute	Vigo
Olson, Donald T.	South Bend	St. Joseph
Olson, Kenneth L.	South Bend	St. Joseph
Olson, William H.	Michigan City	La Porte
Olvey, Ottis N.	Indianapolis	Marion
O'Malley, Martha A.	Indianapolis	Marion
Omstead, Milton	Petersburg	Pike
Omstead, Trevalyn W.	Huntington	Huntington
O'Neill, Martin J.	Valparaiso	Porter
Onorato, Joseph J.	Lafayette	Tippecanoe
Onyett, Harold R.	Greenwood	Johnson
Oppenheimer, Ernst	New York, N. Y.	Vanderburgh
Orders, Clarke E. (S)	Indianapolis	Marion
Oren, William F.	South Bend	St. Joseph
Ormiston, Michael W.	Indianapolis	Marion
Ornelas, Joseph P.	Gary	Lake
O'Rourke, Carroll	Fort Wayne	Allen
Orr, W. Robert	South Bend	St. Joseph
Oster, Jack H.	Westville	La Porte
Osterman, Louis H.	Seymour	Jackson
Oswald, Robert H.	Evansville	Vanderburgh
Oswalt, James T.	Mitchell	Lawrence
Otten, Claude F.	Indianapolis	Marion
Otten, Ralph E.	Darlington	Montgomery
Ottinger, Ross C. (S)	Indianapolis	Marion
Overley, Toney M., Jr.	Indianapolis	Marion
Overpeck, Charles	Greensburg	Decatur
Overpeck, George H.	Alexandria	Madison
Overshiner, Lyman (S)	Columbus	Bartholomew-Brown
Owen, John E.	Indianapolis	Marion
Owen, Margaret A.	Bloomington	Owen-Monroe
Owens, Richard R.	Muncie	Delaware-Blackford
Owens, Thomas R.	Muncie	Delaware-Blackford
Owens, Tracy C.	Indianapolis	Marion
Owsley, Guy A.	Hartford City	Delaware-Blackford
Oyer, John H.	Fort Wayne	Allen

P

Name	City	County
Pace, Jerome V.	Rockville	Parke-Vermillion
Paff, William A.	Elkhart	Elkhart
Pagedas, Tom C.	Indianapolis	Marion
Paine, George E.	Elkhart	Elkhart
Painter, Donald S.	Fort Wayne	Allen
Painter, Lowell W.	Winchester	Randolph
Palmer, Barron M. F.	Hammond	Lake
Palmer, Charman F.	Indianapolis	Marion
Palmer, Harley P.	Indianapolis	Marion
Palmer, Robert M.	Indianapolis	Marion
Palmer, Robert W.	Indianapolis	Marion
Palmer, Russell H.	Gary	Lake
Panares, Solomon V.	Hammond	Lake
Pancost, Vernon K.	Elkhart	Elkhart
Pandolfo, Harry	Indianapolis	Marion
Panos, Constantine O.	Bluffton	Wells
Pappas, Eddie T.	Gary	Lake
Paris, Durward W.	Kokomo	Howard
Paris, John M.	New Albany	Floyd
Park, Byron J.	Richmond	Wayne-Union
Parker, Carey B.	Fort Wayne	Allen
Parker, Carl B.	Wingate	Montgomery
Parker, E. Camille	Logansport	Cass
Parker, Francis W., Jr.	Logansport	Cass
Parker, George F., Jr.	Indianapolis	Marion
Parker, Harry C. (S)	Hobart	Lake
Parker, John C.	Goodland	Jasper-Newton
Parker, John F.	Indianapolis	Marion
Parker, L. Burton	Indianapolis	Marion
Parker, Portia	Indianapolis	Marion
Parks, George	Hartford City	Delaware-Blackford
Parmenter, Harry B.	Indianapolis	Marion
Parr, Robert L.	Indianapolis	Marion
Parratt, Louis W.	Gary	Lake
Parrish, Richard K.	Decatur	Adams
Parrot, Donald J.	Fort Wayne	Allen
Parshall, Dale B.	Elkhart	Elkhart
Parsons, Robert L.	South Bend	St. Joseph
Paskind, J.	Indianapolis	Marion
Passino, James	Richmond	Wayne-Union
Pastor, Julius W.	Evansville	Vanderburgh
Patrick, Glenn B.	Elkhart	Elkhart
Patterson, William K.	Anderson	Madison
Pattison, John D.	Marion	Grant
Patton, Martin T.	Indianapolis	Marion
Paul, Leendert J.	Muncie	Delaware-Blackford
Paul, Leonard G.	Michigan City	La Porte
Pauly, Leonard R.	Fort Wayne	Allen
Paulissen, George T.	Indianapolis	Marion
Pauszek, Thomas B.	South Bend	St. Joseph
Payne, Arthur C.	East Chicago	Lake
Paynter, Morris B.	Southport	Marion
Paynter, William	Pekin	Washington
Paz, Luis	Indianapolis	Marion
Peacock, Norman F.	Crawfordsville	Montgomery
Peacock, Robert C.	Muncie	Delaware-Blackford
Pearce, Roy V.	Terre Haute	Vigo
Pearlman, Samuel S. (S)	Lafayette	Tippecanoe
Pearson, Huey L.	Fort Wayne	Allen
Pearson, John S.	Indianapolis	Marion
Pearson, Lyman R.	Indianapolis	Marion
Pearson, William E.	Wabash	Wabash
Pebworth, Aubrey C. (S)	Indianapolis	Marion
Peck, Edward A.	Hammond	Lake
Peck, Franklin B., Jr.	Indianapolis	Marion
Peck, Franklin B. Sr.	Indianapolis	Marion
Peck, James F.	Princeton	Gibson
Peiffer, Geraldine M.	Hammond	Lake
Peirce, James D.	Indianapolis	Marion
Pemberton, Jack J.	Evansville	Vanderburgh
Penn, Robert A.	East Gary	Lake
Pennington, W. E. (S)	Indianapolis	Marion
Perkins, Powell L.	Kokomo	Howard
Perlov, Sylvan H.	Indianapolis	Marion
Permer, Erwin	Indianapolis	Marion
Perrin, Kermit F.	Fort Wayne	Allen
Perry, Frederic G.	Fort Wayne	Allen
Person, Theodore C.	Veedersburg	Fountain-Warren
Peters, Elmer E.	Brookville	Fayette-Franklin
Peterson, Deward D.	Indianapolis	Marion
Peterson, Joel A.	Lafayette	Tippecanoe
Peterson, Roland L.	Plymouth	Marshall
Petitjean, Harold G.	Haubstadt	Gibson
Petranoff, Theodore V.	Indianapolis	Marion
Petrass, Andrew	South Bend	St. Joseph

Name	City	County
Petrich, Peter R.	Attica	Fountain-Warren
Petry, T. Neal	Delphi	Carroll
Pettijohn, Fred L. (S)	Indianapolis	Marion
Peyton, Frank W.	Lafayette	Tippecanoe
Pfaff, Dudley A.	Indianapolis	Marion
Pfeifer, James M.	Lawrenceburg	Dearborn-Ohio
Pfuetze, Max	Logansport	Cass
Phares, Robert W.	Kokomo	Howard
Phelps, Stephen R.	South Bend	St. Joseph
Philbert, Richard N.	Fort Wayne	Allen
Philbrook, Seth S.	La Porte	La Porte
Phillips, David L.	Indianapolis	Marion
Phillips, John H.	Michigan City	LaPorte
Phipps, Elwood B.	Logansport	Cass
Phipps, Leland K.	Union City	Randolph
Pickett, Merle E.	Fort Wayne	Allen
Pickett, Paul	Dallas, Texas	Parke-Vermillion
Pickett, Robert D.	Indianapolis	Marion
Pierce, Emmett, Jr.	Indianapolis	Marion
Pierce, Gene S.	New Albany	Floyd
Pierce, Harold J. (S)	Terre Haute	Vigo
Pierce, William J.	Vincennes	Knox
Pierson, Pearl H.	Silver Lake	Kosciusko
Pierson, Robert H.	Crawfordsville	Montgomery
Pierson, Thomas A.	New Palestine	Hancock
Pietz, David G.	Bluffton	Wells
Pike, Warren H.	Hobart	Lake
Pilcher, Jack E.	Indianapolis	Marion
Pilecki, Peter J.	Michigan City	La Porte
Pilot, Jean	Hammond	Lake
Pinsky, Sheldon T.	Bellaire, Ohio	Marion
Pippenger, Wayne G.	Muncie	Delaware-Blackford
Pirkle, Hubert B.	Rockville	Parke-Vermillion
Pitkin, McKendree C.	Martinsville	Morgan
Pizzo, Anthony	Bloomington	Owen-Monroe
Plain, George	South Bend	St. Joseph
Plank, C. Robert	Michigan City	La Porte
Plasterer, Edward D.	Indianapolis	Marion
Ploetner, Edward J.	Jasper	Dubois
Ploughe, Ralph R.	Elwood	Madison
Polhemus, Warren C.	Anderson	Madison
Polite, Nicholas L.	Chicago, Ill.	Lake
Pollard, Walter S. (S)	Evansville	Vanderburgh
Pomeroy, Rex K.	Plymouth	Marshall
Ponczek, Edward	Fort Wayne	Allen
Pontius, Edwin E.	Indianapolis	Marion
Poolitsan, George C.	Bloomington	Owen-Monroe
Popp, Milton F.	Fort Wayne	Allen
Popplewell, Arvine G.	Indianapolis	Marion
Poracky, Bernard F.	Gary	Lake
Porro, Francis W.	Evansville	Vanderburgh
Porter, Carl M.	Jasonville	Greene
Porter, Edward A.	Westport	Decatur
Porter, Jack	Lebanon	Boone
Porter, Robert A.	Westport	Decatur
Porterfield, Hubert W.	Indianapolis	Marion
Portney, Fred R.	Hammond	Lake
Portteus, Walter L.	Franklin	Johnson
Poston, Clement L.	Laurel	Fayette-Franklin
Potter, Richard M.	Ridgeville	Randolph
Powell, J. Paxton	Marion	Grant
Powell, M. Jack	Fort Wayne	Allen
Powell, Richard C.	Denver, Colo.	Marion
Prather, Philip E.	Kokomo	Howard
Pratt, Ralph M., Jr.	Madison	Jefferson-Switzerland
Predd, Adolph C.	La Porte	La Porte
Premuda, Franklin F.	Hammond	Lake
Prenatt, Francis	Madison	Jefferson-Switzerland
Prentiss, Nelson H.	Oteen, N. C.	Allen
Present, Julian	Evansville	Vanderburgh
Pribble, Robert H.	Indianapolis	Marion
Price, Ambrose M.	Marion	Grant
Price, Douglas W.	Nappanee	Elkhart
Price, Francis W.	Indianapolis	Marion
Price, James O.	Indianapolis	Marion
Price, Shirley G.	Evansville	Vanderburgh
Priddy, Marvin E.	Fort Wayne	Allen
Priebe, Fred H.	Indianapolis	Marion
Priest, Edward M.	Bluffton	Wells
Proudfit, Charles H.	South Bend	St. Joseph
Province, Oran A.	Franklin	Johnson
Province, William D.	Franklin	Johnson
Pruitt, J. Edward	Gary	Lake
Pryor, Richard C.	Indianapolis	Marion
Pugh, Willis L.	Evansville	Vanderburgh
Pulskamp, Bertrand H.	Wolcottville	Noble
Purcell, Richard J.	Griffith	Lake
Puterbaugh, Karl E.	Albany	Delaware-Blackford
Pyle, Harold D.	South Bend	St. Joseph

Q

Quarles, E. Bryan	Bloomington	Owen-Monroe
Quick, William J.	Muncie	Delaware-Blackford
Quickel, Daniel S. (S)	Anderson	Madison
Quigley, Joseph B.	Indianapolis	Marion
Quilty, Thomas J.	Goshen	Elkhart

R

Rabb, Frank M.	Indianapolis	Marion
Rabb, Harry S.	Indianapolis	Marion
Raber, Robert M.	Indianapolis	Marion
Rader, George S.	Indianapolis	Marion
Radigan, Leo R.	Gary	Lake
Rafalski, Thomas A.	Indianapolis	Marion
Ragan, William D.	Indianapolis	Marion
Rainey, Everett A. (S)	Lebanon	Boone
Ralston, John D.	Indianapolis	Marion
Ramage, Walter F.	Beech Grove	Marion
Ramey, John W.	Kokomo	Howard
Ramker, Daniel T.	Hammond	Lake
Ramos, Alfonso	Crown Point	Lake
Ramsdell, Glen A.	Richmond	Wayne-Union
Ramsey, Frank B.	Indianapolis	Marion
Ramsey, Hugh S.	Bloomington	Owen-Monroe
Ranck, Benjamin	Columbus	Bartholomew-Brown
Randall, Thomas A.	North Liberty	St. Joseph
Raney, Ben B.	Linton	Greene
Rang, A. A. (S)	Washington	Daviess-Martin
Rang, Robert H.	Washington	Daviess-Martin
Rapp, George F.	Indianapolis	Marion
Rasch, George C., Jr.	Hammond	Lake
Rasmussen, Ruth F.	South Bend	St. Joseph
Ratcliff, Frank W.	Lafayette	Tippecanoe
Ratcliffe, Albert W.	Evansville	Vanderburgh
Rau, Charles A.	Columbus	Bartholomew-Brown
Rauh, Robert A.	Wabash	Wabash
Rausch, Norman W.	Angola	Steuben
Rawles, Lyman T. (S)	Fort Wayne	Allen
Rawlins, Carolyn M.	Hammond	Lake
Rawls, George H.	Indianapolis	Marion
Ray, Carl S.	Warren	Huntington
Ray, Herbert A. (S)	Fort Wayne	Allen
Raymundo, Vivencio F.	Attica	Fountain-Warren
Read, John E.	Chesterton	Porter
Reck, John L. (S)	Sheridan	Hamilton
Records, Arthur W.	Franklin	Johnson

Name	City	County
Reed, Donald	Culver	Marshall
Reed, Edsel S.	Jeffersonville	Clark
Reed, John	Hobart	Lake
Reed, John D.	Detroit, Mich.	Clinton
Reed, Nelle C. (S)	Michigan City	La Porte
Reed, Philip B.	Indianapolis	Marion
Reed, Robert C.	Terre Haute	Vigo
Reed, Robert F.	Mishawaka	St. Joseph
Reed, Robert G., Jr.	Plymouth	Marshall
Reed, Roger R.	Anderson	Madison
Reed, William C.	Bloomington	Owen-Monroe
Reeder, Henry H.	Jeffersonville	Clark
Rees, Russel C.	Indianapolis	Marion
Regan, George L.	Sellersburg	Clark
Reibel, Donald B.	New York, N. Y.	Marion
Reich, Clarence E.	Evansville	Vanderburgh
Reid, Charles A.	Indianapolis	Marion
Reid, Donald B.	Columbia City	Whitley
Reid, James D.	Indianapolis	Marion
Reid, Robert H.	Indianapolis	Marion
Reid, Robert M.	Columbus	Bartholomew-Brown
Reid, Robert W. (S)	Union City	Randolph
Reigle, Frederick C.	Greencastle	Putnam
Reilly, Eva Ferro	Beech Grove	Marion
Reilly, James F.	Vincennes	Knox
Reilly, Richard W.	Crete, Ill.	Lake
Reinhardt, Charles F.	South Bend	St. Joseph
Reisler, Simon (S)	Indianapolis	Marion
Remich, Antone C.	Hammond	Lake
Renbarger, Lester L.	Marion	Grant
Rendel, Donald T.	Hammond	Lake
Rendel, Harold E.	Mexico	Miami
Rentschler, Lewis C. (S)	Clay City	Clay
Reppert, Roland L.	Decatur	Adams
Rettig, Arthur C.	Muncie	Delaware-Blackford
Reuter, John W.	Indianapolis	Marion
Reynolds, James S.	Gary	Lake
Reynolds, Ralph E.	Middletown	Henry
Reynolds, Russell P.	Garrett	De Kalb
Reynolds, Richard J.	Terre Haute	Vigo
Rhamy, Arthur P.	Marion	Grant
Rhamy, Donald E.	Marion	Grant
Rhamy, Robert K.	Indianapolis	Marion
Rhea, James C.	Beech Grove	Marion
Rheinheimer, Floyd L.	Milford	Kosciusko
Rhind, Alexander W.	Hammond	Lake
Rhodes, Theodore D.	Nokomis, Fla.	Marion
Rhorer, Herbert M.	Kokomo	Howard
Rhorer, John G.	Marion	Grant
Rhynearson, Hal R.	Fortville	Hancock
Rice, Frederic A.	Indianapolis	Marion
Rice, Raymond M.	Indianapolis	Marion
Rice, Reed P.	Rochester, Minn.	Marion
Rice, Wilkie B. (S)	Fort Wayne	Allen
Rich, Norval	Decatur	Adams
Richard, Norman F.	Shelbyville	Shelby
Richards, David H. (S)	Vincennes	Knox
Richards, Edgar E.	Russellville	Putnam
Richardson, Charles L.	Rochester	Fulton
Richardson, Joseph H.	Marion	Grant
Richardson, Thad T.	Indianapolis	Marion
Richart, James V.	Terre Haute	Vigo
Richer, Orville H.	Warsaw	Kosciusko
Richter, Arthur B.	Indianapolis	Marion
Richter, John C.	La Porte	La Porte
Richter, Samuel	Gary	Lake
Ricketts, Joseph W. (S).	Orman Beach, Fla.	Marion
Ridgeway, Ora W. (S)	Indianapolis	Marion
Ridgway, Alton H.	Lapel	Madison
Ridolfo, Anthony S.	Indianapolis	Marion
Rieger, I. Taylor	Bloomington	Owen-Monroe
Rietman, H. Jerome	Evansville	Vanderburgh
Rifner, Eugene S.	Van Buren	Grant
Rigg, John F.	Miami Shores, Fla.	Marion
Riggs, Floyd C.	Terre Haute	Vigo
Rigley, Edward L.	South Bend	St. Joseph
Riley, Frank H. (S)	Jamestown	Boone
Rimel, James F.	Plymouth	Marshall
Riner, Jack K.	Indianapolis	Marion
Rinne, John I. (S)	Lapel	Madison
Riordan, John F.	Gary	Lake
Ripley, John W.	Seymour	Jackson
Rissing, Walter J.	Fort Wayne	Allen
Ritchey, James O.	Indianapolis	Marion
Ritchie, William D.	Evansville	Vanderburgh
Rittelmeyer, Louis F., Jr.	Evansville	Vanderburgh
Ritteman, George W.	Franklin	Johnson
Ritter, Wayne L.	Indianapolis	Marion
Rivers, Glynn A.	Muncie	Delaware-Blackford
Robb, John A.	Indianapolis	Marion
Roberts, Billy J.	South Bend	St. Joseph
Robertson, Addis N.	New Albany	Floyd
Robertson, David W. (S)	Deputy	Jefferson-Switzerland
Robertson, James S.	Plymouth	Marshall
Robertson, Ray B.	Indianapolis	Marion
Robertson, William C.	Chesterton	Porter
Robertson, William S.	Spiceland	Henry
Robinson, Earle U.	Evansville	Vanderburgh
Robinson, Frank C. (S)	Newport Beach, Calif	Marion
Robinson, Nan	New Albany	Floyd
Robinson, Walter K.	Gary	Lake
Robinson, William H.	Bedford	Lawrence
Roby, Alma L.	Jeffersonville	Clark
Rochlin, Isidore	Indianapolis	Marion
Rockey, Noah A.	Fort Wayne	Allen
Rodin, Herman H.	South Bend	St. Joseph
Rodriguez, Juan	Fort Wayne	Allen
Roesch, Ryland	Indianapolis	Marion
Roeske, Nancy A.	Indianapolis	Marion
Rogers, Arthur R.	Newburgh	Warrick
Rogers, Donald L.	Indianapolis	Marion
Rogers, Evered E.	Auburn	De Kalb
Rogers, Otto F.	Bloomington	Owen-Monroe
Rogers, R. Shirrell	West Terre Haute	Vigo
Rogers, Thomas P.	San Diego, Calif.	Marion
Rohn, Robert J.	Indianapolis	Marion
Rohrbacker, Donald M.	Portland, Ore.	Marion
Rohrer, Bryce B.	Walkerton	St. Joseph
Rohrer, James R.	Elnora	Daviess-Martin
Roll, John W.	Indianapolis	Marion
Roller, Charles W. (S)	Indianapolis	Marion
Rollins, Thomas K.	Bloomington	Owen-Monroe
Romberger, Floyd T., Jr.	Indianapolis	Marion
Rommel, Clarence H.	W. Lafayette	Tippecanoe
Roose, Lisle W.	Nappanee	Elkhart
Ropp, Eldon R.	Oakland City	Gibson
Ropp, Harold E.	New Harmony	Posey
Rosenak, Bernard D.	Indianapolis	Marion
Rosenbaum, David	Indianapolis	Marion
Rosenbaum, Irving, Jr.	Indianapolis	Marion
Rosenbaum, Lloyd E.	Anderson	Madison
Rosenblatt, Bernard B.	Evansville	Vanderburgh
Rosenbloom, Philip J.	Gary	Lake
Rosenheimer, George M.	South Bend	St. Joseph
Rosenthal, Carl	Hammond	Lake
Rosenwasser, Jacob	Mishawaka	St. Joseph
Roser, Arthur J.	Fort Wayne	Allen
Rosevear, Henry J.	Hammond	Lake

Name	City	County
Roshe, Joseph	Indianapolis	Marion
Ross, Alexander T.	Indianapolis	Marion
Ross, Ben R.	Bloomington	Owen-Monroe
Ross, Glenn E.	Washington	Daviess-Martin
Ross, Guy E.	Anderson	Madison
Ross, Harry P.	Richmond	Wayne-Union
Ross, James B.	Bloomington	Owen-Monroe
Ross, James S.	Richmond	Wayne-Union
Rossiter, Dudley L.	Fort Wayne	Allen
Roth, Bertram S.	Indianapolis	Marion
Roth, James R.	Wolf Lake	Noble
Roth, Leo	Gary	Lake
Roth, Melvin I.	Gary	Lake
Rothberg, Maurice	Fort Wayne	Allen
Rothrock, Philip W.	Lafayette	Tippecanoe
Rotman, Harry G.	Jasonville	Greene
Rotman, Sam I.	Jasonville	Greene
Rouen, Robert	Elkhart	Elkhart
Rousseau, John W.	Fort Wayne	Allen
Row, D. Hamilton	Indianapolis	Marion
Row, George S.	Osgood	Ripley
Row, Perrie Q.	Hammond	Lake
Rowe, Howard H.	Rochester	Fulton
Royster, George M. (S)	Evansville	Vanderburgh
Royster, Robert A.	Evansville	Vanderburgh
Rozelle, Clarence V.	Anderson	Madison
Rubens, Eli	South Bend	St. Joseph
Rubin, Milton M.	Terre Haute	Vigo
Rubin, Simon S.	Gary	Lake
Rubright, Robert L.	Hammond	Lake
Ruby, Fred McK. (S)	Wauwatosa, Wis.	Randolph
Ruddell, Karl R. (S)	Indianapolis	Marion
Ruddell, Keith R.	Indianapolis	Marion
Rudesill, Cecil L. (S)	Indianapolis	Marion
Rudesill, Robert L.	Indianapolis	Marion
Rudicel, Max	Kokomo	Howard
Rudolph, Carl J.	South Bend	St. Joseph
Rudolph, Franklin G.	Munster	Lake
Rudolph, Kenneth J.	Indianapolis	Marion
Rudolph, Stephen J., Jr.	Cannon AFB, New Mexico	Marion
Rudser, Donald H.	Whiting	Lake
Rudy, Donald B.	Bluffton	Wells
Runge, Paul W.	Richmond	Wayne-Union
Rupe, Lloyd O.	Elkhart	Elkhart
Rupel, Ernest	Clearwater, Fla.	Marion
Rusche, Henry J.	Evansville	Vanderburgh
Ruschli, Edward B. (S)	Lafayette	Tippecanoe
Rusk, Hubert M.	Wallace	Fountain-Warren
Russell, John R.	Indianapolis	Marion
Russell, Richard H.	Evansville	Vanderburgh
Russo, Andrew E.	Crown Point	Lake
Rust, Byron K.	Indianapolis	Marion
Rust, Roland B.	Indianapolis	Marion
Ruth, Martin L.	Indianapolis	Marion
Rutherford, Cyrus W. (S)	Indianapolis	Marion
Rutherford, Charles E.	Otterbein	Benton
Ryan, Glen V.	Indianapolis	Marion
Ryan, Hubert J.	Gary	Lake
Ryan, William J.	Columbus	Bartholomew-Brown

S

Name	City	County
Sabens, James A.	Indianapolis	Marion
Sacks, Leonard Z.	Valparaiso	Porter
Sage, Charles V.	Richmond	Wayne-Union
Sage, Russell A.	Indianapolis	Marion
Sahlman, Hans	Fort Wayne	Allen
Saint, William K.	New Castle	Henry
Sala, Joseph J.	Gary	Lake
Sala, Walter R.	Gary	Lake
Salb, John P.	Jasper	Dubois
Salb, Leo A. (S)	Jasper	Dubois
Salb, Max C.	Indianapolis	Marion
Salon, Harry W.	Fort Wayne	Allen
Salon, Joel W.	Fort Wayne	Allen
Salon, Nathan L.	Fort Wayne	Allen
Samter, Thomas G.	Indianapolis	Marion
Sanders, Bertram W.	Connersville	Fayette-Franklin
Sanders, Harry M.	Indianapolis	Marion
Sanders, Jesse A. (S)	Auburn	De Kalb
Sanderson, Robert B.	South Bend	St. Joseph
Sandock, Isadore	South Bend	St. Joseph
Sandock, Louis F.	South Bend	St. Joseph
Sandorf, Marvin H.	Indianapolis	Marion
Sandoz, Harry H.	South Bend	St. Joseph
Santare, Vincent J.	Hammond	Lake
Santiago, Carmen	Hammond	Lake
Santiago, Iluminada	Hammond	Lake
Sargent, Wallace B.	Hammond	Lake
Sarver, Francis E.	Fort Wayne	Allen
Savage, Arthur R.	Fort Wayne	Allen
Sayers, Frank E. (S)	Terre Haute	Vigo
Saylors, Rodger D.	Fort Wayne	Allen
Sazama, Francis J.	East Chicago	Lake
Scales, Alfred B.	Huntingburg	Dubois
Scales, Allen D.	Huntingburg	Dubois
Scamahorn, Malcolm O.	Pittsboro	Hendricks
Scamahorn, Oscar T. (S)	Pittsboro	Hendricks
Scea, Wallace A.	Elwood	Madison
Schaaf, Alvin D.	Jamestown	Boone
Schaefer, C. Richard (S)	Indianapolis	Marion
Schafer, William C.	Washington	Daviess-Martin
Schaffer, Edward V.	Indianapolis	Marion
Schantz, Richard	Remington	Jasper-Newton
Schaphorst, Richard A.	South Bend	St. Joseph
Scharbrough, William	Medora	Jackson
Schauwecker, Cleon M.	Greencastle	Putnam
Schechter, John S.	Indianapolis	Marion
Scheetz, Marion R.	Lewisville	Henry
Scheier, Emil W.	Indianapolis	Marion
Scheimann, Lois	Valparaiso	Porter
Schell, Harry D.	Indianapolis	Marion
Schellhouse, Earl M.	Fort Wayne	Allen
Schenck, Foss (S)	Logansport	Cass
Schenck, Ralph E.	Portland	Jay
Scherb, Burton E.	Terre Haute	Vigo
Scherschel, John P.	Bedford	Lawrence
Schetgen, Joseph V.	Geneva	Adams
Scheurich, Virgil	Oxford	Benton
Schiller, Herbert A.	South Bend	St. Joseph
Schimmelpfennig, Robert W.	Evansville	Vanderburgh
Schirmer, Robert H.	Evansville	Vanderburgh
Schlademan, Karl R.	Fort Wayne	Allen
Schlaegel, Theo. F., Jr.	Indianapolis	Marion
Schlegel, Donald M.	Indianapolis	Marion
Schlemmer, George H.	Warsaw	Kosciusko
Schlesinger, Daniel J.	Hammond	Lake
Schloss, Robert P.	Fort Wayne	Allen
Schlosser, Herbert C.	Elkhart	Elkhart
Schmalhausen, Ansel W.	Indianapolis	Marion
Schmidt, Eugene E.	Fort Wayne	Allen
Schmidt, Loren F.	Indianapolis	Marion
Schmidt, Richard H.	Valparaiso	Porter
Schmiedicke, Paul H.	Lafayette	Tippecanoe
Schmitt, Richard K.	Columbus	Bartholomew-Brown
Schmitt, Robert J.	Michigan City	LaPorte

Name	City	County
Schmoll, Robert J.	Fort Wayne	Allen
Schmoyer, Maurice R.	Indianapolis	Marion
Schneider, Carl J.	Indianapolis	Marion
Schneider, Charles P.	Evansville	Vanderburgh
Schneider, Kenneth D.	Nashville	Bartholomew-Brown
Schneider, Louis A.	Fort Wayne	Allen
Schnute, Richard B.	Indianapolis	Marion
Schoen, Frederic L.	Fort Wayne	Allen
Schoolfield, William E.	Orleans	Orange
Schoonveld, Arthur	Brook	Jasper-Newton
Schott, Edward J. (S)	Terre Haute	Vigo
Schreiner, John E.	Bremen	Marshall
Schrepferman, Wayne	Hamilton	Steuben
Schriefer, Victor V.	Evansville	Vanderburgh
Schroeder, Henry R.	Washington	Daviess-Martin
Schroeder, Robert W.	Marion	Grant
Schubert, Jerome C.	Fort Wayne	Allen
Schuchman, Abe	Indianapolis	Marion
Schuchman, Gabriel	Indianapolis	Marion
Schulfer, Richard J.	Hammond	Lake
Schulhof, Maurice G.	Muncie	Delaware-Blackford
Schulz, Kurt J.	Gary	Lake
Schulze, Hans A.	Indianapolis	Marion
Schulze, William	Vincennes	Knox
Schumaker, Robert A.	Terre Haute	Vigo
Schuman, Edith B.	Bloomington	Owen-Monroe
Schuster, Dwight W.	Indianapolis	Marion
Schut, Almon L.	Indianapolis	Marion
Schwartz, Frederick C.	Kokomo	Howard
Schwarz, Anton	Indianapolis	Marion
Scoins, William H.	Fort Wayne	Allen
Scott, Frank M.	South Bend	St. Joseph
Scott, George E.	Indianapolis	Marion
Scott, H. Vaughn	Fort Wayne	Allen
Scott, Irvin H.	Sullivan	Sullivan
Scott, I. Winfield	Indianapolis	Marion
Scott, John S.	La Porte	La Porte
Scott, John R.	Indianapolis	Marion
Scott, Robert P.	Indianapolis	Marion
Scott, Robert S.	Charlottesville	Hancock
Scott, Samuel L.	Indianapolis	Marion
Scott, V. Brown	Shelbyville	Shelby
Scudder, Arthur N.	Brownsburg	Hendricks
Scully, John T.	Gary	Lake
Seal, Perry F.	Brookville	Fayette-Franklin
Seaman, Charles F.	Indianapolis	Marion
Sears, Don	Odon	Daviess-Martin
Sears, M. Maywood (S)	Elkhart	Elkhart
Seat, Marshall H.	Washington	Daviess-Martin
Sedam, Herbert L.	Indianapolis	Marion
Seese, Robert M.	Delphi	Carroll
Segar, Louis H.	Indianapolis	Marion
Segar, William E.	Indianapolis	Marion
Seibel, Robert	Nashville	Bartholomew-Brown
Seipel, Stanley	Lanesville	Harrison-Crawford
Selby, Keith E.	South Bend	St. Joseph
Sellers, Francis M.	South Bend	St. Joseph
Sellmer, George W.	Indianapolis	Marion
Selsam, Etta B. (S)	Terre Haute	Vigo
Senese, Thomas J.	Gary	Lake
Sennett, Cecil M.	Westville	La Porte
Sennett, William K.	Macy	Miami
Senseny, Eugene F.	Fort Wayne	Allen
Sensenich, Roscoe L. (H)	South Bend	St. Joseph
Seward, George W.	North Manchester	Wabash
Sexson, Hiram T.	Indianapolis	Marion
Seyler, Anna G.	La Verne, Calif.	Lake
Shafer, Marion R.	Indianapolis	Marion
Shafer, Richard H.	Alexandria	Madison
Shafer, Sid J.	Chicago, Ill.	Lake
Shaffer, Kenneth L.	Vincennes	Knox
Shaffer, William R.	Greensburg	Decatur
Shallenberger, Henry R.	Modoc	Randolph
Shanafelt, Donald K.	Indianapolis	Marion
Shanklin, Jack L.	Bicknell	Knox
Shanklin, Vernon A. (S)	Terre Haute	Vigo
Shanks, Ray W.	Noblesville	Hamilton
Shannon, Wesley	Crawfordsville	Montgomery
Shapiro, Joseph	East Chicago	Lake
Shapiro, Seymour W.	East Chicago	Lake
Sharp, John L.	Crawfordsville	Montgomery
Sharp, Merle C.	South Bend	St. Joseph
Sharp, William L.	Anderson	Madison
Shattuck, John C.	Brazil	Clay
Shaw, Houston W.	Jeffersonville	Clark
Shaw, James E.	Fort Wayne	Allen
Sheehan, Francis G.	Indianapolis	Marion
Sheek, Kenneth I.	Greenwood	Johnson
Sheets, Charles E.	Manilla	Rush
Sheldon, Suel A.	Anderson	Madison
Sheller, Tom G.	Logansport	Cass
Shelley, Edward S.	South Bend	St. Joseph
Shelley, Richard	Indianapolis	Marion
Shellhouse, Michael	Gary	Lake
Shelton, Clyde F.	New Albany	Floyd
Shenk, Earl M.	Kokomo	Howard
Shepard, Fred F.	College Corner, Ohio	Wayne-Union
Sherer, Kenneth E.	Richmond	Wayne-Union
Sherster, Harry	Indianapolis	Marion
Sherwood, Clarence E.	Fort Wayne	Allen
Sherwood, J. Vincent	Fort Wayne	Allen
Shevick, Alexander	Gary	Lake
Shields, Jack E.	Brownstown	Jackson
Shields, Tom S.	Richmond	Wayne-Union
Shina, Heskel S.	Charlestown	Clark
Shinabery, Lawerence	Fort Wayne	Allen
Shipley, Edward	Indianapolis	Marion
Shively, John L.	Lafayette	Tippecanoe
Shoemaker, Richard L.	Marion	Grant
Sholty, William M.	Lafayette	Tippecanoe
Shonk, Harold W.	Noblesville	Hamilton
Shoptaugh, A. Glenn, Jr.	Wichita Falls, Texas	Marion
Short, John T.	Fort Wayne	Allen
Shoup, Homer B.	Greentown	Howard
Showalter, John P.	Waterloo	De Kalb
Showalter, John R.	Terre Haute	Vigo
Shrader, Carl E.	Warsaw	Kosciusko
Shriner, Richard L.	South Bend	St. Joseph
Shrock, Ethan E.	Amboy	Miami
Shroyer, Herbert	Dunkirk	Jay
Shuck, William A.	Madison	Jefferson-Switzerland
Shullenberger, Wendell A.	Indianapolis	Marion
Shulruff, Harry I.	East Chicago	Lake
Shumacker, Harris B., Jr.	Indianapolis	Marion
Sibbitt, Joseph W.	Bloomington	Owen-Monroe
Sicks, Okla W.	Indianapolis	Marion
Sidebottom, Earl W.	Indianapolis	Marion
Sidell, James P.	New Haven	Allen
Siderys, Harry	Indianapolis	Marion
Siebe, Jack C.	Indianapolis	Marion
Siebenmorgen, Louis (S)	Terre Haute	Vigo
Siebenmorgen, Paul	Terre Haute	Vigo
Siekierski, Joseph M.	Griffith	Lake
Siersdorfer, Theodore N. (S)	Indianapolis	Marion
Sigmond, Harvey W.	Indianapolis	Marion
Sigmund, William B.	Columbus	Bartholomew-Brown

Name	City	County
Silver, Richard A.	Indianapolis	Marion
Silverman, Norman M.	Terre Haute	Vigo
Silvian, Harry A.	Whiting	Lake
Simmons, Frederick H.	Marion	Grant
Simmons, James E.	Indianapolis	Marion
Simmons, Lloyd H.	Goshen	Elkhart
Simms, J. Leon	Indianapolis	Marion
Simpson, Robert L.	Bluffton	Wells
Simpson, William D.	Indianapolis	Marion
Sims, J. Lawrence	Indianapolis	Marion
Singer, Elmer C. (S)	Fort Wayne	Allen
Singer, Paul J.	Jasper	Dubois
Sinn, Charles M.	Evansville	Vanderburgh
Sirlin, Edward M.	Mishawaka	St. Joseph
Sisk, Phillip B.	Indianapolis	Marion
Sisson, Norvel D.	South Bend	St. Joseph
Skeen, Earl D. (S)	Walkerton	St. Joseph
Skillern, Penn G. (S)	South Bend	St. Joseph
Skillern, Scott D.	South Bend	St. Joseph
Skomp, Claud E.	Marion	Grant
Skrentny, Stanley H.	Hammond	Lake
Slabaugh, Jancy S. (S)	Nappanee	Elkhart
Slama, George F.	Gary	Lake
Slama, John T.	Gary	Lake
Slaughter, Howard C.	Evansville	Vanderburgh
Slaughter, John C.	Evansville	Vanderburgh
Slaughter, Owen L.	Evansville	Vanderburgh
Slichenmyer, Jack E.	Indianapolis	Marion
Slick, Crystal R.	Winchester	Randolph
Sloan, Herbert P.	New Albany	Floyd
Sloan, W. Keith	Madison	Jefferson-Switzerland
Slominski, Harry H.	South Bend	St. Joseph
Slough, O. Thomas	Kendallville	Noble
Sluss, David H.	Indianapolis	Marion
Sluss, John W. (S)	Indianapolis	Marion
Smith, A. Wilson	Greencastle	Putnam
Smith, Barton T.	Marion	Grant
Smith, Byron J.	Kingman	Fountain-Warren
Smith, Charles F.	Noblesville	Hamilton
Smith, David L.	Indianapolis	Marion
Smith, Edward B.	Indianapolis	Marion
Smith, E. Rogers	Indianapolis	Marion
Smith, Francis C.	Indianapolis	Marion
Smith, Fred, Jr.	Tell City	Perry
Smith, Frederick R.	Spencer	Owen-Monroe
Smith, Gloster J.	Kokomo	Howard
Smith, Herbert N.	Brookville	Fayette-Franklin
Smith, Herschel S.	Bloomington	Owen-Monroe
Smith, James S.	Muncie	Delaware-Blackford
Smith, Jerald E.	Hammond	Lake
Smith, John H.	Greenfield	Hancock
Smith, Lloyd H.	North Manchester	Wabash
Smith, Lowell C.	Lafayette	Tippecanoe
Smith, Mark E.	New Castle	Henry
Smith, Philip L.	Fort Wayne	Allen
Smith, Ralph O.	Vincennes	Knox
Smith, Richard B.	Fort Wayne	Allen
Smith, Robert D.	Hobart	Lake
Smith, Rodney D. (S)	Bloomington	Owen-Monroe
Smith, R. Lee	Osgood	Ripley
Smith, Roger C.	Fort Wayne	Allen
Smith, Roy Lee	Indianapolis	Marion
Smith, Roy M.	Evansville	Vanderburgh
Smith, S. Joseph	Vincennes	Knox
Smith, Stephen D.	Knightstown	Henry
Smith, Theodore J.	Whiting	Lake
Smith, William B.	Indianapolis	Marion
Smith, William M.	Westville	La Porte
Smoot, Emory B.	Washington	Daviess-Martin
Smoot, Samuel A. (S)	Terre Haute	Vigo
Snapp, Richard A.	Columbus	Bartholomew-Brown
Sneary, Kenneth D.	Avilla	Noble
Sneary, Max E.	Avilla	Noble
Snider, Byron	Indianapolis	Marion
Snively, William D., Jr.	Evansville	Vanderburgh
Snodgrass, Robert E.	Greenwood	Johnson
Snowhite, Arthur B.	Marion	Grant
Snyder, Earl R. (S)	Troy	Perry
Snyder, Morris C.	Richmond	Wayne-Union
Snyder, Parker M.	Peru	Miami
Snyderman, Sanford C.	Fort Wayne	Allen
Sobol, Z. W.	Elkhart	Elkhart
Sokol, Allen B.	Whiting	Lake
Solis, Roger V.	Hammond	Lake
Solomon, Reuben A.	Indianapolis	Marion
Somers, Gerald H.	Fort Wayne	Allen
Sommers, Stephen D.	Dayton, Ohio	Marion
Sonne, Irvin S., Jr.	New Albany	Floyd
Soper, Hunter A.	Indianapolis	Marion
Sorenson, Raymond	Kokomo	Howard
Souder, Bonnell M.	Auburn	De Kalb
Souter, Martha C.	Indianapolis	Marion
Southard, James E.	Danville	Hendricks
Southworth, John W.	Indianapolis	Marion
Sovine, Joe W.	Indianapolis	Marion
Spahr, Donald E.	Portland	Jay
Spahr, John F. Jr.	Indianapolis	Marion
Spalding, Joseph J.	Indianapolis	Marion
Spalding, Wendell L.	Mishawaka	St. Joseph
Spangler, Jesse S.	Kokomo	Howard
Sparks, Alan L.	Indianapolis	Marion
Sparks, Paul W.	Winchester	Randolph
Spears, John K.	Paoli	Orange
Spears, John M.	Indianapolis	Marion
Speas, Robert C.	Terre Haute	Vigo
Speck, Carlson R.	Muncie	Delaware-Blackford
Speckman, Glenn H.	Indianapolis	Marion
Spellman, Frank W.	Gary	Lake
Spencer, Beaufort A.	Bloomington	Owen-Monroe
Spencer, Frederic	Vincennes	Knox
Spencer, C. Herbert	Fort Wayne	Allen
Spenner, Raymond W.	South Bend	St. Joseph
Spindler, Robert D.	Shelbyville	Shelby
Spivack, Mary	Gary	Lake
Spivey, Russell J.	Indianapolis	Marion
Spolyar, Louis W.	Indianapolis	Marion
Sponder, Joseph (S)	Gary	Lake
Spray, Page E.	Elkhart	Elkhart
Sprecher, Herman C.	Evansville	Vanderburgh
Sprenger, Thomas R.	New Orleans, La.	Marion
Springstun, George H.	Oaktown	Knox
Springstun, Walter R.	Evansville	Vanderburgh
Sputh, Carl B., Jr.	Indianapolis	Marion
Sroka, Alexander G.	Hammond	Lake
Sroka, Stanley J.	Highland	Lake
Stadler, Harold E.	Indianapolis	Marion
Staff, Robert A.	Indianapolis	Marion
Stafford, James C. (S)	Plainfield	Hendricks
Stafford, William C.	Plainfield	Hendricks
Stahl, Edward T.	Lafayette	Tippecanoe
Stallman, Carl F.	Kendallville	Noble
Stalter, Gaylord W.	North Webster	Kosciusko
Stamper, Joseph H.	Anderson	Madison
Stamper, Lucian A.	Richmond	Wayne-Union
Stamper, Robert J.	Anderson	Madison
Stander, Richard W.	Indianapolis	Marion
Stangle, William J.	Bloomington	Owen-Monroe
Stanley, John S.	Miami, Fla.	Marion

Name	City	County
Stanley, Robert G.	Fort Wayne	Allen
Stansbury, William E.	Indianapolis	Marion
Stansell, Gilbert B.	Lafayette	Tippecanoe
Starks, William O.	Anderson	Madison
Stasick, Murray	Hammond	Lake
Staten, Jesse C.	Indianapolis	Marion
Stauffer, George E.	Mooreland	Henry
Stauffer, Richard C.	Fort Wayne	Allen
Stauffer, Walter A. (S)	Elkhart	Elkhart
Staunton, Henry A.	South Bend	St. Joseph
Stayton, Chester A., Jr.	Indianapolis	Marion
Steckler, Robert J.	Garden Grove, Calif.	Vanderburgh
Stecy, Peter	Whiting	Lake
Steele, Dick J.	Greencastle	Putnam
Steele, Everett B.	Crown Point	Lake
Steele, Frank M.	Muncie	Delaware-Blackford
Steele, Hugh H.	Lafayette	Tippecanoe
Steele, Paul W.	Evansville	Vanderburgh
Steen, Lowell H.	Whiting	Lake
Steffen, Arthur J.	Wabash	Wabash
Steffen, Julian T.	Wabash	Wabash
Steffy, Ralph M.	Portland	Jay
Steigmeyer, David J.	Fort Wayne	Allen
Stein, Richard H.	Vincennes	Knox
Steinem, Joseph L.	Connersville	Fayette-Franklin
Steinkamp, Emil F. (S)	Huntingburg	Dubois
Steinmetz, Edward F.	Indianapolis	Marion
Stellner, Howard A.	Fort Wayne	Allen
Stephens, Donald E.	Indianapolis	Marion
Stephens, Kuhrman H.	Indianapolis	Marion
Stephens, Lowell R.	Covington	Fountain-Warren
Stepleton, John D.	Richmond	Wayne-Union
Stern, Samuel L.	Hammond	Lake
Sterne, John H.	Evansville	Vanderburgh
Steury, Ernest M.	Kenya Colony, B. E. Africa	Marion
Steussy, Calvin N.	New Castle	Henry
Stevens, Edwin W.	Hammond	Lake
Stevens, Sydney L.	Indianapolis	Marion
Stewart, J. Frank W.	Vincennes	Knox
Stewart, Walter E. (S)	Terre Haute	Vigo
Stibbins, Warren E.	Muncie	Delaware-Blackford
Stier, Paul L.	Fort Wayne	Allen
Stillwell, William R.	Richmond	Wayne-Union
Stimson, Harry R.	Gary	Lake
Stine, Marshall E.	Bremen	Marshall
Stinson, Dean K.	Rochester	Fulton
Stinson, William M.	Anderson	Madison
Stiver, Daniel D.	South Bend	St. Joseph
Stoelting, J. Lewis	Terre Haute	Vigo
Stoelting, Vergil K.	Indianapolis	Marion
Stogdill, William J.	South Bend	St. Joseph
Stogsdill, Willis W.	Franklin	Johnson
Stoltz, Robert M.	Valparaiso	Porter
Stone, Alvin T.	Indianapolis	Marion
Stone, Robert C.	Ligonier	Noble
Stoops, Jean T.	Wabash	Wabash
Storey, D. Edmund	Indianapolis	Marion
Storey, Joseph L.	Indianapolis	Marion
Stork, Harvey K.	Huntingburg	Dubois
Stork, Urban	Evansville	Vanderburgh
Storms, Roy B. (S)	Indianapolis	Marion
Stouder, Albert E.	Kempton	Tipton
Stouder, Charles E.	Ellettsville	Owen-Monroe
Stout, Francis E.	Muncie	Delaware-Blackford
Stout, Harry T.	Frankfort	Clinton
Stout, Richard B.	Elkhart	Elkhart
Stout, Walter M. (S)	New Castle	Henry
Stover, Wendell C.	Boonville	Warrick
Stoycoff, Christ M. (S)	Gary	Lake
Stratigos, Joseph S.	Evanston, Ill.	St. Joseph
Strayer, Joseph W.	Lafayette	Tippecanoe
Streck, Francis A.	Lawrenceburg	Dearborn-Ohio
Strecker, William L.	Terre Haute	Vigo
Streepey, Jefferson I.	New Albany	Floyd
Streeter, Ralph T.	Indianapolis	Marion
Strickland, Karl S. (S)	Princeton	Gibson
Strickland, Neil R.	Indianapolis	Marion
Strong, Daniel S. (S)	Terre Haute	Vigo
Stroup, Tyler J.	Indianapolis	Marion
Strueh, Paul E.	Evansville	Vanderburgh
Stubbins, William M.	Elkhart	Elkhart
Stucky, Elsworth K.	Indianapolis	Marion
Stucky, Jerry L.	Fort Wayne	Allen
Studebaker, Lloyd R.	LaGrange	LaGrange
Stultz, Quentin F.	Ligonier	Noble
Stumer, Myer	Michigan City	La Porte
Stump, Loyd K.	Indianapolis	Marion
Stump, Richard L.	Chesterfield	Madison
Stump, Thomas A.	Indianapolis	Marion
Stumpf, Edwin E.	New Haven	Allen
Sturgis, Donald G.	Sellersburg	Clark
Suelzer, John G.	Indianapolis	Marion
Sugarman, Benjamin E.	French Lick Springs	Orange
Sullenger, Adron A.	Vincennes	Knox
Sullivan, Francis J.	Francesville	Pulaski
Sullivan, John M.	Terre Haute	Vigo
Sullivan, Robert E.	Fort Wayne	Allen
Summerlin, Jack D.	Indianapolis	Marion
Sutton, William E.	Indianapolis	Marion
Suzuki, Tsutomu T.	Covington	Fountain-Warren
Swan, John R.	Indianapolis	Marion
Swan, Richard C.	Anderson	Madison
Swank, Lucretia R.	Pewankee, Wis.	Elkhart
Sweet, Howard E.	Richmond	Wayne-Union
Swihart, Danny D.	Elkhart	Elkhart
Swihart, Homer R.	Elkhart	Elkhart
Swihart, Leonard F.	Elkhart	Elkhart
Syler, Robert W.	Westville	La Porte
Symmes, Alfred T.	Indianapolis	Marion
Symon, William E.	Bluffton	Wells
Szumilas, Peter P.	Indianapolis	Marion
Szynal, John S.	Indianapolis	Marion

T

Tabaka, Francis B.	La Porte	La Porte
Tager, Stephen N.	Evansville	Vanderburgh
Talarico, Leonard H.	Rochester, N. Y.	Marion
Talbert, Pierre C.	Bluffton	Wells
Talbott, Dan E.	Indianapolis	Marion
Tanner, Henry S.	Indianapolis	Marion
Taraba, Ralph W.	Bloomington	Owen-Monroe
Tasher, Dean C.	Westville	La Porte
Tate, Elizabeth	Dunkirk	Jay
Taub, Robert G.	Michigan City	La Porte
Taube, Jack I.	Indianapolis	Marion
Taylor, Clifford C.	Indianapolis	Marion
Taylor, Cyril	Indianapolis	Marion
Taylor, Donald J.	Terre Haute	Vigo
Taylor, Donald R.	Muncie	Delaware-Blackford
Taylor, Everett C.	Upland	Grant
Taylor, Frederic W.	Indianapolis	Marion
Taylor, James A.	Muncie	Delaware-Blackford
Taylor, John R.	Palestine, Ill.	Sullivan
Taylor, Loren F.	Martinsville	Morgan
Taylor, Max T.	Indianapolis	Marion
Taylor, Robert G.	Fort Wayne	Allen

Name	City	County
Taylor, William R.	Richmond	Wayne-Union
Teaboldt, George	Peru	Miami
Teague, Frank W.	Indianapolis	Marion
Teal, Dorothy D.	Columbus	Bartholomew-Brown
Tedford, John H.	Ann Arbor, Mich.	Clinton
Teegarden, Joseph A. (S)	East Chicago	Lake
Teegarden, Joseph A., Jr.	East Chicago	Lake
Teixler, Victor A.	Indianapolis	Marion
Templeton, Ames R.	Mishawaka	St. Joseph
Templeton, Ian S.	Seymour	Jackson
Templin, David B.	Lowell	Lake
Tennant, David L.	Fort Wayne	Allen
Tennis, George T.	Greencastle	Putnam
Tepfer, Milton	Indianapolis	Marion
Teplinsky, Louis L.	East Chicago	Lake
Terbush, Edward L.	Twelve Mile	Cass
Terrill, Richard W.	Fort Wayne	Allen
Terry, Lloyd	Danville	Hendricks
Terry, Robert H.	Boonville	Warrick
Terveer, John B.	Decatur	Adams
Test, Charles E.	Indianapolis	Marion
Teter, George V.	Indianapolis	Marion
Teters, Melvin S.	Middlebury	Elkhart
Tether, Joseph E.	Indianapolis	Marion
Tharpe, Ray	Indianapolis	Marion
Thatcher, Hugh K., Jr.	Indianapolis	Marion
Thayer, Benet W.	North Vernon	Jennings
Theobald, Sterling	Dyer	Lake
Thimlar, James W. (S)	Fort Wayne	Allen
Thom, Julia S.	Terre Haute	Vigo
Thomas, Charles R.	Indianapolis	Marion
Thomas, Daniel D.	Gary	Lake
Thomas, Edward P.	Indianapolis	Marion
Thomas, Everett W.	Warsaw	Kosciusko
Thomas, Fred A.	Indianapolis	Marion
Thomas, Gerald J.	Gary	Lake
Thomas, Lowell I.	Indianapolis	Marion
Thomas, Morris E.	Indianapolis	Marion
Thomas W. Clayton	Carmel	Hamilton
Thompson, Alfred A. (S)	Tyner	Marshall
Thompson, B. Jay	Marion	Grant
Thompson, Claude N.	Waynetown	Montgomery
Thompson, Frank M.	Columbia City	Whitley
Thompson, Holland	Fort Wayne	Allen
Thompson, John M.	South Bend	St. Joseph
Thompson, John V.	Indianapolis	Marion
Thompson, Joseph F.	Indianapolis	Marion
Thompson, Naiad Mason	Evansville	Vanderburgh
Thompson, Paul D.	Indianapolis	Marion
Thompson, Robert A.	South Bend	St. Joseph
Thompson, Walter	Jeffersonville	Clark
Thompson, Wayne H.	Indianapolis	Marion
Thompson, Wm. R.	Winamac	Pulaski
Thornburg, Kenneth E.	Indianapolis	Marion
Thorne, Charles E.	New Castle	Henry
Thornton, Harold C.	Indianapolis	Marion
Thornton, Maurice J.	South Bend	St. Joseph
Thornton, Walter E. (S)	Fort Wayne	Allen
Thrasher, John R. (S)	New Augusta	Marion
Throop, Frank B.	Indianapolis	Marion
Thurston, Harrison S. (S)	Dayton, Ohio	Marion
Tilden, Margaret H.	Evansville	Vanderburgh
Tiley, George A.	Greenwood	Johnson
Tilka, Edward C.	Hammond	Lake
Tindall, George T.	Indianapolis	Marion
Tindall, Paul R. (S)	Shelbyville	Shelby
Tindall, William R.	Shelbyville	Shelby
Tinney, William E. (S)	Pass-A-Grille, Fla.	Marion
Tinsley, Frank W.	Indianapolis	Marion
Tinsley, Walter B. (S)	Indianapolis	Marion
Tinsley, Walter B., Jr.	Indianapolis	Marion
Tipton, William R.	Greencastle	Putnam
Tirman, Wallace S.	South Bend	St. Joseph
Tischer, E. Paul	Indianapolis	Marion
Tisserand, John B. Jr.	Evansville	Vanderburgh
Todd, David D. (S)	LaJolla, Calif.	Elkhart
Tomak, Milton E.	Linton	Greene
Tomlin, Hugh M.	Muncie	Delaware-Blackford
Tomusk, August N.	Fort Wayne	Allen
Tondra, John M.	Indianapolis	Marion
Topolgus, James N.	Bloomington	Owen-Monroe
Topping, Malachi C.	Terre Haute	Vigo
Torella, Jose A.	Indianapolis	Marion
Tosick, William A.	Indianapolis	Marion
Toumey, Fred L.	Indianapolis	Marion
Tower, James H., Jr.	Shelbyville	Shelby
Tower, Thomas K.	Campbellsburg	Washington
Trachtenberg, Lee	Hammond	Lake
Tranter, William F.	Sharpsville	Tipton
Traver, Perry C. (S)	South Bend	St. Joseph
Travis, Floyd D.	Shelbyville	Shelby
Tremain, Milton A. (S)	Adams	Decatur
Treon, James F. (S)	Aurora	Dearborn-Ohio
Trepagnier, Francis B.	E. Chicago	Lake
Trimble, John G.	Kokomo	Howard
Trinosky, Frank G.	Gary	Lake
Trout, Carl J.	Lafayette	Tippecanoe
Troutwine, William R.	Crown Point	Lake
Troy, Jack M.	Whiting	Lake
Troyer, Dana	Goshen	Elkhart
Trusler, Harold M.	Indianapolis	Marion
Tschetter, David J.	Indianapolis	Marion
Tubbs, George R. (S)	Lafayette	Tippecanoe
Tuchman, Joseph H.	Indianapolis	Marion
Tucker, Oral A.	Daleville	Delaware-Blackford
Tucker, Warren S.	Indianapolis	Marion
Tuholski, James M.	Evansville	Vanderburgh
Tully, John A. (S)	New Castle	Henry
Turgi, Robert W.	Gary	Lake
Turley, Verne L.	Fowler	Benton
Turner, Anna Goss	Madison	Jefferson-Switzerland
Turner, Harold B.	Bloomfield	Greene
Turner, Isabel B.	Evansville	Vanderburgh
Turner, Jack J.	Bloomfield	Greene
Turner, John P.	Goshen	Elkhart
Turner, Oscar A. (S)	Madison	Jefferson-Switzerland
Tweedall, Daniel C.	Evansville	Vanderburgh
Tyler, Edward A.	Indianapolis	Marion
Tyler, Frank T. (S)	New Albany	Floyd
Tyner, Harlan H.	Indianapolis	Marion
Tyrrell, Joseph J.	Chicago, Ill.	Lake
Tyrrell, Thomas C.	Calumet City, Ill.	Lake

U

Ullom, Ralph B.	Indianapolis	Marion
Ulmer, David R. (S)	Terre Haute	Vigo
Ulrey, Robert P.	Elwood	Madison
Underwood, George M.	Lafayette	Tippecanoe
Urschel, Dan L.	Mentone	Kosciusko

V

Vagner, S. Bernard	South Bend	St. Joseph
Vail, George A.	Lawrenceburg	Dearborn-Ohio
Valencia, M. M.	Gary	Lake

Name	City	County
VanArsdall, Clarence R.	Terre Haute	Vigo
Van Bokkelen, Robert W.	Mooresville	Morgan
Van Buskirk, Edmund L.	Lafayette	Tippecanoe
Vance, William C.	Richmond	Wayne-Union
Van Den Bosch, Wallace R.	Lafayette	Tippecanoe
Vandivier, Robert M.	Indianapolis	Marion
Van Campen, Warren M.	South Bend	St. Joseph
Van Dorn, Myron J.	Indianapolis	Marion
Van Fleet, Josephine	Indianapolis	Marion
Van Kirk, John R.	Burlington	Carroll
Van Kirk, Paul P.	Frankfort	Clinton
Van Meter, C. Powell	Indianapolis	Marion
Van Ness, William C.	Summitville	Madison
VanNest, Willard A.	New Smyrna Beach, Fla.	De Kalb
Van Nuys, John D.	Indianapolis	Marion
Van Rie, Leo P. (S)	Mishawaka	St. Joseph
Van Sandt, Frank A. (S)	Bloomfield	Greene
Van Tassel, Charles J.	Indianapolis	Marion
Van Vactor, Helen D.	Indianapolis	Marion
Van Wienen, John	Martinsville	Morgan
Vaughn, Walter R.	Vincennes	Knox
Veach, Lester W.	Bainbridge	Putnam
Veach, William L.	Terre Haute	Vigo
Veach, Richard L.	Bainbridge	Putnam
Vellios, Frank	Indianapolis	Marion
Venable, George L.	North Manchester	Wabash
Venis, Kemper N.	Muncie	Delaware-Blackford
Vergara, Abelardo F.	East Chicago	Lake
Vermilya, Robert W.	Lafayette	Tippecanoe
Verplank, Grover L. (S)	Gary	Lake
Viehe, Robert W.	Evansville	Vanderburgh
Vietzke, Paul C. F.	Valparaiso	Porter
Vingis, Bronie	Greenfield	Hancock
Viney, Charles L.	Logansport	Cass
Visher, John W.	Evansville	Vanderburgh
Vivian, Donald E.	New Castle	Henry
Vogel, John L.	Columbia City	Whitley
Vogel, Lloyd A., Jr.	Fort Wayne	Allen
Vogel, L. John	Mount Vernon	Posey
Voges, Edward C.	Terre Haute	Vigo
Vollrath, Victor J.	Indianapolis	Marion
VonAsch, George	La Porte	La Porte
von der Lieth, Wm. C.	Vincennes	Knox
Von Der Haar, Gerard	Indianapolis	Marion
vonder Haar Thomas E.	Evansville	Vanderburgh
Voorhees, Robert J.	Fort Wayne	Allen
Voorhies, McKinley	Gary	Lake
Vore, Louring W.	Plymouth	Marshall
Vore, Robert E.	Indianapolis	Marion
Voss, Gert	Muncie	Delaware-Blackford
Voyles, Charles F. (S)	Indianapolis	Marion
Voyles, Harry E.	New Albany	Floyd
Vurpillat, Francis J.	South Bend	St. Joseph
Vye, James P.	Gary	Lake

W

Name	City	County
Wachob, Tom W., Jr.	Kokomo	Howard
Wade, Alfred A. (S)	Howe	LaGrange
Wade, Reynolds W.	New Haven	Allen
Wagner, Anabel R.	Indianapolis	Marion
Wagner, Arthur L.	Jasper	Dubois
Wagner, David G.	Goshen	Elkhart
Wagner, Lindley H.	Indianapolis	Marion
Wagner, Richard	Huntington	Huntington
Wagoner, B. D.	Union City	Randolph
Wagoner, George W.	Delphi	Carroll
Wagoner, John R.	Anderson	Madison
Wainscott, Clinton S.	Indianapolis	Marion
Wait, Jerome H.	Columbia City	Whitley
Waits, Chester L.	Colfax	Clinton
Waitt, Paul M.	Sheridan	Hamilton
Waldo, Guy H.	Bedford	Lawrence
Waldo, J. Thayer	Indianapolis	Marion
Walerko, Frank	Mishawaka	St. Joseph
Walker, Adolph P.	East Chicago	Lake
Walker, Edwin M., Jr.	South Bend	St. Joseph
Walker, Floyd B.	Fort Wayne	Allen
Walker, Jack M.	Muncie	Delaware-Blackford
Walker, James L. (S)	LaFontaine	Wabash
Walker, Louis	Greensburg	Decatur
Walker, Robert K.	Indianapolis	Marion
Walker, William F.	Evansville	Vanderburgh
Wallace, Collins R.	Fort Knox, Ky.	Marion
Wallace, Elmer L.	New Albany	Floyd
Wallace, Hawthorne C.	Crawfordsville	Montgomery
Walter, Robert F.	Evansville	Vanderburgh
Walters, Charles E.	Mishawaka	St. Joseph
Walters, Eleanore	Gary	Lake
Walters, Jack	Franklin	Johnson
Walters, Richard E.	Columbus	Bartholomew-Brown
Walters, William H.	Michigan City	La Porte
Walther, Joseph E.	Indianapolis	Marion
Walton, R. Lee	Marion	Grant
Walton, William M.	Indianapolis	Marion
Wanninger, Horace	Richmond	Wayne-Union
Warbinton, Fred P.	Plainfield	Hendricks
Ward, Gerald F.	Fort Wayne	Allen
Ward, James W.	South Bend	St. Joseph
Ward, Paula B.	Fort Wayne	Allen
Ward, Wesley C.	Indianapolis	Marion
Ware, Herbert E.	Muncie	Delaware-Blackford
Ware, John R.	Russiaville	Howard
Warfel, Frederick C. (S)	Indianapolis	Marion
Warfield, Chester H.	Fort Wayne	Allen
Warman, Alvah P. (S)	Indianapolis	Marion
Warn, William J.	Milan	Ripley
Warner, Charles L.	Evansville	Vanderburgh
Warren, Carroll B.	Marion	Grant
Warren, Lewis T.	Michigan City	La Porte
Warrick, Francis B.	Richmond	Wayne-Union
Warrick, Homer L.	Osceola	St. Joseph
Warriner, James B.	Indianapolis	Marion
Warshaw, Seymour	Indianapolis	Marion
Warvel, John H., Jr.	Fort Bragg, N. C.	Marion
Warvel, John H.	Indianapolis	Marion
Warvel, Joseph L. (S)	North Manchester	Wabash
Washington, G. Kenneth	Gary	Lake
Waters, George W.	Evansville	Vanderburgh
Watson, James L.	Evansville	Vanderburgh
Watterson, Gerald T.	Connersville	Fayette-Franklin
Waymire, William	Franklin	Johnson
Weaver, Marlin	Indianapolis	Marion
Weaver, Richard J.	Lafayette	Tippecanoe
Weaver, Timothy M. (S)	Brazil	Clay
Weaver, Wm. W.	New Albany	Floyd
Webb, Harry D.	Anderson	Madison
Weber, Edgar H.	Evansville	Vanderburgh
Weber, John R.	Fort Wayne	Allen
Weber, Joseph G. S.	Terre Haute	Vigo
Weber, Norbert	Louisville, Ky.	Marion
Webster, Paul L.	Indianapolis	Marion
Webster, Robert K.	Brazil	Clay
Weddle, Chas. O.	Lebanon	Boone

Name	City	County
Weeks, Patrick H. (S)	Michigan City	La Porte
Weems, Mallory P.	Jeffersonville	Clark
Wehrman, Jule O. (S)	Indianapolis	Marion
Weigand, Clayton G.	Indianapolis	Marion
Weinbaum, Jack G.	Terre Haute	Vigo
Weinberg, Benjamin A.	Whiting	Lake
Weinberg, Samuel	Marion	Grant
Weinland, George C.	Indianapolis	Marion
Weinstein, Edwin B.	Richmond	Wayne-Union
Weinstock, Adolph	Rolling Prairie	La Porte
Weir, Dale	LaGrange	LaGrange
Weirich, Charles I.	Butler	De Kalb
Weisenberger, Brockton L.	Rosebud, S. Dakota	Marion
Weiskopf, Henry S.	Gary	Lake
Weiss, Albert E.	Michigan City	LaPorte
Weiss, Eugene	South Bend	St. Joseph
Weiss, Henry G.	Evansville	Vanderburgh
Weiss, John T.	Hobart	Lake
Weiss, Louis L.	Anderson	Madison
Weissman, Charles G.	Hammond	Lake
Weitzel, Roland	Princeton	Gibson
Welborn, Mell B.	Evansville	Vanderburgh
Welch, Norbert M.	Vincennes	Knox
Weldy, Bryce P.	Hartford City	Delaware-Blackford
Weller, Charles A. (S)	Indianapolis	Marion
Weller, Ralph D.	Rossville	Clinton
Wells, William R.	Princeton	Gibson
Welty, Scudder G.	Fort Wayne	Allen
Wenzler, Paul J.	Bloomington	Owen-Monroe
Werry, Leslie E.	Hartford City	Delaware-Blackford
Wertenberger, Morris D.	Richmond	Wayne-Union
West, Joseph L.	Indianapolis	Marion
Westfall, B. Kemper	Indianapolis	Marion
Westfall, George S.	Goshen	Elkhart
Westfall, John B.	Indianapolis	Marion
Westhaysen, Peter	Hammond	Lake
Whallon, Arthur J. (S)	Richmond	Wayne-Union
Wharton, Russell O. (S)	Gary	Lake
Wheeler, David E.	Indianapolis	Marion
Whipps, Charles E. (S)	Carlisle	Sullivan
Whisler, Frederick M. (S)	Wabash	Wabash
Whitcomb, Roger F.	Shelbyville	Shelby
White, Chester S. (S)	Rosedale	Parke-Vermillion
White, Donald G.	South Bend	St. Joseph
White, Donald J.	Indianapolis	Marion
White, Douglas H.	Indianapolis	Marion
White, Gilbert H., Jr.	Hammond	Lake
White, Harvey E.	Farmland	Randolph
White, Isaac D. (S)	Clinton	Parke-Vermillion
White, James V.	Terre Haute	Vigo
White, John B.	Indianapolis	Marion
White, Nicholas	Indianapolis	Marion
White, Philip T.	Indianapolis	Marion
Whitlock, Francis C.	Mishawaka	St. Joseph
Whitlock, Merle E.	Mishawaka	St. Joseph
Whitsitt, Schuyler A. (S)	Madison	Jefferson-Switzerland
Wiatt, Leonard	Knightstown	Henry
Wible, James H.	Kokomo	Howard
Wickstrom, Otto W.	Indianapolis	Marion
Widdifield, G. E.	Indianapolis	Marion
Wiedemann, Frank E. (S)	Terre Haute	Vigo
Wierzalis, Edward F.	Hartford City	Delaware-Blackford
Wiethoff, Clifford A.	Seymour	Jackson
Wiggins, Dulania S. (S)	Newcastle	Henry
Wiland, Olin K.	Richmond	Wayne-Union
Wilder, Gordon B.	Anderson	Madison
Wildman, Roscoe E.	Peru	Miami
Wilhelm, Agatha M.	South Bend	St. Joseph
Wilhelmus, C. Kenneth	Evansville	Vanderburgh
Wilhelmus, Charles M. (S)	Newburgh	Warrick
Wilhelmus, Gilbert M.	Evansville	Vanderburgh
Wilkens, Irvin W.	Indianapolis	Marion
Willan, Horace R.	Martinsville	Morgan
Williams, A. Berniece	Fort Wayne	Allen
Williams, Aubrey H.	Fort Wayne	Allen
Williams, Alexander S.	Gary	Lake
Williams, Carl N.	Gary	Lake
Williams, Charles D.	Indianapolis	Marion
Williams, Clifford L.	Indianapolis	Marion
Williams, Earl K.	Rensselaer	Jasper-Newton
Williams, Edwin D.	Gary	Lake
Williams, Everett W.	Columbus	Bartholomew-Brown
Williams, Francis M.	Anderson	Madison
Williams, Fred	Gary	Lake
Williams, Fielding P.	Huntingburg	Dubois
Wililams, Harold W.	Indianapolis	Marion
Williams, Howard S.	Indianapolis	Marion
Williams, Hugh L.	Indianapolis	Marion
Williams, John H.	Shipshewana	LaGrange
Williams, Paul A.	Rensselaer	Jasper-Newton
Williams, Robert D.	Markleville	Madison
Williams, Robert E.	Lafayette	Tippecanoe
Williams, Robert H.	Anderson	Madison
Williams, Russell S.	APO 696, New York, N.Y.	Marion
Willis, Charles F.	Evansville	Vanderburgh
Willison, George W.	Evansville	Vanderburgh
Willitts, Bruce K.	Indianapolis	Marion
Willner, Alan	Clarksville	Clark
Wills, Max	Auburn	De Kalb
Wilmore, Ralph C.	Indianapolis	Marion
Wilms, John H.	W. Lafayette	Tippecanoe
Wilson, David	Evansville	Vanderburgh
Wilson, Fred L.	Terre Haute	Vigo
Wilson, Fred M.	Indianapolis	Marion
Wilson, Guy H.	Bicknell	Knox
Wilson, James M.	South Bend	St. Joseph
Wilson, John	Columbia City	Whitley
Wilson, John D.	Evansville	Vanderburgh
Wilson, Leslie	Fort Wayne	Allen
Wilson, Ned A.	Indianapolis	Marion
Wilson, Oliver R.	Indianapolis	Marion
Wilson, Orley E.	Elkhart	Elkhart
Wilson, Paul E. (S)	Boonville	Warrick
Wilson, Paul H.	Logansport	Cass
Wilson, Ralph	Evansville	Vanderburgh
Wilson, Roland B.	Fort Wayne	Allen
Wilson, Talmage L.	Bloomington	Owen-Monroe
Wilson, Wymond B.	Mentone	Kosciusko
Wimmer, Robert N. (S)	Gary	Lake
Winklepleck, A. M.	Connersville	Fayette-Franklin
Winter, Donald K.	Logansport	Cass
Winter, William P.	Martinsville	Morgan
Wise, Charles L.	Camden	Carroll
Wise, William R.	Indianapolis	Marion
Wiseheart, Oscar H. (S)	North Salem	Hendricks
Wiseheart, Robert H.	Lebanon	Boone
Wiseman, V. Earle	Greencastle	Putnam
Wisener, Guthrie H. (S)	Richmond	Wayne-Union
Wishard, Wm. N., Jr.	Indianapolis	Marion
Witham, Robert L.	Indianapolis	Marion
Wixted, John F.	Mishawaka	St. Joseph
Wixted, Julia F.	Mishawaka	St. Joseph
Wohlfeld, Gerald	New Albany	Floyd

Name	City	County
Wohlfeld, Julius B.	Bedford	Lawrence
Wojcik, Ladislas D.	Marion	Grant
Wolfe, John W.	Indianapolis	Marion
Wolfe, William E.	La Porte	La Porte
Wolfe, Nelson	New Albany	Floyd
Wolfram, Don J.	Indianapolis	Marion
Wolverton, George M.	Clarksville	Clark
Woner, John W.	Linton	Greene
Wong, Norman F.	Linden	Montgomery
Wong, Samuel N.	Hammond	Lake
Wood, Donald E.	Indianapolis	Marion
Wood, Elmer U. (S)	Columbus	Bartholomew-Brown
Wood, Opal L.	Brazil	Clay
Wood, Russell W.	Oakland City	Gibson
Wood, William H.	Indianapolis	Marion
Woodard, Abram S., Jr.	Indianapolis	Marion
Woodbury, John W.	Marion	Grant
Wooden, Thomas F.	East Chicago	Lake
Woods, Arba L. (S)	Poseyville	Posey
Woods, Haldon C.	Markle	Huntington
Woods, James R., Jr.	Greenfield	Hancock
Woods, Wm. P. (S)	Evansville	Vanderburgh
Woodson, Dan E.	Boonville	Warrick
Woolery, Richard H.	Bedford	Lawrence
Woolling, Kenneth R.	Indianapolis	Marion
Work, Bruce A.	Frankfort	Clinton
Work, James A., Jr. (S)	Elkhart	Elkhart
Worley, Ansel C.	Fort Wayne	Allen
Worley, Henry L.	New Albany	Floyd
Worley, Joseph P.	Indianapolis	Marion
Worley, Richard H.	Indianapolis	Marion
Worth, C. Willard	Milroy	Rush
Wrege, Malcolm L.	Indianapolis	Marion
Wright, J. Wm., Jr.	Indianapolis	Marion
Wright, Wm. C.	Fort Wayne	Allen
Wurster, Herbert C.	Mishawaka	St. Joseph
Wyatt, James L., II	Fort Wayne	Allen
Wyatt, James L., III	Fort Wayne	Allen
Wyeth, Charles (S)	Terre Haute	Vigo
Wygant, Marion D.	Westville	La Porte
Wynn, Justice F.	Evansville	Vanderburgh
Wynne, Roland E. (S)	Bedford	Lawrence
Wyttenbach, John E.	Indianapolis	Marion

Y

Yacko, Michael L.	Indianapolis	Marion
Yale, Charles A.	Fairmount	Grant
Yanson, Mannfredo R. S.	Bluffton	Wells
Yast, Charles J.	Gary	Lake
Yegerlehner, Roscoe S.	Kentland	Jasper-Newton
Yencer, Martin W. (S)	Richmond	Wayne-Union
Yingling, Robert J.	Indianapolis	Marion
Yocum, Paul S.	Gary	Lake
Yocum, Paul S., Jr.	Gary	Lake
Yocum, William S.	Gary	Lake
Yoder, Albert C. (S)	Goshen	Elkhart
Yoder, C. Richard	Elkhart	Elkhart
Yoder, Dewey D.	Columbus	Bartholomew-Brown
Yoder, Jonathan G.	Goshen	Elkhart
Yoder, Richard P.	Bluffton	Wells
Young, C. Curtis	Evansville	Vanderburgh
Young, George M.	Gary	Lake
Young, Gerald S.	Muncie	Delaware-Blackford
Young, James W.	Indianapolis	Marion
Young, John E.	Indianapolis	Marion
Young, John M.	Indianapolis	Marion
Young, John T.	Indianapolis	Marion
Young, Ralph H.	Goshen	Elkhart
Young, Robert G.	Marion	Grant
Young, Robert L.	Gary	Lake
Yunker, Philip E.	Howe	LaGrange

Z

Zalac, Donald A.	Michigan City	La Porte
Zallen, Stanley G.	East Chicago	Lake
Zaring, Byron K.	Columbus	Bartholomew-Brown
Zehr, Noah (S)	Fort Wayne	Allen
Zeiger, Irvin	South Bend	St. Joseph
Zell, Evertson H.	Indianapolis	Marion
Zeps, E. Frances	Richmond	Wayne-Union
Zerfas, Charles P. A.	Beech Grove	Marion
Zerfas, Leon G.	Camby	Marion
Zerfas, Phyllis K.	Indianapolis	Marion
Zeier, Francis G.	Evansville	Vanderburgh
Zierer, Reuben O.	Rockville	Parke-Vermillion
Zimmer, Henry J.	Mishawaka	St. Joseph
Zimmerman, Harold	Evansville	Vanderburgh
Zimmerman, Wm. H.	Syracuse	Kosciusko
Zink, Robert O.	Madison	Jefferson-Switzerland
Ziperman, H. Haskell	San Francisco, Calif.	Marion
Ziss, Robert C.	Evansville	Vanderburgh
Zivich, J. M.	East Chicago	Lake
Zore, Joseph J.	Indianapolis	Marion
Zucker, Edward	Gary	Lake
Zweig, Elmer S.	Fort Wayne	Allen
Zwerner, Paul F.	Terre Haute	Vigo
Zwick, Harold F.	Decatur	Adams
Zwickel, Ralph E.	Evansville	Vanderburgh

ROSTER OF MEMBERS BY COUNTIES

Physicians are listed in the counties in which they reside.

(Paid-up members of the Indiana State Medical Association as of April 15, 1960.)

ADAMS COUNTY

Berne

Beaver, Norman E.....165 W. Water St.
Boze, Robert L.....265 W. Water St.
Luginbill, Howard M.....165 S. Jefferson St.

Decatur

Burk, James M.....115 N. Third St.
Carrol, John C.....226 S. Second St.
Freeby, C. William.....227 S. Second St.
Girod, Arthur H.....203 N. Twelfth St.
Kohne, Gerald J.....134 S. Third St.
Parrish, Richard K.....238 S. Second St.
Reppert, Roland L.....222 S. Second St.
Rich, Norval.....415 W. Madison St.
Terveer, John B.....222 S. Second St.
Zwick, Harold F.....227 S. Second St.

Hinchman, Clarence P.....Geneva
Schetgen, Joseph V.....Geneva

ALLEN COUNTY

Fort Wayne

A

Adams, E. Wade.....710 W. Wayne
Ahlbrand, Roland C.....1417 N. Anthony Blvd.
Aiken, Arthur F.....1923 E. State Blvd.
Aiken, Nevin E.....1923 E. State Blvd.
Arata, Justin E.....304 Medical Center Bldg.

B

Bahr, Robert E.....533 W. Washington St.
Bailey, Paul P.....206 Medical Center Bldg.
Ball, John R.....320 Medical Center Bldg.
Ball, Margaret J.....4112 S. Harrison Blvd.
Baltes, Joseph H.....821 Broadway
Barch, John W.....1301 S. Harrison St.
Bash, Wallace E.....2424 Fairfield Ave.
Beams, Ralph H.....715 Medical Center Bldg.
Beierlein, Karl M.....446 W. Pontiac
Benninghoff, Daniel R. (S)
418 Medical Center Bldg.
Bergendahl, Emil H.
102 Medical Center Bldg.
Berghoff, James R.....306 E. Jefferson St.
Berghoff, Raymond J.....306 E. Jefferson St.
Beutler, Theodore V.....527 W. Berry St.
Blichert, Peter A.....334 Medical Center Bldg.
Blosser, Howard V. (S)
1122 W. Washington Blvd.
Bolman, Ralph M.....717 Broadway
Borders, Theodore R.....1147 S. Lafayette St.
Bossard, John W.....115 Medical Center Bldg.
Bowers, Gah T.....1417 N. Anthony Blvd.
Bowers, Jesse W. (S).....418 Gettle Bldg.
Brandt, William E.....228 Medical Center Bldg.
Bridges, William L.....520 Medical Center Bldg.
Bromley, Luman W.....2730 E. State St.
Brosius, Robert H. W.....1603 Wells St.
Brown, Frederic W.....2609 Fairfield Ave.
Bryan, Franklin A.....512 Medical Center Bldg.
Buckner, George D.....1003 Fulton St.

C

Carlo, Ernest R.....2902 Fairfield Ave.
Cartwright, Emor L. (S).....3718 Hiawatha Blvd.
Chambers, Alan R.....601 W. Wayne St.
Clark, William R.....3622 S. Calhoun St.
Cochran, Harry A., Jr.....1301 S. Harrison St.
Conley, John E.....620 W. Berry St.
Connelly, Richard D.....810 Lake Ave.
Cooney, Charles J.....527 W. Berry St.
Cottrell, Robert F.....234 Medical Center Bldg.
Craig, Richard M.....2902 Fairfield Ave.
Culp, John E.....2902 Fairfield Ave.

D

Dancer, Charles R. (S).....905 Columbia Ave.
Datzman, Richard C.....520 Medical Center Bldg.
Dieter, William J.....1002 Somerset Lane
Ditton, Irvin W. (S).....1214 E. Wayne St.
Duemling, Arnold H.....Weyrick Bldg.
Dunstone, Harry C.....502 Medical Center Bldg.

E

Elston, Lynn W.....604 Medical Center Bldg.
Elston, Ralph W.....604 Medical Center Bldg.
Emenhiser, John L.....1411 Reed Rd.

F

Ferguson, Arthur N.....2902 Fairfield Ave.
Fichman, Abraham M.....323 W. Berry St.
Flaherty, Robert A.....2902 Fairfield Ave.
Foy, Hayward W.....1747 Wells St.
Franke, Gordon R.....1202 E. State Blvd.
Frankhouser, Charles M. A.
520 Medical Center Bldg.
Fullam, Richard G.....234 Medical Center Bldg.

G

Garton, Harry W.....1635 Broadway
Gastineau, David C.....520 Medical Center Bldg.
Gerding, William J.....2638 S. Anthony Blvd.
Gladstone, Naf H.....335 W. Berry St.
Glassey, Stephen H.....1927 E. State St.
Glock, Homer E. (S).....324 Medical Center Bldg.
Glock, Maurice E.....229 Medical Center Bldg.
Glock, Wayne R.....2609 Fairfield Ave.
Goebel, Carl W.....327 W. Creighton
Gould, John C.....612 Medical Center Bldg.
Graham, George M.....1301 S. Harrison St.
Graham, James C.....805 E. Creighton Ave.
Greenlee, Robert L.....1110 W. Washington Blvd.
Greist, Walter D.....3024 Fairfield Ave.
Griffith, Harold R.....520 Medical Center Bldg.

H

Hackett, Walter G.....6028 U. Huntington Rd.
Haffner, Herman G.....202 E. Jefferson St.
Haley, Alvin J.....533 W. Washington Blvd.
Hamilton, Emory D.....234 Medical Center Bldg.
Harshman, Louis P.....Veterans Hospital
Harvey, Harry C.....406 W. Berry St.
Hasewinkle, August M.....1129 E. State St.
Hastings, Warren C.....111 Medical Center Bldg.
Hattendorf, Anton P.....725 Medical Center Bldg.
Havens, Russell E.....228 Medical Center Bldg.
Helmer, Fredric A.....604 W. Wayne St.
Hershberger, Philip.....2609 Fairfield Ave.
Hickman, Donald.....3408 N. Anthony
Higgins, Kenneth E.....801 E. State St.
Hipskind, Richard E.....332 E. Pontiac
Hoffman, Arthur F.....519 Medical Center Bldg.

Holsinger, Robert E.....115 Medical Center Bldg.
Horning, Richard R.....416 Medical Center Bldg.
Howe, Fordyce L.....1525 Oxford St.
Humphreys, John L.....1301 S. Harrison St.

J

Jackson, John F.....519 Medical Center Bldg.
Johnston, Richard M.....519 Medical Center Bldg.
Jontz, Joe G. .....304 Medical Center Bldg.
Juergens, Richard B.....R. R. 13, Lima Road
Jurgensen, Walter T.....3415 Fairfield Ave.

K

Karol, Herbert J.....324 Medical Center Bldg.
Kaufman, Julian.....229 W. Berry St.
Keck, Carleton A.....2902 Fairfield Ave.
Kent, Richard N.....731 Medical Center Bldg.
Keyes, Robert C.....3714 S. Calhoun
Kidder, Orva T.....Irene Byron Hospital
Kimbrough, Robert F.....2730 E. State St.
Kleifgen, William A.....617 W. Washington Blvd.
Klooze, Kenneth W.....2156 Fairfield Ave.
Knight, Lewis W.....446 W. Pontiac
Krueger, John E.....204 E. Suttenfield
Kruse, Edward H. (S).....705 Lincoln Tower
Kruse, Walter E.....410 McKinnie

L

Ladig, Donald S.....337 W. Berry St.
Lampe, Elfred H.....2902 Fairfield Ave.
Land, Francis L. .....116 W. Rudisill Blvd.
Laycock, Richard M.....6642 St. Joe Road
Leming, Ben L.....2902 Fairfield Ave.
Lenk, George G.....1805 E. Washington St.
Lloyd, Robert P.....723 Fulton St.
Lohman, Robert M.....4017 S. Wayne St.
Lorman, James G.....520 Medical Center Bldg.
Loudermilk, Jack L.....520 Medical Center Bldg.
Lyon, William C.....710 W. Wayne St.

M

Mackel, Frederick O.....2609 Fairfield Ave.
Manning, George.....111 Medical Center Bldg.
Marshall, Caesar L. .....438 E. Lewis St.
McArdle, Edward G.....2201 S. Calhoun St.
McCallister, John W.....212 Medical Center Bldg.
McCoy, Roy R.....3701 S. Harrison St.
McDowell, George A.....215 Medical Center Bldg.
McEachern, Cecil G. .....2424 Fairfield Ave.
McKeeman, Donald H.....633 W. Wayne St.
McKeeman, Leland S.....302 Medical Center Bldg.
Mercer, Samuel R.....710 Medical Center Bldg.
Meyer, Hans.....801 E. State St.
Meyer, Herman A.....1030 W. Wayne St.
Meyer, Theodore O.....622 Medical Center Bldg.
Michaelis, Stephen C.....2154 Fairfield Ave.
Miller, Edward D. .....1402 E. State Blvd.
Miller, H. Paul.....2715 Broadway
Miller, Mahlon F.....222 Medical Center Bldg.
Miller, Orval J.....324 W. Berry St.
Miller, Richard H.....511 Medical Center Bldg.
Miller, Robert B.....412 Medical Center Bldg.
Miller, William J.....2902 Fairfield Ave.
Moats, Carl F.....4007 S. Wayne St.
Moats, George E. (S).....615 E. Washington Blvd.
Moeller, Victor C.....2424 Fairfield Ave.
Moravec, Arthur E.....705 Lincoln Tower
Mortenson, Leland J.....214 Medical Center Bldg.
Mueller, Lawrence W.
533 W. Washington Blvd.
Murdock, Harvey L.....417 Medical Center Bldg.

N-O

Nill, John H.....204 E. Suttenfield St.
Nolan, Gerald R.....1626 Oxford St.
O'Brian, John F.....1807 E. Washington Blvd.
O'Rourke, Carroll.....604 W. Berry St.
Oyer, John H.....2609 Fairfield Ave.

P

Painter, Donald S.....222 Medical Center Bldg.
Parker, Carey B.....1105 S. Harrison St.
Parrot, Donald J.....810 W. State St.
Pauly, Leonard R.....730 W. Berry St.
Pearson, Huey L.....1801 S. Hanna
Perrin, Kermit F.....2701 S. Anthony Blvd.
Perry, Frederic G.....2902 Fairfield Ave.
Philbert, Richard N.....4349 S. Anthony Blvd.
Pickett, Merle E.....228 Medical Center Bldg.
Ponczek, Edward .....3418 S. Hanna
Popp, Milton F.....606 Medical Center Bldg.
Powell, M. Jack.....730 W. Berry St.
Priddy, Marvin E.....5010 Riviera Court

Q-R

Rawles, Lyman T. (S).....Covington Road
Ray, Herbert A. (S).....402 Medical Center Bldg.
Rice, Wilkie B. (S).....1101 E. Pontiac
Rissing, Walter J.....229 W. Berry St.
Rockey, Noah A.....1224 E. State
Rodriguez, Juan.....2902 Fairfield Ave.
Roser, Arthur J.....617 W. Washington Blvd.
Rossiter, Dudley L.....3629 S. Harrison
Rothberg, Maurice.....625 W. Berry St.
Rousseau, John W.....446 W. Pontiac

S

Sahlmann, Hans.....3418 S. Hanna
Salon, Harry W.....535 W. Berry
Salon, Joel W.....604 W. Wayne St.
Salon, Nathan L.....604 W. Wayne St.
Sarver, Francis E.....320 Medical Center Bldg.
Savage, Arthur R.....302 W. Berry St.
Saylors, Rodger D.....R. R. #2
Schellhouse, Earl M.....1240 W. Main St.
Schlademan, Karl R.....510 Medical Center Bldg.
Schloss, Robert P.....3504 Quimby Arcade
Schmidt, Eugene E.....228 Medical Center Bldg.
Schmoll, Robert J.....515 W. Wayne St.
Schneider, Louis A.....730 W. Berry St.
Schoen, Frederic L.....902 W. Wayne St.
Schubert, Jerome C.....1320 Broadway
Scoins, William H.....1301 S. Harrison St.
Scott, H. Vaughn.....2902 Fairfield Ave.
Senseny, Eugene F.....2902 Fairfield Ave.
Shaw, James E.....3103 Bowser Ave.
Sherwood, Clarence E.....Irene Byron Hospital
Sherwood, J. Vincent.....Irene Byron Hospital
Shinabery, Lawerence.....1850 Broadway
Short, John T.....2902 Fairfield Ave.
Singer, Elmer C. (S).....310 Medical Center Bldg.
Smith, Philip L.....2902 Fairfield Ave.
Smith, Richard B.....629 Medical Center Bldg.
Smith, Roger C.....629 Medical Center Bldg.
Snyderman, Sanford C.
102 Medical Center Bldg.
Somers, Gerald H.....2506 Lower Huntington Rd.
Spencer, C. Herbert.....519 Medical Center Bldg.
Stanley, Robert G.....3415 S. Fairfield Ave.
Stauffer, Richard C.....2730 E. State St.
Steigmeyer, David J.....1411 N. Anthony Blvd.
Stellner, Howard A.....324 W. Berry St.
Stier, Paul L.....721 Broadway
Stucky, Jerry L. .....5010 Riviera Court
Sullivan, Robert E.....2424 Fairfield Ave.

T

Taylor, Robert G.....2902 Fairfield Ave.
Tennant, David L.....1832 S. Calhoun
Terrill, Richard W.....446 W. Pontiac

Thimlar, James W. (S) ..... 602 E. Lewis
Thompson, Holland ..... Irene Byron Hospital
Thornton, Walter E. (S) ..... 601 W. Oakdale Dr.
Tomusk, August N. ..... 717 Broadway

V-W

Vogel, Lloyd A., Jr. ..... 116 W. Rudisill
Voorhees, Robert J. ..... 717 Broadway
Walker, Floyd B. ..... 3505 S. Monroe
Ward, Gerald F. ..... 716 Medical Center Bldg.
Ward, Paula B. ..... 2014 Curdes Ave.
Warfield, Chester H. ..... 730 W. Berry St.
Weber, John R. ..... 710 W. Wayne St.
Welty, Scudder, G. ..... 2423 S. Calhoun St.
Williams, A. Berniece ..... 3526 N. Washington Rd.
Williams, Aubrey H. ..... 2902 Fairfield Ave.
Wilson, Leslie ..... Veterans Hospital
Wilson, Roland B. ..... 1207 S. Lafayette
Worley, Ansel C. ..... 317 Medical Center Bldg.
Wright, William C. ..... 621 Medical Center Bldg.
Wyatt, James L., III ..... 310 E. Washington St.
Wyatt, James L., II ..... 233 E. Jefferson

X-Y-Z

Zehr, Noah (S) ..... 301 W. Creighton
Zweig, Elmer S. ..... 344 W. Berry St.

Emme, Richard W. ..... Harlan
Cutshaw, James A. ..... Monroeville
Harless, Fred ..... Monroeville

New Haven

Dahling, Clemens W. ..... 910 Summit
Emenhiser, Donald C. ..... 608 State St.
Hoetzer, Eldore M. ..... 502 Henry
Sidell, James P. ..... 502 Henry
Stumpf, Edwin E. ..... 716 Broadway
Wade, Reynolds W. ..... 1018 Bell Ave.

Miller, Kenneth D. ..... Woodburn
Moser, Edward (S) ..... Woodburn

Bichacoff, Billie D.
914 S. Grand Ave., Bozeman, Mont.
Draper, Merlin H. (S)
59 Dolphin Dr., St. Petersburg, Fla. (6)
Havice, Jay F. ..... Box 102, Lake Lure, N. C.
Mayes, Warren E. ..... 34 El Patio, Oakland 4, Calif.
Mensch, James R.
875 Cleveland St., Oakland, Calif.
Prentiss, Nelson H. ..... V. A. Hospital, Oteen, N. C.

BARTHOLOMEW-BROWN COUNTIES

Columbus

Adler, David L. ..... Bartholomew County Hospital
Beggs, Lowell F. ..... 832 Washington St.
Clay, Eleanor ..... 2739 Central Ave.
Davis, Marvin R. ..... 908 Washington St.
Echsner, Herman J. ..... 1815 25th St.
Fisher, Walter S. ..... 422 Ninth St.
Hart, Robert B. ..... 712 Washington St.
Hawes, James K. (S) ..... P. O. Box 308
Hawes, Marvin E. ..... 522 Seventh St.
Henry, Alvin L. ..... 621 Franklin St.
Jacobs, E. Robert ..... 1919 25th St.
Knotts, Halleck S. ..... 405½ Washington St.
Knotts, Slater ..... Bartholomew County Hospital
Krueger, Robert B. ..... 814 Washington St.
Macy, George W. ..... 718 Washington St.
Marr, Griffith ..... R. R. 1
McCullough, Henry G. ..... R. R. 4
Mohler, Floyd W. ..... 2739 Central Ave.
Norton, Harold J. ..... 909 Pearl St.
O'Bryan, Richard B. ..... 2739 Central Ave.
Overshiner, Lyman (S) ..... 503 California
Ranck, Benjamin A. ..... 2438 Cottage Ave.
Rau, Charles A. ..... 2438 Cottage Ave.
Reid, Robert M. ..... 2225 Central Ave.
Ryan, William J. ..... 911 Washington St.
Schmitt, Richard K. ..... 423 Ninth St.
Sigmund, William B. ..... 2355 Central Ave.
Snapp, Richard A. ..... 2225 Central Ave.
Teal, Dorothy D. ..... 728 Franklin St.
Walters, Richard E. ..... Fifth and Union Sts.
Williams, Everett W. ..... 2225 Central Ave.
Wood, Elmer U. (S) ..... 120 S. Hughes St.
Yoder, Dewey D. ..... 415½ Seventh St.
Zaring, Byron K. ..... 718 Washington St.

Dudding, Joseph E. ..... Hope
Moran, William ..... Hope
Schneider, Kenneth D. ..... Nashville
Seibel, Robert ..... Nashville

BENTON COUNTY

Leak, Robert H. ..... Boswell
Coddens, Avery L. ..... Earl Park
Altier, William H. ..... Fowler
Miller, Dan T. (S) ..... Fowler
Turley, Verne L. ..... Fowler
Rutherford, Charles E. ..... Otterbein
Scheurich, Virgil ..... Oxford

BLACKFORD COUNTY

(See **Delaware-Blackford**)

BOONE COUNTY

Riley, Frank H. (S) ..... Jamestown
Schaaf, Alvin D. ..... Jamestown

Lebanon

Beck, Herma A. (S) ..... Boone County Bank Bldg.
Coons, John D. ..... Boone County Bank Bldg.
Coons, Ritchie ..... 303 W. Washington St.
Grigsby, Hardin B. ..... 916 N. East St.
Headley, Lloyd M. ..... 1111 N. Lebanon St.
Honan, Paul R. ..... 1720 N. Lebanon St.
Kern, Clarence G. ..... 1720 N. Lebanon St.
Lenox, Jack ..... 303 W. Washington St.
Porter, Jack ..... 209 W. North St.
Rainey, Everett A. (S) ..... 912 N. Meridian St.
Weddle, Charles O. ..... 905 N. Lebanon St.
Wiseheart, Robert H. ..... 905 N. Lebanon St.

Bassett, Margaret A. ..... Thorntown
Gregg, Edwin E. ..... Thorntown
Bailey, Lawrence S. ..... Zionsville
Harvey, Ralph J. ..... Zionsville
Lovett, Harvey D. ..... Whitestown

BROWN COUNTY

(See **Bartholomew-Brown**)

CARROLL COUNTY

Van Kirk, John R. ..... Burlington
Kennedy, Eva N. (S) ..... Camden
Wise, Charles L. ..... Camden

Delphi

Baker, Eldon E. ..... 109 S. Union
Crampton, Charles C. (S) ..... 115 E. Main St.
Petry, T. Neal ..... 111 E. Franklin St.

Seese, Robert M.....101 W. North St.
Wagoner, George W.....Front & Union Sts.

Adams, Max R.....Flora
McLaughlin, James R.....Flora

CASS COUNTY

Dutchess, C. Toney.....Galveston

Logansport

Adamski, Michael.....408 North St.
Bailey, Earl W.....212 Fifth St.
Ballard, Charles A (S).....325½ E. Market St.
Bean, Joseph S.....Memorial Hospital
Burnett, Paul C.....Logansport State Hosp.
Caffrey, James F.....Logansport State Hosp.
Cheng, Sylvia F.....Logansport State Hosp.
Chu, Johnson C. S.....Logansport State Hosp.
Cobb, Clarence M.....Memorial Hosp.
Davis, John C. (S).....Masonic Temple
Eckert, Russell A.....1101 Michigan Ave.
Fitzgerald, Brice E.....126 Fourth St.
Fogel, Ernest.....Logansport State Hosp.
Gatzimos, Christos D.....1101 Michigan Ave.
Glendening, Richard L.....422 North St.
Hall, Bernard R.....422 High St.
Harrington, James F.....1001 E. Broadway
Hedde, Eugene L.....211 S. Third St.
Hillis, Lowell J.....203 S. Third St.
Hochhalter, Marian.....86 9th St.
Holloway, William A. (S).....200 Eel River Ave.
Jewell, Earl B. (S).....3019 S. Pennsylvania St.
Jones, J. Carl.....422 North St.
King, Jay M.....201 S. Third St.
Mackey, Colonel G.....Logansport State Hospital
Maschmeyer, Robert H.....Logansport State Hosp.
Mikan, V. Robert.....216 9th St.
Morrical, Russell J.....212 Fifth St.
Parker, E. Camille.....2500 E. Broadway
Parker, Francis W., Jr.....2500 E. Broadway
Pfuetze, Max.....408 North St.
Phipps, Elwood B.....Logansport State Hosp.
Schenck, Foss (S).....Logansport State Hosp.
Sheller, Tom G.....Logansport State Hosp.
Viney, Charles L.....Masonic Temple
Wilson, Paul H.....422 North St.
Winter, Donald K.....422 North St.

Newcomb, William K.....Royal Center
Terbush, Edward L.....Twelve Mile
Flanangan, Estle P. (S).....Walton
Lybrook, Daniel E. (S).....Young America

CLARK COUNTY

Goodman, Eli S.....Charlestown
Jones, David H.....Charlestown
Marshall, Thomas J. (S).....Charlestown
Shina, Heskel S.....Charlestown
Mudd, Joseph P.....Clarksville
Willner, Alan.....Clarksville
Wolverton, George M.....Clarksville
Carr, Joseph H.....Henryville
Greene, William R.....Henryville

Jeffersonville

Adair, Samuel.....201 E. Market
Baldwin, John H. (S).....425 Meigs Ave.
Bizer, Mier.....155 Forest, Oak Park
Bruner, Ralph W.....437 Spring St.
Buehler, George M.....414 Wall St.
Byrd, Ryland P.....210 Sparks Ave.
Carlberg, Dale L.....226 E. Maple
Carney, Joel T.....347 Spring St.
Clark, William B., Jr.....437 Spring St.
Dare, Lee A.....209 E. Maple St.
Forsee, Norman E.....211 E. Market St.
Havens, A. Lyle.....432 Wall St.
Havens, Thomas R.....432 Wall St.
Huoni, John S...1405 Youngstown Shopping Center
Isler, Nathaniel C.....519 Spring St.
Reed, Edsel S.....Clark Co. Memorial Hosp.
Reeder, Henry H.....Jeffersonville
Roby, Alma L.....201 E. Market St.
Shaw, Houston W.....430 Wall St.
Thompson, Walter.....1403 Youngston Dr.
Weems, Mallory P.....404 Spring St.

Regan, George L.....Sellersburg
Sturgis, Donald G.....Sellersburg

CLAY COUNTY

Brazil

Garvin, Donald B.....111 N. Walnut St.
Maurer, J. Frank.....111 N. Walnut St.
Maurer, Robert M.....111 N. Walnut St.
McCormick, Wilbur C.....R. R. 2
Mehne, Richard G.....1½ E. National Ave.
Shattuck, John C.....1½ E. National Ave.
Weaver, Timothy M. (S).....Brazil Trust Bldg.
Webster, Robert K.....28 N. Franklin St.
Wood, Opal L.....111 N. Walnut St.

Moon, Charles E.....Center Point
Bond, Walter C.....Clay City
Glosson, Jack R.....Clay City
Rentschler, Lewis C. (S).....Clay City

CLINTON COUNTY

Waits, Chester L.....Colfax

Frankfort

Applegate, Albert E.....51 E. Walnut St.
Beardsley, Frank A.....51 S. Jackson St.
Carrel, Francis E.....214 Ross Bldg.
Dykhuizen, Theodore A.....59 S. Main St.
Erdel, Milton W.....2 E. White St.
Flora, Fred W.....1256 S. Jackson St.
Hammersley, George K.....361 E. Clinton St.
Hedgcock, Robert A.....259 E. Clinton St.
Holmes, Claude D. (S).....555 E. Walnut St.
Stout, Harry T.....1256 S. Jackson St.
Van Kirk, Paul P.....204 W. Washington St.
Work, Bruce A.....306 Peoples Life Bldg.

Bush, Charles E.....Kirklin
Carlyle, Ivan E. (S).....Michigantown
Lind, Jaap J.....Mulberry
Ketcham, John S.....Rossville
Weller, Ralph D.....Rossville

Reed, John D.....Henry Ford Hosp., Detroit, Mich.
Tedford, John H.
Univ. of Michigan, Ann Arbor, Mich.

CRAWFORD COUNTY

(See **Harrison-Crawford**)

DAVIESS-MARTIN COUNTIES

Rohrer, James R.....Elnora

Loogootee

Chattin, Robert E. ..... 102 Wood
Gootee, Francis H. ..... 206 W. Main St.
Lett, Emory B. ..... 408 E. Main

Sears, Don ..... Odon
Gilkison, John S. (S) ..... Shoals

Washington

Arthur, Nora M. (S) ..... R. R. 4
Blazey, Arthur G. ..... 7 E. Walnut St.
Chattin, Vance J. ..... 514 E. Main St.
Farris, John J. ..... 514 E. Main St.
Fox, C. Philip ..... 305 Peoples Bank Bldg.
Lindsay, Hamlin B. ..... 511 E. Main St.
McKittrick, Jack ..... Peoples Bank Bldg.
McNaughton, Lawrence M. ..... 400 E. Hefron St.
Norton, Horace ..... 511 E. Hefron St.
Rang, A. A. (S) ..... 211 N. E. 9th St.
Rang, Robert H. ..... 1312 Bedford Rd.
Ross, Glenn E. ..... 1307 Bedford Road
Schafer, William C. ..... 1312 Bedford Rd.
Schroeder, Henry R. ..... 101 N. E. First St.
Seat, Marshall H. ..... Williams Bldg.
Smoot, Emory B. ..... 507 E. Main St.

DEARBORN-OHIO COUNTIES

Aurora

Baker, Leslie M. ..... 501 Fourth St.
Jackson, John K. ..... 223 Mechanic St.
Olcott, Charles W. ..... 203 Main St.
Treon, James F. (S) ..... 505 Fifth St.

McNeely, Matthew J. ..... Dillsboro
Elliott, John C. (S) ..... Guilford

Lawrenceburg

Aldred, A. W. ..... 370 Bielby Road
Conrad, Henry ..... 370 Bielby Road
Fagaly, William J. ..... 238 Short St.
Frable, Frank L. ..... 370 Bielby Road
Houston, Fred D. ..... 30 W. High St.
Hunter, Lowell G. ..... 370 Bielby Road
Irmscher, George W. ..... 6 W. High St.
Morrison, George G. ..... 209 Fourth St.
Pfeifer, James M. ..... 319 Front St.
Streck, Francis A. ..... 326 Walnut St.
Vail, George A. ..... 209 Fourth St.

Fessler, Gordon S. ..... Rising Sun

DECATUR COUNTY

Tremain, Milton A. (S) ..... Adams

Greensburg

Acher, Robert P. ..... 221 E. Washington St.
Callaghan, Winship C. ..... 304 Bates Bldg.
Dickson, Dale D. ..... Bates Bldg.
Dietz, Richard A. ..... 221 E. Washington St.
Miller, James C. ..... 205 Bates Bldg.
Morrison, James T. ..... 207 N. Franklin
Overpeck, Charles ..... Murphy Bldg.
Shaffer, William R. ..... 214 N. Franklin
Walker, Louis ..... 215 N. Franklin

Harkcom, Harry E. ..... St. Paul
Porter, Edward A. ..... Westport
Porter, Robert A. ..... Westport

DE KALB COUNTY

Auburn

Covell, Harry M. ..... 127 W. Seventh St.
Geisinger, Lewis N. (S) ..... 805 S. Indiana Ave.
Hines, Archie V. ..... 401 S. Main St.
Hines, John H. ..... 403 S. Main St.
Hippensteel, Harland V. ..... 208 W. Seventh St.
Nugen, Harold ..... 223 W. Seventh St.
Rogers, Evered E. ..... 212 W. Sixth St.
Sanders, Jesse A. (S) ..... 1007 S. Main St.
Souder, Bonnell M. ..... 206 W. Seventh
Wills, Max ..... 127 W. Seventh St.

Weirich, Charles I. ..... Butler

Garrett

Carpenter, Ramesh S. ..... 315 S. Randolph
Jinnings, Loren E. ..... 200 S. Randolph
Kantzer, Floyd B. ..... 200 S. Randolph
Nason, Robert A. ..... 123 E. King
Novy, Charles A. ..... 200 S. Randolph
Reynolds, Russell P. ..... 215 S. Randolph

Coleman, Floyd B. ..... Waterloo
Showalter, John P. ..... Waterloo

Van Nest, Willard A.
501 Magnolia St., New Smyrna Beach, Fla.

DELAWARE-BLACKFORD COUNTIES

Brown, Stewart D. ..... Albany
Puterbaugh, Karl E. ..... Albany
Hurley, John R. ..... Daleville
Tucker, Oral A. ..... Daleville
Ko, Richard C. B. ..... Gaston

Hartford City

Dodds, James U. ..... 227 W. Main St.
Dudgeon, Charles A. ..... 720 N. Spring
Jackson, Dean B. ..... 401 W. Washington St.
Owsley, Guy A. ..... 214 N. High St.
Parks, George ..... 720 N. Spring St.
Weldy, Bryce P. ..... 227 W. Franklin St.
Werry, Leslie E. ..... 218 W. Washington St.
Wierzalis, Edward F. ..... Rural Loan Bldg.

Burns, Paul E. ..... Montpelier
Douglas, William T. ..... Montpelier

Muncie

Adams, Julia L. ..... Ball State Teachers College
Adams, William B. ..... Ball Memorial Hosp.
Alvey, Charles R. ..... 217 S. Cherry St.
Ball, Clay A. (S) ..... 303 W. Adams St.
Ball, Phillip ..... 2620 W. Jackson St.
Batt, David J. ..... 420 W. Washington St.
Benken, Lawrence D. ..... 2423 W. Jackson
Bergwall, Warren L. ..... 223 Tillotson Ave.
Bibler, Henry E. ..... 311 W. Adams St.
Botkin, Charles (S) ..... 508 W. Jackson St.
Botkin, Clyde G. ..... 508 W. Jackson St.
Botkin, Thomas ..... 400 White River Blvd.
Brown, Leland G. ..... 412 White River Blvd.
Brown, Thomas M. ..... 412 White River Blvd.
Burwell, Stanley W. ..... 424 W. Jackson St.
Butterfield, Robert M. ..... 315 W. Jackson St.
Butz, Ralph O. ..... 408 Western Reserve Bldg.
Christie, Robert W. ..... Ball Memorial Hosp.
Clevenger, Joseph H. ..... 424 W. Jackson St.
Cochran, Robert B. ..... 420 W. Washington St.
Covalt, Wendell E. ..... 305 Western Reserve Bldg.

Cooper, John ..... 2327 Madison St.
Cure, Elmer T. ..... 122 W. Jackson St.
Davis, Edgar C. ..... 107 Plaza Bldg.
Deutsch, William ..... 406 White River Blvd.
Dunn, Ferrell W. (S) ..... 1417 Wheeling Ave.
Dunning, Thomas W. ..... 400½ White River Blvd.
Fair, Herbert D. (S) ..... 201 Alameda Ave.
Funk, John W. ..... 217 W. Charles St.
Galliher, Marjorie J. ..... 410 White River Blvd.
Garling, Luvern C. ..... 420 W. Washington St.
Geckler, Charles E. ..... 203 Western Reserve Bldg.
Greiber, Marvin F. ..... 420 W. Washington St.
Gustafson, Milton ..... 808 W. Jackson St.
Hall, Orville A. ..... 514 Wysor Bldg.
Hall, Robert S. ..... 514 Wysor Bldg.
Hayes, Theodore R. ..... 210 S. High St.
Henderson, Ramon A. ..... 806 W. Main St.
High, Ralph L. ..... 420 W. Washington St.
Hill, Howard E. ..... 402 W. Jackson St.
Hostetter, Irwin S. ..... 115 N. Cherry St.
Hurley, Anson G. ..... 1111 W. Jackson St.
Imhof, Joseph D. ..... 318 W. Adams St.
Kammer, Walter F. ..... 420 W. Washington St.
Kirshman, Forrest E. ..... 211 S. High St.
Koss, K. William ..... 1600 W. Jackson St.
Kress, James W. ..... 420 W. Washington St.
LaDuron, Jules F. ..... 615 S. Liberty St.
McClintock, James A. ..... 316 W. Adams St.
McCoy, George E. ..... 806 W. Jackson St.
McDowell, Fletcher W. ..... 315 S. Jefferson St.
Mathewson, Russell C. ..... 420 W. Washington St.
Molloy, William J. (S) ..... 619 E. Charles St.
Montgomery, Lall G. ..... Ball Memorial Hosp.
Moore, Thomas C. ..... 110 N. Cherry St.
Moore, Will C. (S) ..... 110 N. Cherry St.
Morris, Jean W. ..... 247 Johnson Bldg.
Nelson, Harold E. ..... 424 W. Jackson St.
O'Connor, Joseph M. ..... 420 W. Washington St.
Owens, Richard R. ..... 406 Western Reserve Bldg.
Owens, Thomas R. ..... 202 Western Reserve Bldg.
Paul, Leendert J. ..... 3220 Riverside Ave.
Peacock, Robert C. ..... 124 S. High St.
Pippenger, Wayne G. ..... Ball State Teachers College
Quick, William J. ..... 314 E. Washington St.
Rettig, Arthur C. ..... 314 W. Jackson St.
Rivers, Glynn A. ..... 625 W. Adams St.
Schulhof, Maurice G. ..... 420 W. Washington St.
Smith, James S. ..... 501 Kirby
Speck, Carlson R. ..... Ball Memorial Hospital
Steele, Frank M. ..... 420 W. Washington St.
Stibbens, Warren ..... 2210 Janney St.
Stout, Francis E. ..... 2423 W. Jackson St.
Taylor, Donald R. ..... Ball Memorial Hosp.
Taylor, James A. ..... Delco Remy Plant
Tomlin, Hugh M. ..... 420 W. Washington St.
Venis, Kemper N. ..... 108 N. Liberty St.
Voss, Gert ..... 420 W. Washington St.
Walker, Jack M. ..... 412 White River Blvd.
Ware, Herbert E. ..... 514 Wysor Bldg.
Young, Gerald S. ..... 316 W. Jackson St.

Jump, Charles A. (S) ..... Selma
Hill, Robert E. ..... Yorktown
Moss, Mavor J. ..... Yorktown

DUBOIS COUNTY

Backer, Henry G. ..... Ferdinand

Huntingburg

Amini, Sohrab ..... 521 Fourth St.
Bretz, John M. ..... 302 Fourth St.
Heaton, Elton ..... 409 Van Buren
Scales, Alfred B. ..... 409 Van Buren
Scales, Allen D. ..... 409 Van Buren
Steinkamp, Emil F. (S) ..... 302 Walnut St.
Stork, Harvey K. ..... 532 Fourth St.
Williams, Fielding P. ..... 215 W. Walnut St.

Jasper

Beaven, John B. ..... 111 Central Bldg.
Blessinger, Paul J. ..... 325 E. Sixth St.
Gootee, Thomas H. ..... 101-4 Central Bldg.
Heck, Martin C. ..... 801 Newton
Held, George A. ..... 716 W. Ninth St.
Klamer, Charles H. ..... Metzger Bldg.
Lukemeyer, St. John ..... 109 W. 12th St.
Ploetner, Edward J. ..... 201 W. Sixth St.
Salb, John P. ..... 106 Metzger Bldg.
Salb, Leo A. (S) ..... 301 E. Sixth St.
Singer, Paul J. ..... 116 E. Seventh St.
Wagner, Arthur L. ..... 115 E. Ninth St.

ELKHART COUNTY

Horswell, Richard G. ..... Bristol
Neidballa, Edward G. ..... Bristol

Elkhart

Arlook, Theodore D. ..... 912 W. Franklin St.
Atwood, William H. ..... 405 S. Second St.
Bender, Robert L. ..... 411 S. Third St.
Benson, James E. ..... 405 S. Second St.
Billings, Elmer R. ..... 405 S. Third St.
Bloom, George R. ..... 506 S. Second St.
Bowdoin, George E. ..... 515 S. Second St.
Campbell, Patrick B. ..... 605 Oakland Ave.
Classen, Pete R. C. ..... 4112 S. Main St.
Compton, Walter A. ..... 2225 Greenleaf Blvd.
Cormican, Herbert L. ..... 316 S. Fourth St.
Crandall, Lathan A.
Miles-Ames Research Laboratory
Dovey, Edward G. ..... 513 Oakland Ave.
Elliott, Lloyd A. (S) ..... 405 S. Second St.
Elliott, Thomas A. ..... 405 S. Second St.
Fleming, Claude F. (S) ..... 217 W. Jefferson St.
Futterknecht, James O. ..... 405 S. Second St.
Gattman, George B. ..... 427 S. Second St.
Graber, Virgil R. ..... 413 W. Franklin St.
Hannah, Jack W. ..... 1906 E. Jackson Blvd.
Heminway, Norman L. ..... Miles-Ames Research Labs.
Hull, Arthur W. ..... 221 Jefferson
Hurley, James W. ..... 405 S. Second St.
Ivy, John H. ..... 405 S. Second St.
Keating, John U. ..... 215½ W. Lexington
Kintner, Burton E. ..... 506 S. Second St.
Kistner, Arthur W. ..... 400 Equity Bldg.
Koehler, Elmer G. ..... 416 W. Lexington Ave.
Krause, Friedrich ..... 4112 S. Main St.
Leasure, Kenneth ..... 1000 W. Marion St.
Lundt, Milo O. ..... 521 S. Second St.
McArt, Bruce A. ..... 123 W. Marion St.
Martin, Paul H. ..... 202 Harrison St.
Mendez, Carlos ..... 116 W. Marion St.
Middleton, Ramona J. ..... 209 S. Second St.
Miller, Galen R. ..... 903 W. Franklin St.
Miller, Hugh A. ..... 819 McNaughton Ave.
Miller, Samuel T. (S) ..... 506 S. Second St.
Mininger, Edward P. ..... 413 W. Franklin St.
Mishkin, Irving ..... 209 S. Second St.
Norris, Allen A. (S) ..... 401 W. Marion St.
Paff, William A. ..... 115 S. Third St.
Paine, George E. ..... 329 Meisner Ave.
Pancost, Vernon K. ..... 200 Equity Bldg.
Parshall, Dale B. ..... 133 W. Lusher Ave.
Patrick, Glenn B. ..... 427 S. Second St.
Rouen, Robert ..... 114 Monger Bldg.
Rupe, Lloyd O. ..... 209 Equity Bldg.
Schlosser, Herbert C. ..... 116 W. Marion St.
Sears, Murray M. (S) ..... 304 Equity Bldg.
Sobol, Z. W. ..... 405 S. Second St.

Spray, Page E. ..... 316 Fourth St.
Stauffer, Walter A. (S) ..... 701 Strong Ave.
Stout, Richard B. ..... 1501 Greenleaf Blvd.
Stubbins, William M. ..... 412 S. Second St.
Swihart, Danny D. ..... 506 S. Second St.
Swihart, Homer R. ..... 1200 W. Marion St.
Swihart, Leonard F. ..... 214 W. Marion St.
Wilson, Orley E. ..... 217 N. Main St.
Work, James A., Jr. (S) ..... 406 S. Second St.
Yoder, C. Richard ..... 603 Oakland

Goshen

Amstutz, Henry C. ..... 112 W. High Park
Bartholomew, Mary L. ..... 317 E. Lincoln
Bender, Cecil K. ..... 320 S. Fifth St.
Bigler, Frederick W. ..... 314 S. Fifth St.
Bosler, Howard A. ..... 214 Waterford Road
Bowser, Philip G. ..... 107 S. Fifth St.
Chandler, Leon H. ..... 43 Shoots Bldg.
Hostetler, Carl M. ..... 304 E. Lincoln
Kaufman, Lillie S. ..... 901 Mervin Ave.
Krabill, Willard S. ..... 112 W. High St.
Martin, Floyd S. ..... 127 E. Lincoln
Quilty, Thomas J. ..... 112 E. Madison St.
Simmons, Lloyd H. ..... 208 E. Lincoln
Troyer, Dana ..... 122 E. Clinton St.
Turner, John P. ..... 115 E. Washington St.
Wagner, David G. ..... 307 S. Seventh St.
Westfall, George S. ..... 214 E. Lincoln St.
Yoder, Albert C. (S) ..... 816 S. Sixth St.
Yoder, Jonathan G. ..... 314 E. Lincoln
Young, Ralph H. ..... 113 E. Madison

Massanari, Walter ..... Millersburg
Miller, Donald G. ..... Middlebury
Teters, Melvin S. ..... Middlebury

Nappanee

Fleetwood, Raymond A. ..... 357 N. Nappanee
Kendall, Forest M. ..... 252 W. Market St.
Price, Douglas W. ..... 162 E. Market St.
Roose, Lisle W. ..... 357 N. Nappanee
Slabaugh, Jancy S. (S) ..... 111 N. Main St.

De Fries, John J. ..... New Paris
Abel, Robert ..... Wakarusa
Guttman, John B. ..... Wakarusa

Swank, Lucretia R.
1824 Rocky Point Rd., Pewankee, Wis.
Todd, David D. (S)
5835 Beaumont Ave., La Jolla, Calif.

FAYETTE-FRANKLIN COUNTIES

Brookville

Foreman, Walter A. ..... 617 Main St.
Peters, Elmer E. ..... 830 Main St.
Seal, Perry F. ..... 901 N. Main St.
Smith, Herbert N. ..... 812 Main St.

Connersville

Dale, Maxwell H. ..... 818 Grand
Ellis, George M. ..... 108 E. 10th St.
Entner, Charles L. ..... 716 Grand Ave.
Gregg, Albert F. ..... 124 E. Sixth St.
Hudson, Arlington M. ..... 321 W. 20th
Kemp, William A. ..... 122 W. Seventh St.
Kerrigan, William F. ..... 718 Central Ave.
Lockhart, Jack M. ..... 707 W. Third St.
Mountain, Francis B. ..... 930 Central Ave.
Neukamp, Frank H. ..... 707 W. Third St.
Sanders, Bertram W. ..... 930 Central Ave.
Steinem, Joseph L. ..... 812 Grand Ave.
Watterson, Gerald T. ..... 1910 Virginia Ave.
Winklepleck, A. M. ..... R. R. #6

Poston, Clement L. ..... R. R. 2, Laurel

FLOYD COUNTY

Engleman, Harry K. (S) ..... Georgetown

New Albany

Baker, Avey M. ..... 811 E. Spring St.
Baxter, Samuel M. ..... 1201 E. Spring St.
Brown, Kenneth H. ..... 410 E. Spring St.
Buchman, Marshall H. ..... 1824 State St.
Byrn, Howard W. (S) ..... 415 Elsby Bldg.
Cannon, Daniel H. ..... 1203 E. Spring St.
Davis, Parvin M. ..... 601 E. Spring St.
Eckerle, John E. ..... 1514 State St.
Edwards, William F. ..... Floyd County Bank Bldg.
Garner, William H. Jr. ..... 919 E. Spring St.
Garner, William H. ..... 919 E. Spring St.
Gentile, John P. ..... 101 Adams St.
Geyer, Joseph ..... Silvercrest Sanitarium
Harris, Robert W. ..... 2652 Charlestown Rd.
Hauss, Augustus P. (S) ..... 212 Elsby Bldg.
Hess, Paul P. ..... Floyd Co. Bank Bldg.
Higgins, John R. ..... 700 E. Spring St.
LaFollette, Donald ..... 1000 E. Spring St.
LaFollette, Robert E. ..... 1000 E. Spring St.
McCullough, James Y. ..... 700 E. Spring St.
Paris, John M. ..... 602 E. Spring St.
Pierce, Gene S. ..... 1696 Garretson Lane
Robertson, Addis N. ..... 820 E. Spring St.
Robinson, Nan ..... 601 E. Spring St.
Shelton, Clyde F. ..... 601 E. Spring St.
Sloan, Herbert P. ..... 1207 E. Spring St.
Sonne, Irvin S., Jr. ..... 1850 State St.
Streepey, Jefferson I. ..... 1102 E. Spring St.
Tyler, Frank T. (S) ..... Hausfeldt Lane
Voyles, Harry E. ..... 213 Elsby Bldg.
Wallace, Elmer L. ..... 1516 State St.
Weaver, William W. ..... 1104 E. Spring St.
Wohlfeld, Gerald ..... Silvercrest Sanitarium
Wolfe, Nelson ..... 1117 E. Spring St.
Worley, Henry L. ..... 1104 E. Spring St.

FOUNTAIN-WARREN COUNTIES

Attica

Fisher, John E. ..... 217 S. Perry St.
Maris, Lee J. ..... 201 Brady
Petrich, Peter R. ..... 401 S. Perry St.
Raymundo, Vivencio F. ..... 401 S. Perry St.

Hoffman, Max N. ..... Covington
Humphrey, Edward M.
Olin Mathieson Corp., Covington
Stephens, Lowell R. ..... Covington
Suzuki, Tsutomu T. ..... Covington
Smith, Byron J. ..... Kingman
McCord, Carl B. (S) ..... Veedersburg
Person, Theodore C. ..... Veedersburg
Rusk, Hubert M. ..... Wallace
Nelson, Carl A. ..... West Lebanon
Crain, James W. ..... Williamsport
Harding, James H. ..... Williamsport

FULTON COUNTY

Herrick, Charles L. ..... Akron
Miller, Virgil C. ..... Akron
Dielman, Franklin C. (S) ..... Fulton

Kelsey, Lawrence E.....Kewanna
Kraning, Kenneth K.....Kewanna

Rochester

Herendeen, Elbie V.....120 W. Ninth St.
Johnson, Frank P.....817 E. 9th St.
Richardson, Charles L.....121 W. Eighth St.
Rowe, Howard H.....705 Jefferson St.
Stinson, Dean K.....816 Main St.

GIBSON COUNTY

Geick, Raymond G.....Fort Branch
Marchand, Edwin V.....Haubstadt
Petitjean, Harold G.....Haubstadt
Dye, William E.....Oakland City
Ropp, Eldon R.....Oakland City
Wood, Russell W.....Oakland City

Princeton

Carpentier, Harry F.....105 E. Broadway
Folck, John K.....115 N. Prince St.
Graves, Orville M.....116 S. Hart St.
McCarty, Virgil.....113 S. Main St.
McElroy, Robert S.....116 S. Main St.
Peck, James F.....218 Broadway
Strickland, Karl S. (S).....230 W. Broadway
Weitzel, Roland.....114 S. Hart St.
Wells, William R.....109 E. State St.

Brazelton, O. T. (S)
5450 55th St., No. 14, San Diego 15, Calif.

GRANT COUNTY

Grant, M. Arthur.....Fairmount
Henley, Glenn (S).....Fairmount
Yale, Charles A.....Fairmount
Garrison, Leon J.....Gas City
Koontz, William A.....Gas City
Baskett, Russell J.....Jonesboro

Marion

Abell, Charles F.....321 Marion Nat'l Bank Bldg.
Alderfer, Henry.....131 N. Washington St.
Ansbacher, Stefan (H).....R. R. 1
Ayres, Wendell W.....303 Glass Block
Bailey, Douglas A.....107 E. 31st St.
Bloom, Asa W.....724 W. Third St.
Boyer, Grace B.....605 Locust St.
Braunlin, Robert F.....711 Marion Nat'l Bank Bldg.
Brown, Robert M.....520 Marion Nat'l Bank Bldg.
Comeau, William J.....Marion General Hosp.
Cunningham, Robert D.....510 Glass Block
Daniels, George R. (S).....106 N. E Street
Davis, Joseph B.....131 N. Washington St.
Davis, Merrill S.....131 N. Washington St.
Davis, Richard.....131 N. Washington St.
Diamond, Leo L.....413 Marion Nat'l Bank Bldg.
Dunbar, Fred.....Fisher Body Division General Motors Corp.
Fisher, Henry.....1502 S. Washington St.
Ganz, Max.....930 S. Adams
Goldsmith, David A.....Veterans Hospital
Gustafson, Carl J.....Veterans Hospital
Hover, Galen M.....Veterans Hospital
Hummel, Russel M.....317 Marion Nat'l Bank Bldg.
Jarrett, John C.....131 N. Washington St.
Kelly, John F.....Veterans Hospital
Lahr, Richard E.....1121 W. Third St.
Langrall, Harrison M. Jr.....131 N. Washington St.
Lavengood, Russell W.....225 Glass Block
Long, Max R.....803 S. Boots St.
Lonngren, Dudley H.....131 N. Washington St.
Love, V. Logan.....131 N. Washington St.
Miller, H. Allison.....320 Glass Block
Oatman, Jack G.....131 N. Washington St.
Pattison, John D.....131 N. Washington St.
Powell, J. Paxton.....501 Glass Block
Price, Ambrose M.....309½ Adams St.
Renbarger, Lester L.....1531 W. Second
Rhamy, Arthur P.....506 Glass Block
Rhamy, Donald E.....1632 Broadview Dr.
Rhorer, John G.....201 S. D St.
Richardson, Joseph H.....131 N. Washington St.
Schroeder, Robert W.....317 N. Western Ave.
Shoemaker, Richard L.....211 E. South St. A
Simmons, Frederick H.....1009 N. Baldwin
Skomp, Claud E.....302 Marion Nat'l Bank Bldg.
Smith, Barton T.....131 N. Washington St.
Snowhite, Arthur B.....311 Glass Block
Thompson, B. Jay.....Marion General Hosp.
Walton, R. Lee.....131 N. Washington St.
Warren, Carroll B.....511 Glass Block
Weinberg, Samuel.....104 W. Third St.
Wojcik, Ladislas D.....131 N. Washington St.
Woodbury, John W.....131 N. Washington St.
Young, Robert G.....2927 S. Washington St.

Beck, Thomas A.....Swayzee
Taylor, Everett C.....Upland
Rifner, Eugene S.....Van Buren

Breedlove, Dane
Indian Hospital, Ft. Defiance, Ariz.

GREENE COUNTY

Bloomfield

Graf, Jerome A.....6 E. Main St.
Mount, Mathias S.....55 N. Franklin St.
Turner, Harold B.....126 E. Indiana Ave.
Turner, Jack J.....126 E. Indiana Ave.
Van Sandt, Frank A. (S).....110½ E. Main St.

Porter, Carl M.....Jasonville
Rotman, Harry G.....Jasonville
Rotman, Sam I.....Jasonville

Linton

Bailey, Edwin B.....129 E. Vincennes
Broshears, Kenneth P.....129 E. Vincennes
Raney, Ben B.....129 E. Vincennes
Tomak, Milton E.....289 N. Main St.
Woner, John W.....Linton

Hamilton, M. Luther (S).....Newberry
Moses, George E.....Worthington
Moses, Robert E.....Worthington

HAMILTON COUNTY

Karlick, Joseph.....Arcadia
McDaniel, Franklin P. (S).....Atlanta
Donahue, Claude M.....Carmel
Hasewinkel, Carroll W.....R. R. 2, Box 354, Carmel
Thomas, W. Clayton.....Carmel
Havens, Oscar.....Cicero

Noblesville

Ambrose, Jesse C.....298 N. Ninth Street
Campbell, Sam W.....88 S. 19th St.
Harris, Robert F.....120 N. 11th St.
Hash, John S.....139 S. 10th St.
Haywood, John G.....120 N. 11th St.
Hooke, Samuel W. (S).....P. O. Box 224
Kern, Charles B. (S).....10 Heather Lane, R. R. 3

Land, Richard N. ..... Riverview Hospital
Lanning, R. Adrian ..... 10th and North Dr.
Lloyd, Joe R. ..... 148 N. 9th St.
Shanks, Ray W. ..... 104 S. 10th St.
Shonk, Harold W. ..... 1084 Clinton St.
Smith, Charles F. ..... 23 N. 10th St.

Griffith, James W. ..... Sheridan
Newby, Eugene ..... Sheridan
Reck, John L. (S) ..... Sheridan
Waitt, Paul M. ..... Sheridan
Connoy, Andrew F. ..... Westfield
Connoy, Leo F. ..... Westfield

HANCOCK COUNTY

Scott, Robert S. ..... Charlottesville
Ferrell, Mars B. ..... Fortville
Navin, Hugh K. ..... Fortville
Rhynearson, Hal R. ..... Fortville

Greenfield

Beeson, Wilbur ..... 114 N. State St.
Endicott, Wayne ..... 10 W. Boyd
Farrell, John J., Jr. ..... 1001 N. State St.
Gibbs, Charles M. (S) ..... 203 E. North St.
Gill, Dee D. ..... 1001 N. State St.
Henn, R. Anthony ..... 211 W. Main St.
Hunter, Donn ..... 10 W. Boyd
Kinneman, Robert E. ..... 114 N. State St.
Kirby, Ted C. ..... 114 N. State St.
Smith, John H. ..... 744 N. State St.
Vingis, Bronie ..... 746 N. State
Woods, James R., Jr ..... 11 N. State St.

Cagle, Bob R. ..... New Palestine
Larrabee, William H. (S) ..... New Palestine
Pierson, Thomas A. ..... New Palestine
Kuhn, Robert W. ..... Wilkinson

HARRISON-CRAWFORD COUNTIES

Corydon

Amy, William E. (S) ..... 120 S. Capitol
Blessinger, Louis H. ..... 101 W. Chestnut St.
Brockman, Wilfred ..... 439 E. Chestnut St.
Dillman, Carl E. ..... Beaver & Oak Sts.
Dukes, David J. ..... 439 E. Chestnut St.
Jordan, Richard A. ..... Harrison Dr.
Martin, Samuel W. ..... R.R. 1

Baker, Guy D (S) ..... Crandall
Gobbel, Novy E. (S) ..... English
Seipel, Stanley ..... Lanesville
Benz, Jesse (S) ..... Marengo
Lynch, Otis R. ..... Marengo
Mathys, Alfred (S) ..... Mauckport
Johnson, Jerome M ..... Palmyra

HENDRICKS COUNTY

Able, Walter ..... 702 E. Main St., Brownsburg
Black, James ..... 702 E. Main St., Brownsburg
Foltz, Lloyd E. ..... 20 W. Main, Brownsburg
Scudder, Arthur N. ..... 24 N. Grant St., Brownsburg
Ellett, John, Jr. ..... Coatesville

Danville

Kirtley, Robert W. ..... 138 W. Marion St.
Koch, Elmer L. ..... 201 E. Columbia St.
Southard, James E. ..... 985 W. Main St.
Terry, Lloyd ..... 138 W. Marion St.

Ellis, Lyman H. ..... Lizton
Wiseheart, Oscar H. (S) ..... North Salem
Scamahorn, Malcolm O. ..... Pittsboro
Scamahorn, Oscar T. (S) ..... Pittsboro

Plainfield

Aiken, Milo M. ..... 140 N. Center St.
Cohen, Irving ..... 645 E. Main St.
Haggard, David B. ..... P. O. Box 191
Stafford, James C. (S) ..... 107 W. Main St.
Stafford, William C. ..... 107 W. Main St.
Warbinton, Fred P. ..... P. O. Box 191

Frantz, Mount E.
3530th USAF Hosp., Bryan AFB, Texas

HENRY COUNTY

Call, Earle B. (S) ..... Knightstown
Smith, Stephen D. ..... Knightstown
Wiatt, Leonard ..... Knightstown
Scheetz, Marion R. ..... Lewisville
Hammer, Jay W. ..... Middletown
Reynolds, Ralph E. ..... Middletown
Stauffer, George E. ..... Mooreland
Marshall, Lloyd C. (S) ..... Mt. Summit

New Castle

Amos, Robert L. ..... 1219½ Race St.
Balcolm, Francis H. ..... R. R. 2, Lewisville Rd.
Bledsoe, James G. ..... 319 S. 14th St.
Burnett, Arthur B. ..... 106 N. Main St.
Craig, Alexander F. ..... 711 Crescent Dr.
Davies, Robert ..... 1319 Church St.
Dyken, Mark L. ..... New Castle State Hosp.
Fisher, John E. ..... 540 S. Main St.
Foster, Ray T. ..... 420 N. Main St.
Grant, Phyllis ..... New Castle State Hosp.
Harrison, Benjamin L. ..... 540 S. Main St.
Heilman, William C. (S) ..... 1319 Church St.
Heilman, William C., Jr. ..... 1319 Church St.
Hill, Kenneth G. ..... 1319 Church St.
Iterman, George E. (S) ..... 1319 Church St.
Kennedy, Walter U. ..... 208 Union Block
Life, Homer L. ..... 101 S. 11th St.
Lowery, George E. ..... New Castle State Hosp.
McDonald, Frank C. ..... 527 S. Main St.
McElroy, James S. ..... 1319 Church St.
McGee, Robert R. ..... 527 S. Main St.
McKee, Roy G. ..... 319 S. 14th St.
Murray, William E. ..... New Castle State Hosp.
Saint, William K. ..... 540 "B" South Main St.
Smith, Mark E. ..... 1319 Church St.
Steussy, Calvin, N. ..... Henry Co. Hospital
Stout, Walter M. (S) ..... 1319 Church St.
Thorne, Charles E. ..... 200 N. 12th St.
Tully, John A. (S) ..... 502 S. Main St.
Vivian, Donald E. ..... Henry County Hospital
Wiggins, Dulania S. (S) ..... 219 S. 12th St.

Robertson, William S. ..... Spiceland
Canaday, Clifford E. (S) ... 453 Meadowcrest Circle
Memphis 17, Tenn.
Marsh, Chester A. (S)
906 Dexter St., Los Angeles 42, Calif.

HOWARD COUNTY

Denton, Larkin D. ..... Greentown
Shoup, Homer B. ..... Greentown

Kokomo

Alward, John H.....321 W. Walnut St.
Artis, Myrle E.....107½ S. Union St.
Ault, Carl H.....421 W. North St.
Behn, Walter M., Jr.....700 E. Firmin
Belding, Ray T.....3130 S. La Fountain St.
Boughman, Joe D.....2008 W. Sycamore
Bowers, Copeland C.....210 W. Mulberry St.
Bowers, Garvey B.....210 W. Mulberry St.
Bowers, John A.....210 W. Mulberry St.
Brown, Earl R., Jr.....1907 W. Sycamore St.
Bruegge, Theodore J.....2108 W. Sycamore
Cattell, Lee M.....214 E. Mulberry St.
Clarke, Elton R.....304 W. Taylor St.
Conley, Thomas M.....520 Union Bank Bldg.
Craig, Reuben A.....514 W. Superior St.
Craig, Reuben.....514 W. Superior St.
Crawford, Theodore R.....2114 W. Sycamore St.
Earl, Max M.....502 S. Berkley Rd.
Ferry, Paul W.....406 Union Bank Bldg.
Fretz, Richard C.....215 W. Superior St.
Golper, Marvin N.....1907 W. Sycamore St.
Good, Richard P.....308 Armstrong-Landon Bldg.
Halfast, Richard W.....214 E. Mulberry St.
Hoyt, John M.....1017 S. Delphos
Hutto, William H.....215 W. Superior St.
Jewell, George M.....610 Armstrong-Landon Bldg.
Knepple, LaMarr R. (S).....534 W. Sycamore St.
Kremers, George A...522 Armstrong-Landon Bldg.
McClure, Warren N.....407 W. Taylor St.
McIndoo, Ralph E.....313 W. Taylor St.
Mendelson, Stanley M.....117 W. Markland
Michael, Robert L.....321 W. Walnut St.
Morrison, William R.....504 Union Bank Bldg.
Murray, Ernest C.....501 N. Washington St.
Paris, Durward W...614 Armstrong-Landon Bldg.
Perkins, Powell L.....2112 W. Sycamore
Phares, Robert W.....905 W. Mulberry St.
Prather, Philip E.....909 S. Courtland
Ramey, John W.....107½ S. Union St.
Rhorer, Herbert M.....210 W. Mulberry St.
Rudicel, Max.....1907 W. Sycamore St.
Schwartz, Frederick C.....2016 W. Sycamore
Shenk, Earl M.....208½ N. Main St.
Smith, Gloster J.....102½ S. Main St.
Sorenson, Raymond..522 Armstrong-Landon Bldg.
Spangler, Jesse S.....215 E. Taylor St.
Trimble, John G.....116 S. Buckeye St.
Wachob, Tom W., Jr.
406 Armstrong-Landon Bldg.
Wible, James H.....2112 W. Sycamore St.

Miller, Arthur H. (S).....Russiaville
Ware, John R. .....Russiaville

HUNTINGTON COUNTY

Huntington

Brubaker, Harold S.....42 W. Park Dr.
Casey, Stanley M.....408 E. Market St.
Clunie, William A.....323 W. Park Dr.
Cope, Stanton E.....1022 N. Jefferson St.
Erehart, Mark G.....232 W. Market St.
Eviston, John B.....34 E. Washington St.
Gray, Paul M.....340 E. Market St.
Grayston, Wallace S. (S).....303 E. Market St.
James, Thomas, Jr.....202 U. B. Publishing Bldg.
Johnston, Robert G. (S).....339 E. Market St.
Marks, Howard H.....248 W. Park Dr.
Meiser, Robert D.....612 N. Jefferson St.
Miller, Wayne S.....354 E. Washington St.
Mitman, Floyd B.....210 W. Park Dr.
Nie, Grover M. (S).....650 Cherry St.
Omstead, Trevalyn W. .....229 Vine St.
Wagner, Richard.....1355 Guilford

Woods, Halden C.....Markle
Cooper, B. Trent.....Roanoke
Bennett, J. B.....Warren
Eby, Ida L. (S).....Methodist Home, Warren
McIlwain, Eleanor E.....Methodist Home, Warren
McIlwain, Robert E.....Methodist Home, Warren
Ray, Carl S.....Warren

JACKSON COUNTY

Gillespie, Garland R.....Brownstown
Shields, Jack E.....Brownstown
Adair, William K. (S).....Crothersville
Bard, Frank B.....Crothersville
Butler, Joe B.....Crothersville
Scharbrough, William.....Medora

Seymour

Baxter, Harry R.....326 N. Walnut St.
Black, Joe M.....502 W. Second St.
Bobb, Kenneth E.....406 S. Chestnut St.
Bosch, Ralph .....635 W. Second St.
Day, William D. C.....510 W. Second St.
Graessle, Harold P.....304 W. Second St.
Martin, Guy.....105 N. Walnut St.
Miller, Harold E.....Vehslage Bldg.
Osterman, Louis H.....315 W. Second St.
Ripley, John W.....321 Bruce St.
Templeton, Ian S.....205 N. Pine St.
Wiethoff, Clifford A.....214 N. Walnut St.

JASPER-NEWTON COUNTIES

Schoonveld, Arthur .....Brook
Lee, Robert Y.....De Motte
Parker, John C.....Goodland
Kresler, Leon E.....Kentland
Yegerlehner, Roscoe S.....Kentland
Brady, Kingdon.....Morocco
Hartsough, Ralph I.....Remington
Schantz, Richard.....Remington

Rensselaer

Beaver, Ernest R.....111 Thompson St.
Greene, Robert W.....212 S. Van Rensselaer St.
O'Brien, Francis E..McKinley and Washington Sts.
Ockerman, Kenneth R.....119 W. Harrison St.
Williams, Earl K.....Jasper County Hosp.
Williams, Paul A.....119 W. Harrison St.

Gwin, Merle D. (S)
2111 Regatta Ave., Miami Beach, Fla.

JAY COUNTY

Girod, Donald A.....Dunkirk
Heller, Nelson L. R. (S).....Dunkirk
Shroyer, Herbert .....Dunkirk
Tate, Elizabeth .....Dunkirk

Portland

Badders, Ara C.....226 W. Main St.
Cring, George V. (S).....210 W. Walnut St.
Cripe, William .....302 N. Meridian St.
Cronin, H. Joseph.....Weiler Bldg.
Fitzpatrick, James S.....603 W. Arch St.
Gillum, Eugene M.....522 W. Arch St.
Keeling, Forrest E.....504 W. Arch St.
Lyon, Florence M.....127 E. North St.
Moran, Mark M. (S).....105 S. Commerce
Morrison, George C.....Weiler Bldg.
Schenck, Ralph E.....603 W. Arch St.
Spahr, Donald E.....615 W. Race St.
Steffy, Ralph M.....504 W. Arch St.

JEFFERSON-SWITZERLAND COUNTIES

Madison

Alcorn, Merritt O., Jr.....R. R. 2
Childs, A. G. W. (S).....412 E. Main St.
Childs, Wallace E.....412 E. Main St.
Davis, Lloyd H. (S).....Madison State Hospital
Fong, Theodore C. C.....Madison State Hospital
Gambill, J. Randolph .....Madison State Hospital
Haney, William .....445 Clifty Dr.
Hare, Francis W., Jr.....722 W. Main St.
Jolly, Lewis E.....722 W. Main St.
May, George A.....426 E. Main St.
McAtee, Ott B. .....Madison State Hospital
Modisett, Jackson W.....722 W. Main St.
Modisett, Marcella S.....722 W. Main St.
Moore, Martha.....Madison State Hospital
Pratt, Ralph M., Jr.....323 Poplar St.
Prenatt, Francis.....Madison State Hospital
Shuck, William A.....Odd Fellows Bldg.
Sloan, W. Keith.....426 E. Main St.
Turner, Anna Goss..... ...104 E. Third St.
Turner, Oscar A. (S).....602 E. Second St.
Whitsitt, Schuyler A. (S).....722 W. Main St.
Zink, Robert O.....722 W. Main St.

Graves, Noel S.....Vevay
Hamilton, Antha A.....Vevay

JENNINGS COUNTY

Easter, James N.....Muscatatuck State School, Butlerville

Hingeley, John E.
Muscatatuck State School, Butlerville

Hopkins, Lester H.
Muscatatuck State School, Butlerville

North Vernon

Berkshire, Shaffer B.....Medical Center
Calli, Louis.....408 S. State St.
Green, John H. (S).....202 E. Walnut St.
Johnson, William A.....Medical Center
Matthews, Dennis W. (S).....109 E. Walnut St.
Thayer, Benet W.....20 S. Jackson St.

Guthrie, William H.
Mission Frateryelle Lutherinne Yagoua, Cameroun, W. Africa

JOHNSON COUNTY

Gammell, Lindley L...118 S. Holland St., Edinburg
Michaels, Joseph F. (S).....Edinburg

Franklin

Andrews, Hugh K.....176 E. Jefferson St.
Bullers, Robert C.....551 Center St.
Bullington, George E.....251 E. Jefferson St.
Chappel, Alfred T.....100 N. Main St.
Deppe, Charles F.....301 E. Jefferson St.
Ferrara, Joseph F.....25 E. Madison St.
Foster, Robert.....301 E. Jefferson St.
Hibbs, William G. .....Masonic Hospital
Jones, Charles A.....251 E. Jefferson St.
Mock, Harry E., Jr.....901 N. Main St.
Portteus, Walter L.....1551 N. Main St.
Province, Oran A.....100 N. Main St.
Province, William D.....100 N. Main St.
Records, Arthur W.....198 E. Jefferson St.
Ritteman, George W...Johnson Co. Memorial Hosp.
Stogsdill, Willis W.....176 E. Jefferson St.
Walters, Jack.....1551 N. Main St.
Waymire, William.....1551 N. Main St.

Greenwood

Barnes, Helen Beall.....360 S. Madison Ave.
Brown, George E.....374 S. Madison Ave.
Chambers, Pauline D.....360 S. Madison Ave.
Fox, Richard .....110 Rose Lane
Onyett, Harold R.....Smith Valley Rd.
Sheek, Kenneth I.....188 Madison Ave.
Snodgrass, Robert E.....360 S. Madison Ave.
Tiley, George A.....41 N. Madison Ave.

Machledt, John H.....Whiteland

KNOX COUNTY

Bicknell

Byrne, Robert J. .....207 N. Main St.
Meade, Walter W.....403 N. Main St.
Shanklin, Jack L.....417 N. Main St.
Wilson, Guy H.....120 W. Third St.

Springstun, George H.....Oaktown

Vincennes

Anderson, John B.....301 LaPlante Bldg.
Anderson, Richard M.....301 LaPlante Bldg.
Arbogast, Paul B.....915 Main St.
Barrett, Thomas L.....1019 Dubois St.
Bartlett, Donald T.....429 S. Sixth St.
Beckes, Ellsworth W.....220 N. Fifth St.
Black, Boyd K.....Good Samaritan Hospital
Chattin, Herbert O.....729 Main St.
Coffel, Melvin H.....424 LaPlante Bldg.
Corsentino, Bart.....Good Samaritan Hospital
Curtner, Myron L. (S).....222 N. Sixth St.
Edwards, Edward T., Jr.....34 S. Seventh St.
Ewing, Nathaniel D.....14 N. Third St.
Green, Carl L.....1004 Main St.
Hendrix, Charles E.....603 Busseron
Hoffman, Doris.....720 Perry St.
Humphreys, Joe E.....1516 N. Second St.
Jones, John G. (S).....210 N. Third St.
Kline, Charles D.....301 American Bank Bldg.
McCormick, Hubert D. (S)....325 LaPlante Bldg.
McDowell, Mordecai M.....611 Dubois St.
McMahan, Virgil C.....609 Dubois St.
Moore, Robert G.....21 N. Third St.
Nichols, Robert J.....605 Busseron St.
Pierce, William J.....Good Samaritan Hospital
Reilly, James F.....401 Buntin St.
Richards, David H. (S).....1529 Old Orchard
Schulze, William.....810 Buntin St.
Shaffer, Kenneth L.....404 LaPlante Bldg.
Smith, Ralph O.....603 Busseron
Smith, S. Joseph .....301 LaPlante Bldg.
Spencer, Frederic.....429 S. Sixth St.
Stein, Richard H.....301 American Bank Bldg.
Stewart, J. Frank W.....Hillcrest Hospital
Sullenger, Adron A.....605 Busseron
Vaughn, Walter R.....615 Dubois St.
von der Lieth, William C.....14 N. Third St.
Welch, Norbert M.....615 Dubois St.

KOSCIUSKO COUNTY

Murphy, Harold O.....Claypool
Bahler, Dean R.....Leesburg
Urschel, Dan L. .....Mentone
Wilson, Wymond B.....Mentone
Hursey, Virgil G.....Milford
Rheinheimer, Floyd L.....Milford
Stalter, Gaylord W.....North Webster

Mishler, Joseph B.....Pierceton
Pierson, Pearl H.....Silver Lake
Clark, Jack P.....Syracuse
Craig, Robert A.....Syracuse
Fosbrink, Ephraim L.....Syracuse
Zimmerman, William H.....R. R. #2, Syracuse

Warsaw

Arford, John E.....102 E. Fort Wayne
Baum, John R.....212 S. Indiana
Cron, William J.....215 S. High St.
Dormire, Robert D.....600 E. Winona Ave.
DuBois, Charles C. (S).....800 E. Center St.
Hashemi, Hossein.....215 S. High St.
Hillery, John.....208 E. Center St.
Johnson, John J.....Court House
Richer, Orville H.....914 E. Main St.
Schlemmer, George H.....Murphy Medical Center
Shrader, Carl E.....600 E. Winona Ave.
Thomas, Everett W.....212 S. Indiana

LAGRANGE COUNTY

Wade, Alfred A. (S).....Howe
Yunker, Philip E.....Howe

LaGrange

Benedict, Charles D.....203 W. Wayne St.
Flannigan, Harley F.....213 W. Lafayette
Studebaker, Lloyd R.....Medical Bldg.
Weir, Dale.....220 Poplar

Williams, John H.....Shipshewana
Lehman, Kenneth M.....Topeka

LAKE COUNTY

King, Robert W.....R. R. 1, Box 6, Cedar Lake
Miller, Donald C.....R. R. 2, Box 337, Cedar Lake
Misch, William.....R. R. 2, Box 337, Cedar Lake

Crown Point

Amico, Pasquale J...Lake County Tuberculosis San.
Becker, Philip H.....Lake County Tuberculosis San.
Bernoske, Daniel G.....Co. Health Department
Birdzell, John P.....124 N. Main St.
Carroll, Mary E.....124 N. Main St.
Dhein, Donald T.....R.R. 5, Box 495
Doherty, Raymond J.....47 W. 68th Place
DuSold, Donald D.....306 E. Joliet
Gray, Daniel E.....182 W. North St.
Gutierrez, Peter E.....123 N. Court St.
Horst, William N.....123 N. Court St.
Ramos, Alfonso
Lake County Tuberculosis Sanitarium
Russo, Andrew E.....224 S. Court St.
Steele, Everett B.....109 E. North St.
Troutwine, William R.....224 S. Court

Theobald, Sterling.....212 Joliet St., Dyer

East Chicago

Angel, Virgil E.....4712 Magoun
Bacevich, Andrew J.....3406 Guthrie St.
Balingit, Bienvenido L.....Inland Steel Co.
Barron, Elmer A.....3406 Guthrie St.
Beam, Vernon B.....5215 Kennedy Ave.
Beilke, Clifford A.....815 W. Chicago Ave.
Benchik, Frank A.....4712 Magoun Ave.
Bonaventura, Angelo P.....3701 Main St.
Boyd, Charles S.....4739 Melville Ave.
Boys, Fay F.....4712 Magoun Ave.
Brauer, Abraham A.....3528 Main St.
Braun, Benjamin D.....St. Catherine's Hospital
Broomes, Edward L. C.....2402 Broadway
Bryant, Edward G.....2220 Broadway
Callahan, Richard H.....3704 Main St.
Campagna, Ettro A.....3406 Guthrie St.
Claybourn, Norman L.....3210 Watling St.
Dainko, Alfred J.....823 W. Chicago Ave.
Fleischer, Jacob C.....4035 Elm St.
Gardiner, H. Glenn.....3210 Watling
Geronimo, Manuel M.....3502 Main St.
Geronimo, Rita R. V.....3502 Main St.
Govorchin, Alexander.....724 W. Chicago Ave.
Grosso, William G.....1919 E. Columbus Dr.
Harper, James W.....3912 Euclid
Hayes, Frank W.....4742 Melville Ave.
Hayes, Jesse D.....4804 Alexander
Hernandez, I. C.....1802 Columbus Dr.
Irish, Wilbur J.....806 W. Chicago Ave.
Johns, David R. (S).....1211 Beacon St.
Kmak, Chester.....608 W. 151st St.
Komoroske, John E.....4710 Indianapolis Blvd.
Kopanko, Bernard F.....823 W. Chicago Ave.
Levin, Eli.....4105 Grand Blvd.
McGauvran, Theodore.....3406 Guthrie
McGuire, Desmond F. (S).....3429 Michigan Ave.
Madlang, R. M.....3406 Guthrie
Marks, Ora L.....815 W. Chicago Ave.
Marquinez, Adoracin A.....St. Catherine's Hospital
Mella, Ramon E.....2402 Broadway
Nicosin, John B.....1802 E. Columbus Dr.
Payne, Arthur C.....2020 Broadway
Sazama, Francis J.....Inland Steel Co.
Shapiro, Joseph.....3738 Main St.
Shapiro, Seymour W.....3738 Main St.
Shulruff, Harry I.....3701 Main St.
Teegarden, Joseph A., Jr.....1919 E. Columbus Dr.
Teegarden, Joseph A. (S).....1919 E. Columbus Dr.
Teplinsky, Louis L.....1802 E. Columbus Dr.
Trepagnier, Francis B.....3700 Main St.
Vergara, Abelardo F.....4035 Elm St.
Walker, Adolph P.....1820 E. Columbus Dr.
Wooden, Thomas F.....1820 E. Columbus Dr.
Zallen, Stanley G.....720 W. Chicago Ave.
Zivich, J. M.....3701 Main St.

Gary

Abramson, Allan L.....3290 Grant St.
Albrecht, Willard H..3792 Central Ave., East Gary
Alfano, Paul A.....2717 Wabash
Almquist, Carl O.....504 Broadway
Ambrozaitis, Kazys.....1600 W. Sixth Ave.
Angeles, Uldarico A.....504 Broadway
Armalavage, Leon J.....2620 W. Fifth Ave.
Atienza, Rizalino T.....638 Fillmore
Baitinger, Herbert M.....504 Broadway
Barton, Reginald R.....427 S. Lake
Behn, Walter M.....504 Broadway
Bendler, Carl H.....3290 Grant St.
Bergal, Milton B.....738 Broadway
Bernard, Marvin R.....3807 Washington St.
Bills, R. James.....504 Broadway
Bills, Robert N.....504 Broadway
Bisgyer, Jay L.....400 Broadway
Boardman, Carl (S).....630 Buchanan St.
Borak, Walter J.....5000 Ridge Road
Borenstein, Herschel.....3290 Grant
Brady, Samuel G.....757 Broadway
Brandman, Harry.....504 Broadway
Brincko, John.....504 Broadway
Bringas, Irineo B.....858 Broadway
Brink, Calvin C. (S).....504 Broadway
Brown, David B.....504 Broadway
Brown, Jesse F.....Methodist Hospital
Brown, Leo R.....4645 Broadway
Bullard, Mattie J.....620 E. Tenth Place

Burcham, James B. ..... 738 Broadway
Burger, Robert A. ..... Methodist Hospital
Carberry, George A. ..... 3656 Grant St.
Carbone, Joseph A. ..... 504 Broadway
Carey, J. Albert ..... 1903 Broadway
Carmody, Raymond F. ..... 504 Broadway
Chevigny, Julius J. ..... 504 Broadway
Chube, David D. ..... 1606 Broadway
Cooper, Leo K. ..... 504 Broadway
Corrao, Gaetano ..... 2471 Colfax
Daniel, Robert A. ..... 738 Broadway
Danieleski, Ladislaus J. ..... 738 Broadway
Darling, Dorothy ..... 1600 W. Sixth Ave.
Davis, Neal ..... 1600 W. Sixth Ave.
De Bois, Elon ..... 1649 Broadway
Dian, August J. ..... 504 Broadway
Dierolf, Edward J. ..... 504 Broadway
Donchess, Joseph C. ..... 215 Broadway
Dosado, Elpidio B. ..... 3807 Washington
Duncan, John S. ..... 2165 W. 11th St.
Elliott, Ralph A. ..... 504 Broadway
English, Hubert M. ..... 673 Broadway
Espy, Theodore R. ..... 1901 Broadway
Fadell, Matthew J. ..... 4655 Broadway
Fadul, Armand ..... 5317 W. Fifth Ave.
Franklin, Philip L. ..... 936 W. 5th Ave.
Fukumoto, Richard I. ..... Methodist Hospital
Galante, Vincent J. ..... St. Mary Mercy Hospital
Gallinatti, John J. ..... 1034 Aetna St.
Gannon, George W. (S) ..... 602 Broadway
Glover, William J. ..... 504 Broadway
Goldberg, Harold B. ..... 3656 Grant
Golding, Robert F. ..... P. O. Box 727
Goldstone, Adolph ..... 3229 Broadway
Goldstone, Joseph ..... 3229 Broadway
Goldstone, Sidney R. ..... 3233 Broadway
Grant, Benjamin F. ..... 1706 Broadway
Gregoline, Amadeo F. ..... 729 Broadway
Griem, Sylvia F. ..... 504 Broadway
Hadey, James H. ..... 3807 Washington
Hayes, J. D., Jr. ..... 633 East 21st St.
Hedrick, James T. ..... 1649 Washington St.
Hodurski, Zigfield ..... 4319 Broadway
Hoit, Leonard ..... 504 Broadway
Jahns, Albin A. ..... 504 Broadway
Johnson, Arnold L. ..... 1903 Broadway
Johnson, Lonnie B. ..... 123 W. 21st St.
Johnson, William H. ..... 3792 Central Ave., East Gary
Kamen, Jack M. ..... 304 Cleveland Ave.
Kendrick, Frank J. ..... 504 Broadway
Khaton, Odessa M. ..... 1649 Broadway
Kobrin, Meyer W. ..... 3229 Broadway
Kolettis, John G. ..... 504 Broadway
Kopcha, Joseph E. ..... 504 Broadway
Korn, Jerome M. ..... 3290 Grant St.
Kyle, Michael ..... 517 Marshall
Lazo, Vicente R. ..... 756 Broadway
Lebioda, Henry S. ..... 4655 Broadway
Lewis, George N. ..... 504 Broadway
Lipschutz, Harold ..... 504 Broadway
Lipsey, Alfred J. ..... 504 Broadway
Loh, Hwei Ya (Chang) ..... Methodist Hospital
Loh, Wei-Ping ..... 1600 W. Sixth Ave.
Lorenty, Thaddeus B. ..... 504 Broadway
Lovell, Martin H. ..... 1606 Broadway
Lutz, Georgianna ..... 504 Broadway
McMath, Samuel B. ..... 1649 Broadway
Majsterek, Stanley L. ..... 1034 Aetna St.
Manalo, Francisco M. ..... 538 Lincoln
Mangan, Frank P. ..... 3807 Washington
Marcus, Morris C. ..... 3229 Broadway
Marshall, Millard R. ..... 504 Broadway
Mather, J. Winford ..... 2250 Ripley St., East Gary
May, Richard M. ..... 583 Broadway
Milos, Robert J. ..... 504 Broadway
Minczewski, Richard C. ..... 517 Marshall St.
Mitchell, Georgia B. ..... 1706 Broadway
Molengraft, Cornelius J. ..... 504 Broadway
Monroe, F. Bruce ..... 401 S. Lake St.
Moore, E. Gregory ..... 2367 Madison
Moore, Edwin G. ..... 1606 Broadway
Morris, Hyman ..... 3229 S. Broadway
Moswin, Jack A. ..... 504 Broadway
Nelson, Walfred A. ..... 559 S. Lake St.
Nilges, Richard G. ..... 2717 Wabash Ave.
Ornelas, Joseph P. ..... 3656 Grant St.
Palmer, Russell H. ..... 2006 W. 4th Place
Pappas, Eddie T. ..... 2717 Wabash Ave.
Parratt, Louis W. ..... 708 Broadway
Penn, Robert A. ..... 3792 Central Ave., East Gary
Poracky, Bernard F. ..... 504 Broadway
Pruitt, J. Edward ..... 4655 Broadway
Radigan, Leo R. ..... 504 Broadway
Reynolds, James S. ..... 504 Broadway
Richter, Samuel ..... 504 Broadway
Riordan, John F. ..... Methodist Hospital
Robinson, Walter K. ..... 504 Broadway
Rosenbloom, Philip J. ..... 571 Lincoln St.
Roth, Leo ..... 3229 Broadway
Roth, Melvin I. ..... 3229 Broadway
Rubin, Simon S. ..... 504 Broadway
Ryan, Hubert J. ..... 504 Broadway
Sala, Joseph J. ..... 2705 Wabash
Sala, Walter R. ..... 2705 Wabash
Schulz, Kurt J. ..... 4655 Broadway
Scully, John T. ..... 504 Broadway
Senese, Thomas J. ..... 504 Broadway
Shellhouse, Michael ..... 3811 Washington St.
Shevick, Alexander ..... 504 Broadway
Slama, George F. ..... 4431 Broadway
Slama, John T. ..... 4481 Broadway
Spellman, Frank W. ..... 401 S. Lake
Spivack, Mary ..... 504 Broadway
Sponder, Joseph (S) ..... 1512 Broadway
Stimson, Harry R. ..... 504 Broadway
Stoycoff, Christ M. (S) ..... 860 Broadway
Thomas, Daniel D. ..... 3290 Grant St.
Thomas, Gerald J. ..... 504 Broadway
Trinosky, Frank G. ..... 504 Broadway
Turgi, Robert W. ..... 504 Broadway
Valencia, M. M. ..... 2620 Central Ave., East Gary
Verplank, Grover L. (S) ..... 527 Broadway
Voorhies, McKinley ..... 1606 Broadway
Vye, James P. ..... 607 Broadway
Walters, Eleanore ..... 602 Broadway
Washington, G. Kenneth ..... 1645 Broadway
Weiskopf, Henry S. ..... 504 Broadway
Wharton, Russell O. (S) ..... 6559 Ash Place
Williams, Alexander S. ..... 436 W. 25th St.
Williams, Carl N. ..... 436 W. 25th St.
Williams, Edwin D. ..... 436 W. 25th St.
Williams, Fred ..... 2501 Polk St.
Wimmer, Robert N. (S) ..... 9 W. Sixth St.
Yast, Charles J. ..... 504 Broadway
Yocum, Paul S., Jr. ..... 757 Broadway
Yocum, Paul S. ..... 757 Broadway
Yocum, William S. ..... 790 Broadway
Young, George M. ..... 3656 Grant St.
Young, Robert L. ..... 504 Broadway
Zucker, Edward ..... 504 Broadway

Griffith

Hazinski, Robert T. ..... 401 N. Broad
Lundeberg, Ralph A. ..... 1212 N. Broad St.
Purcell, Richard J. ..... 145 N. Griffith
Siekierski, Joseph M. ..... 145 N. Griffith

Hammond

Allegretti, Michael L. ..... 6850 Hohman Ave.
Arrowsmith, James L. ..... 5231 Hohman Ave.
Bakos, Edward R. ..... 7016 Indianapolis Blvd.
Beconovich, Robert ..... 6850 Hohman Ave.
Bethea, Dennis A. (S) ..... 1021 Fields St.
Bombar, Leslie E. ..... 6850 Hohman Ave.
Chael, Thomas C. ..... 6850 Hohman Ave.

Chidlaw, Benjamin W. (S).....29 Wildwood Rd.
Clancy, James F.....6223 Hohman Ave.
Costello, Albert J.....30 Douglas St.
Cotter, Edward R.....2415 169th St.
Davis, Alice Hall (S).....264 Highland St.
Davis, Thomas N. III.....5246 Hohman Ave.
Eggers, Ernest L. (S).....635 165th St.
Eggers, Henry W.....30 Douglas St.
Egnatz, Nicholas.....820 Highland
Elledge, Ray.....6415 Forest Ave.
Elstun, Wesley B.....5231 Hohman Ave.
Farquhar, John S., Jr.....6827 Magoun
Fischer, Burnell.....5217 Hohman Ave.
Fitzpatrick, William J.....30 Douglas St.
Foster, Douglas L.....6010 Columbia Ave.
Fox, Jack.....236 169th St.
Friedman, Isadore E.....7217 Indianapolis Blvd.
Gevirtz, Milton B.....6850 Hohman Ave.
Hickman, A. Lee.....7127 Indianapolis Blvd.
Hopkins, Joseph R.....430 Conkey
Howard, William Harry.....5231 Hohman Ave.
Husted, Robert G.....6850 Hohman Ave.
Jones, Eli S.....30 Douglas St.
Kenney, Francis D.....30 Douglas St.
Kolanko, Leon A.....30 Douglas St.
Koransky, David S.....7217 Indianapolis Blvd.
Kuhn, Arthur J.....112 Rimbach St.
Kuhn, Hedwig S.....112 Rimbach St.
LaFollette, Forrest R.....7016 Indianapolis Blvd.
Lautz, Herbert A.....112 Rimbach St.
Long, Keith.....30 Douglas St.
McVey, Clarence A.....5231 Hohman Ave.
Mansueto, Mario D.....5231 Hohman Ave.
Marcus, Emanuel.....7127 Indianapolis Blvd.
Marks, Salvo P.....30 Douglas St.
Mason, Richard L.....132 Rimbach St.
Mintz, Alfred M.....5217 Hohman Ave.
Modjeski, Joseph R.....5451½ Hohman Ave.
Neal, Leonard W.....6850 Hohman Ave.
Nodinger, Louis.....540 165th St.
Palmer, Barron M. F.....6134 Columbia
Panares, Solomon V.....5434 Hohman Ave.
Peck, Edward A.....430 Conkey St.
Peiffer, Geraldine M.....5217 Hohman Ave.
Pilot, Jean.....5231 Hohman Ave.
Portney, Fred R.....6850 Hohman Ave.
Premuda, Franklin F.....6727 Kennedy Ave.
Ramker, Daniel T.....7040 Kennedy Ave.
Rasch, George C., Jr.....8148 Calumet
Rawlins, Carolyn M.....6223 Hohman Ave.
Remich, Antone C.....30 Douglas St.
Rendel, Donald T.....5231 Hohman Ave.
Rhind, Alexander W.....422 Conkey St.
Rosenthal, Carl.....St. Margaret's Hospital
Rosevear, Henry J.....30 Douglas St.
Row, Perrie Q.....7217 Indianapolis Blvd.
Rubright, Robert L.....7025 Monroe St.
Santare, Vincent J.....5231 Hohman Ave.
Santiago, Carmen.....5217 Hohman Ave.
Santiago, Iluminada.....2804 Duluth
Sargent, Wallace B.....112 Rimbach
Schlesinger, Daniel J.....6850 Hohman Ave.
Schulfer, Richard J.....7134 Calumet Ave.
Skrentny, Stanley H.....5231 Hohman Ave.
Smith, Jerald E.....6850 Hohman Ave.
Solis, Roger V.....422 Conkey
Sroka, Alexander G.....5305 Hohman Ave.
Stasick, Murray.....837 169th St.
Stern, Samuel L.....5231 Hohman Ave.
Stevens, Edwin W.....6850 Hohman Ave.
Tilka, Edward C.....7134 Calumet
Trachtenberg, Lee.....112 Rimbach
Weissman, Charles G.....5246 Hohman Ave.
Westhaysen, Peter.....6223 Hohman Ave.
White, Gilbert H., Jr.....6429 Kennedy Ave.
Wong, Samuel N.....7127 Indianapolis Blvd.

Highland

Sroka, Stanley J.....2942 Highway Ave.

Hobart

Bjorklund, C. Ray.....295 S. Wisconsin St.
Bradley, Charles F.....701 W. Ridge Rd.
Carter, John O.....295 S. Wisconsin St.
Faulkner, Donald J.....295 S. Wisconsin St.
Kellar, Philip E.....295 S. Wisconsin St.
Klos, Stanley J.....10 N. Michigan Ave.
Krsek, Archie J.....10 N. Michigan Ave.
Markle, Joseph G.....201 Main St.
Parker, Harry C. (S).....831 Garfield St.
Pike, Warren H.....108 E. Third St.
Reed, John.....10 N. Michigan Ave.
Smith, Robert D.....295 S. Wisconsin St.
Weiss, John T.....295 S. Wisconsin St.

Lowell

Mirro, John A.....317 E. Commercial
Templin, David B.....308 E. Commercial

Munster

Arbeiter, Herbert I.....7550 Hohman Ave.
Espino, Jose C.....8144 Calumet Ave.
Lanman, John U.....8146 Calumet Ave.
Larrabee, James F.....130 Ridge Road
McLean, James S.....1836 Ridge Road
Rudolph, Franklin G.....7550 Hohman Ave.

Whiting

Becker, Samuel W.....1900 Indianapolis Blvd.
Best, Robert C.....1900 Indianapolis Blvd.
Ferry, John L.....1902 Indianapolis Blvd.
Frankowski, Clementine E.....1907 New York Ave.
Greisen, Jack G.....1902 Indianapolis Blvd.
Gustaitis, John W.....1900 Indianapolis Blvd.
Kaiser, George D.....1900 Indianapolis Blvd.
Kudele, Louis T.....1321 119th St.
McCarthy, Jeremiah A.....1341 119th St.
Navarre, Vincent J.....1900 Indianapolis Blvd.
Rudser, Donald H.....1902 Indianapolis Blvd.
Silvian, Harry A.....1400 119th St.
Smith, Theodore J.....1902 Indianapolis Blvd.
Sokol, Allen B.....1900 Indianapolis Blvd.
Stecy, Peter.....1902 Indianapolis Blvd.
Steen, Lowell H.....1900 Indianapolis Blvd.
Troy, Jack M.....1900 Indianapolis Blvd.
Weinberg, Benjamin A.....1346 119th St.

Bolin, John T. (S).....Mountain Home, Arkansas
Detrick, Herbert W. (S)
4845 Northwood Avenue, Sarasota, Fla.
Gill, John R.....St. Luke's Hosp., Denver, Colo.
McMichael, Frank J. (S)
Box 227, Hernando, Florida
Murphy, Joseph F...3508 Ridge Rd., Lansing, Ill.
Nixon, Richard R.....6212th USAF Disp.,
APO 160, San Francisco, Calif.
Polite, Nicholas L.
Cook Co. Hospital, Chicago, Illinois
Seyler, Anna G. .....2780 Hillcrest Dr.,
La Verne, Calif.
Shafer, Sid J.
55 E. Washington St., Chicago, Ill.
Tyrrell, Joseph J.....V. A. Hosp., West Side Hosp.,
820 Damen, Chicago, Ill.
Tyrrell, Thomas C.
800 State Line, Calumet City, Ill.

LA PORTE COUNTY

Oak, David, Jr.....Hanna
Oak, David D. (S).....LaCrosse

La Porte

Backer, George P.....806 Maple Ave.
Backer, Mary B.....1533 Michigan Ave.
Carpentier, James R.....903 Indiana Ave.
Carter, Fred S.....912 Indiana Ave.
Cartwright, Jack D.....1003 Indiana Ave.
Datzman, Basil J.....216 E Street
Durham, Lowell J.....1012 Harrison St.
Elshout, Clem H.....1004 Indiana Ave.
Erwin, W. Robert.....216 "E" St.
Fargher, Robert A.....811 Jefferson Ave.
Farnsworth, Samuel A.....1012 Michigan Ave.
Feinn, Harry S.....1013 Indiana Ave.
Fischer, Carlton N.....1001 Maple Ave.
Jones, Robert B. (S).....1515 Indiana Ave.
Kelsey, Robert M.....702 Maple Ave.
Kepler, Robert W.....708 Harrison St.
Kistler, James J.....911 Maple Ave.
Larson, Goyt O.....1110 Indiana Ave.
Mead, Frank E.....801 Madison St.
Mueller, Edwin C.....905 Indiana Ave.
Muhleman, Charles E.....901 Indiana Ave.
Philbrook, Seth S.....705 Harrison St.
Predd, Adolph C.....909 Madison St.
Richter, John C.....1110 Indiana Ave.
Scott, John S.....806 Maple Ave.
Tabaka, Francis B.....1201 Michigan Ave.
Von Asch, George.....912 Monroe St.
Wolf, William E.....102 Lincoln Way

Michigan City

Armstrong, Thomas D.....120 W. Ninth St.
Arney, Amos.....125 E. Fifth St.
Baker, Warren.....427 Warren Bldg.
Bankoff, Milton L.....125 E. Fifth St.
Bergan, Joseph A.....719 Franklin
Berkson, Myron E.....801 Washington St.
Brooks, Harry L.....100 Beverly Court
Burris, Floyd L.....731 Spring St.
Carlson, Norman R.....913 Wabash St.
Cleveland, John B.....117 W. Seventh St.
Fargher, Francis M.....907 Washington St.
Frost, Robert J.....817 Pine St.
Gardner, Melvin D.....801 Washington St.
Gardner, Russell A.....801 Washington St.
Gilmore, Robert W.....304 Warren Bldg.
Gilmore, Russell A.....304 Warren Bldg.
Grotts, Bruce F.....2110 Oriole Trail, Long Beach
Henderson, Norman C.....131 E. Eighth St.
Hillenbrand, Charles.....128 W. 10th St.
Jones, King S.....328½ Franklin St.
Kemp, John T.....122 E. Seventh St.
Kerr, Charlotte H.....Warren Bldg.
Kerr, John E.....507 Warren Bldg.
Kerrigan, John F.....916 Washington St.
Kubik, Francis J.....902 Pine St.
Liddell, Charles K.....916 Washington St.
Marske, Robert L.....311-13 Warren Bldg.
McGue, Frank J.....P. O. Box 41
Miller, Maurice.....125 E. Fifth St.
Milne, Walter S.....916 Washington St.
O'Brien, Raymond J.....1412 Franklin St.
Olson, William H.....P. O. Box 41
Paul, Leonard G.....506 Pine St.
Phillips, John H.....120 W. Ninth St.
Pilecki, Peter J.....125 E. Fifth St.
Plank, C. Robert.....732 E. Pine St.
Reed, Nelle C. (S).....3210 Tilden Ave.
Schmitt, Robert J.....2020 Goldengate Dr.
Stumer, Myer.....1412 Franklin St.
Taub, Robert G.....125 E. Fifth St.
Walters, William H.....Warren Bldg.
Warren, Lewis T.....2936 Belle Plaine
Weeks, Patrick H. (S).....119 E. Sixth St.
Weiss, Albert E.....125 E. Fifth St.
Zalac, Donald A.....723 Pine St.

Weinstock, Adolph.....Rolling Prairie
Moosey, Louis.....Union Mills
Benz, Owen F.....Wanatah

Westville

Caplin, Samuel S.....Beatty Memorial Hospital
Hetman, Mitchell J.....Westville
Johnston, Donald D. (S)
Beatty Memorial Hospital
Morton, David P.....Beatty Memorial Hospital
Oster, Jack H.....Beatty Memorial Hospital
Sennett, Cecil M.....Beatty Memorial Hospital
Smith, William M.....Beatty Memorial Hospital
Syler, Robert W.....Beatty Memorial Hospital
Tasher, Dean C.....Beatty Memorial Hospital
Wygant, Marion D.....Beatty Memorial Hospital

LAWRENCE COUNTY

Bedford

Allen, L. Howard.....1622 24th St.
Austin, Richard P.....209 Citizens Nat'l Bank Bldg.
Benham, Lawrence E.....310 Stone City Bank Bldg.
Bridwell, Edgar.....1626 24th St.
Campbell, William T.....2900 W. 16th St.
Duncan, Raymond.....2900 W. 16th St.
Dusard, Joseph C.....304 Citizens Nat'l Bank Bldg.
Edmonds, Kendrick.....1303 15th St.
Emery, Charles B.....1027 15th St.
Fountaine, Thomas J.....2900 W. 16th St.
Greer, William.....2900 W. 16th St.
Hammel, Howard T.....1501 J St.
Hawkins, Richard D.....2900 W. 16th St.
Kasting, Gerald.....206 Citizens Nat'l Bank Bldg.
Kerr, Donald M.....2900 W. 16th St.
Morrow, Robert J.....1317 L St.
Newland, Arthur E.....Masonic Temple
Noe, William R.....2900 W. 16th St.
Robinson, William H.....2900 W. 16th St.
Scherschel, John P.....1711 H St.
Waldo, Guy H.....2900 W. 16th St.
Wohlfeld, Julius B.....1222 15th St.
Woolery, Richard H.....1310 W. 16th St.
Wynne, Roland E. (S).....1310 W. 16th St.

Lutes, David L. (S).....R. #1, Heltonville
Hamilton, James R.....Mitchell
Oswalt, James T.....Mitchell
Dollens, Claude (S).....Oolitic

MADISON COUNTY

Alexandria

Gaunt, Everett W.....214 E. John
Leroy, Alvin G.....1309 N. Harrison St.
McClelland, Harry N.....118 E. Church St.
Overpeck, George H.....313 N. Harrison St.
Shafer, Richard H.....111 S. Harrison St.

Anderson

Aagesen, Walter J.....702 Citizens Bank Bldg.
Armington, Charles L.....655 Anderson Bank Bldg.
Armington, Robert L.....1504 Broadway
Austin, Charles E.....1612 Westwood Ave.
Ayres, Kenneth D.....2210 Meridian St.
Baughn, William L.....Guide Lamp
Beeler, Franklin K.....1931 Brown St.
Bixler, Donald P.....1931 Brown St.
Blassaras, Chris.....2005 Broadway
Bowers, Charles R.....207 Anderson Loan Bldg.
Brauchla, Carl H. (S).....117 W. 17th St.
Bridges, Alvin.....1302 Madison Ave.

Brock, Earl E. (S).....931 Meridian St.
Brown, James M.....12 W. 29th St.
Buckles, David L.....St. John's Hospital
Dixon, Rex W.....934 W. 8th St.
Doenges, James L.....1931 Brown St.
Donaldson, Frank C.....1931 Brown St.
Drake, James R.....229 Citizens Bank Bldg.
Drake, John C.....604 Anderson Bank Bldg.
Drennen, Robert V.....318 Rangeline Road
Dulin, Basil B.....St. John's Hospital
Ellis, Seth W.....717 Anderson Bank Bldg.
Elsten, Aubrey W.....512 Anderson Bank Bldg.
Erehart, Archie D.....714 Anderson Bank Bldg.
Faust, Howard M., Jr.....315 Anderson Bank Bldg.
Ferguson, Donald H.....402 Anderson Bank Bldg.
Fischer, Warren E.....St. John's Hospital
Gante, Henry W. (S).....2005 Nichol Ave.
Hart, William D.....126 W. 12th St.
Hensler, Benton M.....1709 Nichol Ave.
Irwin, Seth (S).....2209 Cedar St.
Jarrett, Paul E.....315 Citizens Bank Bldg.
Jones, Albert T.....1307 Park Road
Jones, David G.....126 W. 12th St.
Kelly, Wendell C.....704 E. Eighth St.
Kiely, John T.....1931 Brown St.
King, Joseph W.....1110 N. Meridian St.
Kopp, Otis A.....333 Jackson St.
Kopp, William R.....333 Jackson St.
Lamey, James L.....447 Citizens Bank Bldg.
Lamey, Paul T.....423 Citizens Bank Bldg.
Larmore, Joseph L.....612 Anderson Bank Bldg.
Larmore, Sarah H.....1301 Winding Way
Litzenberger, Sam W.....610 Citizens Bank Bldg.
Long, Paul L.....710 Anderson Bank Bldg.
McDonald, Vergil G. (S).....1110 Meridian St.
Meister, Doris (S).....315 W. 9th St.
Moneyhun, James E.....621 Citizens Bank Bldg.
Morris, Robert A.....1309 Park Road
Neale, Alfred E.....1931 Brown St.
Nelson, Paul L.....330 W. Seventh St.
Nesbit, Leonard L.....415 Citizens Bank Bldg.
Patterson, William K.....713 Anderson Bank Bldg.
Polhemus, Warren C.....1803 Pearl St.
Quickel, Daniel S. (S).....608 Central Way
Reed, Roger R.....412 Anderson Bank Bldg.
Rosenbaum, Lloyd E.....647 Citizens Bank Bldg.
Ross, Guy E.....1931 Brown St.
Rozelle, Clarence V.....611 Citizens Bank Bldg.
Sharp, William L.....449 Citizens Bank Bldg.
Sheldon, Suel A.....508 Anderson Bank Bldg.
Stamper, Joseph H.....412 Anderson Bank Bldg.
Stamper, Robert J.....412 Anderson Bank Bldg.
Starks, William O.....507 Citizens Bank Bldg.
Stinson, William M.....333 Jackson St.
Swan, Richard C.....Delco Remy
Wagoner, John R.....708 Anderson Bank Bldg.
Webb, Harry D.....515 Citizens Bank Bldg.
Weiss, Louis L.....1225 N. Madison
Wilder, Gordon B.....338 W. Eighth St.
Williams, Francis M.....1132 Central Ave.
Williams, Robert H.....1132 Central Ave.

Stump, Richard L.....Chesterfield

Elwood

Buechler, William F.....1817 S. A St.
Drake, Marion C.....1201 Main St.
Fitzpatrick, Harry W. (S)...1309 S. Anderson St.
Hanson, Martin F.....1102 S. Anderson St.
Hoppenrath, Wesley M.....1300 Main St.
Hoppenrath, William H. (S).....1300 Main St.
Laudeman, Walter A.....1515 N. A St.
Oldag, George E.....1301½ Main St.
Ploughe, Ralph R.....517 S. Anderson St.
Scea, Wallace A.....1300 Main St.
Ulrey, Robert P.....1201 Main St.

Bishop, Harry A.....Frankton
Ridgway, Alton H.....Lapel
Rinne, John I. (S).....Lapel
Williams, Robert D.....Markleville
Advincula, Luis .....Box 28, Pendleton
Bogmenko, Leon T.....Box 28, Pendleton
Leahy, Howard J.....103 E. State St., Pendleton
McLaughlin, Calvin P.
200 W. State St., Pendleton
Van Ness, William C.....Summitville

MARION COUNTY

Beech Grove

Berger, Morley.....902 Main St.
Christie, Marvin C.....3655 S. Sherman Dr.
Dill, Charles W.....3655 S. Sherman Dr.
Kim, Young D.....136 N. 17th St.
Ramage, Walter F.....244 S. First St.
Reilly, Eva F.....St. Francis Hospital
Rhea, James C.....801 Main St.
Zerfas, Charles P. A.....926 Main St.

Hade, Frederick L. (S).....Bridgeport
Johnson, William F. (S)....201 Main St., Clermont
Zerfas, Leon G.....R. R. 1, Camby
Garrison, James L..11890 Welland St., Cumberland

Indianapolis

A

Abreu, Benedict E.
Pitman-Moore Co., 1200 Madison Ave. (6)
Adams, Daniel S. (S)..520 Hume Mansur Bldg. (4)
Addleman, Robert H.....5540 Woodside Dr. (8)
Adkins, Harold C.....409 E. 30th St. (5)
Albertson, Frank P.....3544 W. 16th St. (22)
Aldrich, Harry D.....201 Hume Mansur Bldg. (4)
Aldrich, Howard.....4316 E. Washington St. (1)
Alexander, Ezra D.....617 Indiana Ave. (2)
Allen, Robert K.....3202 N. Meridian St. (8)
Alvis, Edmond O.....320 Hume Mansur Bldg. (4)
Anderson, James W.....623 N. West St. (2)
Anderson, John T.....3349 Georgetown Rd. (24)
Anderson, Wendell C.
Indiana State Board of Health,
1330 W. Michigan St. (7)
Anshutz, William M...313 Hume Mansur Bldg. (4)
Antreasian, Berj .....4829 E. 38th St. (18)
Appel, Richard H.....320 Hume Mansur Bldg. (4)
Arbogast, John L.....I. U. Medical Center (7)
Arbuckle, William E. (S)....1150 S. Sheffield (21)
Armer, Robert M.....Riley Hospital (7)
Arnold, Aaron L.....607 E. 38th St. (5)
Arnold, Robert D.....3419 E. 10th St. (1)
Aronson, Sidney S.....618 Hume Mansur Bldg. (4)
Aust, Charles H.....1119 N. Linwood (1)
Avery, George O.....17 S. Traub (22)

B

Bacastow, Merle S.....Methodist Hospital (7)
Bachmann, Arnold J.....3440 N. Meridian St. (8)
Baird, Melvin S.....17½ W. 22nd St. (2)
Bakemeier, Otto H. .5503 E. Washington St. (19)
Bakemeier, Robert E.
Marion Co. General Hospital (7)
Balch, James F.....709 Hume Mansur Bldg. (4)
Ball, Joseph E.....4312 E. 10th St. (1)
Banister, Revel F. (S).....2958 Central Ave. (5)
Banks, Horace M.....Methodist Hospital (7)
Baptisti, Arthur Jr.
Marion Co. General Hospital (7)
Barden, Tom P. Marion Co. General Hospital (7)
Barry, Maurice J. (S).....501 Doctors' Bldg. (4)
Bartle, James L.....7450 Pendleton Pike (26)
Bartley, Max D.....607 Hume Mansur Bldg. (4)

Bastnagel, William F....3602 N. Meridian St. (8)
Batman, Gordon W...723 Hume Mansur Bldg. (4)
Battersby, J. Stanley....I. U. Medical Center (7)
Batties, Paul A.....617 Indiana Ave. (2)
Bauer, Thomas B.....408 Hume Mansur Bldg. (4)
Baumeister, Herbert E....314 W. Hampton Dr. (8)
Baxter, John P.....1633 N. Capitol Ave. (2)
Beach, Robert R.....2630 E. 10th St. (1)
Beamer, Parker R. .....I. U. Medical Center (7)
Beaver, Howard W.....8 E. Troy (3)
Beck, Evart M.....915 E. 38th St. (5)
Becker, Harry G. .....6060 College Ave. (20)
Beeler, John W. ...712 Hume Mansur Bldg. (4)
Beeler, Raymond C. (S)
712 Hume Mansur Bldg. (4)
Behnke, Roy H....VA Hosp., 1481 W. 10th St. (7)
Belshaw, George.....5317 E. 16th St. (18)
Belt, James H.....6225 Broadway (20)
Benedict, Paul F.....3939 Meadows Dr. (5)
Bennett, Ivan F.
Lilly Clinic, Marion Co. General Hospital (7)
Berman, Edward J...920 Hume Mansur Bldg. (4)
Berman, Jacob K.....920 Hume Mansur Bldg. (4)
Beverland, Malon E. (S)
3036 E. Washington St. (1)
Bibler, Lester D.....811 Underwriters Bldg. (4)
Bill, Robert O.....2901 N. Meridian St. (8)
Bird, Charles R. (S) 301 Hume Mansur Bldg. (4)
Black, Henry R...Marion Co. General Hospital (7)
Blackford, Florence.....5909 E. 10th St. (19)
Blackford, Ralph E.....5909 E. 10th St. (19)
Blackwell, Donald S.. ....2121 Allison Ave. (24)
Blake, Albert L.....1802 N. Illinois St. (2)
Blatt, A. Ebner.....3400 N. Meridian St. (8)
Bloemker, Edward F.....2729 Shelby St.(3)
Boggs, Eugene F.....2901 N. Meridian St. (8)
Boling, Grover C., Jr.....1440 E. 46th St. (5)
Bond, George S. (S)....1221 N. Delaware St. (2)
Bond, Virginia.....3236 W. 34th St. (22)
Bond, William H..... I. U. Medical Center (7)
Bonsett, Charles A.....902 Hume Mansur Bldg. (4)
Booher, Norman R.....447 E. 38th St. (5)
Booher, Olga Bonke.....447 E. 38th St. (5)
Booker, Harold E.....Riley Hospital (7)
Booth, Boynton H....707 Hume Mansur Bldg. (4)
Booze, James.....Marion Co. General Hosp. (7)
Bowers, George W. .....Methodist Hospital (7)
Bowman, George W. (S).....1101 W. 10th St. (7)
Boyer, Floyd A.....442 N. Drexel Ave. (1)
Boyer, Philip A.
Pitman-Moore Co., 1200 Madison Ave. (6)
Brady, Thomas A.....818 Hume Mansur Bldg. (4)
Brayton, John R.....704 Underwriters Bldg. (4)
Brayton, Lee.....3342 N. Illinois St. (8)
Brickley, Richard A...605 Hume Mansur Bldg. (4)
Briggs, Robert W.....2140 N. Capitol (2)
Brillhart, James R. .....I.U. Medical Center (7)
Brodie, Donald W. .....817 C. of C. Bldg. (4)
Brooks, Fred R., Jr.....Methodist Hospital (7)
Brown, Archie E.....1220 S. Belmont Ave. (21)
Brown, David E.....1944 N. Capitol Ave. (2)
Brown, DeWitt W.....1633 N. Capitol Ave. (2)
Brown, Frances T.....2126 N. Talbot Ave. (2)
Brown, Frank M.....2875 Clifton (23)
Brown, Gordon T.....1949 E. 11th St. (1)
Brown, Thomas C.....Methodist Hospital (7)
Brown, Wendell E.....3426 N. Meridian St. (8)
Browning, James S.....2901 N. Meridian St. (8)
Browning, William M.....3740 Central Ave. (5)
Brownley, Emma J.....5101 W. 13th St. (24)
Bruce, Reginald A.....848 Indiana Ave. (2)
Brueckman, F. Robert
Marion Co. General Hospital (7)
Bruetsch, Walter L...3000 W. Washington St. (22)
Bunde, Carl A.
Pitman-Moore Co., 1200 Madison Ave. (6)
Burdette, Harold F.....3202 N. Meridian (8)
Burghard, Rolla D.....4829 E. 38th St. (18)
Burkle, Robert J.....I. U. Medical Center (7)
Butler, John O.....234 E. Southern Ave. (25)
Butler, Robert M.....3426 N. Meridian St. (8)

C

Cahn, Hugo M.....418 E. 30th St. (5)
Caldwell, Marilyn R.....111 E. 53rd St. (20)
Call, Herbert F.....2901 N. Meridian (8)
Calvert, John H., Jr.....5202 N. Illinois St. (8)
Campbell, H. Edwin, Jr. St. Vincent's Hospital (7)
Campbell, John A. .....I. U. Medical Center (7)
Campbell, Robert L.....1100 W. Michigan St. (7)
Canaday, James W. (S)....5154 Central Ave. (5)
Cantwell, Edgar R.....St. Vincent's Hospital (7)
Capestany, Max A.....St. Vincent's Hospital (7)
Caplin, Irvin.....3120 N. Meridian St. (8)
Carson, Wayne.....1802 N. Illinois St. (2)
Carter, Oren E.....668 E. 38th St. (5)
Chattin, William R.....4829 E. 38th St. (18)
Chen, Ko Kuei
Eli Lilly & Co., 740 S. Alabama St. (6)
Chernish, Stanley M.
Marion Co. General Hospital (7)
Chevalier, Robert A.
Marion Co. General Hospital (7)
Childress, Richard H.....I. U. Medical Center (7)
Childress, Robert C. ....I. U. Medical Center (7)
Chivington, Paul V...407 Hume Mansur Bldg. (4)
Christiansen, Philip A.
V. A. Hosp., 1481 W. Tenth St. (7)
Chroniak, Walter.....5508 E. Washington St. (19)
Clark, Cecil P.....922 Hume Mansur Bldg. (4)
Clark, Lawson J.....3736 N. Delaware St. (5)
Clevinger, William G.....1610 Auburn St. (24)
Close, Gerald A.....Methodist Hospital (7)
Close, W. Donald.....I. U. Medical Center (7)
Coade, George E.....I. U. Medical Center (7)
Coates, Jacqueline.....2060 N. Senate Ave. (2)
Coble, Ralph R. (S).....3311 N. Meridian St. (8)
Coddington, Robert C.
V. A. Hospital, 1481 W. 10th St. (7)
Coggeshall, Warren E.
1015 Hume Mansur Bldg. (4)
Cohn, Alvin F.....1120 Southview Dr. (27)
Collins, Hubert L.....985 N. Arlington Ave. (19)
Collins, Robert C.....3414 Clifton (23)
Conley, Joseph L. (S)..2443 E. Washington St. (1)
Conway, Chester C.....4402 E. New York St. (1)
Conway, Glenn.....1620 S. East St. (25)
Cornacchione, Matthew.....814 S. East St. (25)
Cortese, James V.....435 S. East St. (25)
Cortese, Thomas A.....435 S. East St. (25)
Coughenour, J. Robert....2809 S. Holt Road (41)
Countryman, Frank W....3233 N. Meridian St. (8)
Cox, Clifford E. (S).....R. R. 14, Box 811 (20)
Craft, Kenneth L.....1002 Hume Mansur Bldg. (4)
Craig, Harry L.....Methodist Hospital (7)
Crawford, John A.....321 Hume Mansur Bldg. (4)
Cross, David G.....1002 Troy Ave. (3)
Culbertson, Clyde G.
Eli Lilly & Co., 740 S. Alabama St. (6)
Cullen, Paul K.....422 Hume Mansur Bldg. (4)
Culloden, William G.....710 E. 46th St. (5)
Culmer, Walter N. (S)
3541 N. Meridian St., #204 (8)
Cunningham, Gene C.
Eli Lilly & Co., 740 S. Alabama St. (6)
Cure, Charles W.....315 Hume Mansur Bldg. (4)
Currie, Robert W.....512 E. 57th St. (20)
Curry, R. Louis.....3375 Forest Manor (18)
Cuthbert, Marvin P.....3400 N. Meridian (8)
Czenkusch, Helen G.....5101 W. 13th St. (24)

D

Daley, Edward H.....1502 N. Emerson (18)
Dallas, Fred R.....5317 E. 16th St. (18)
Dallas, Mary E.
V. A. Hospital, 1481 W. 10th St. (7)
Dalton, John E...Marion Co. General Hospital (7)

Dalton, William W.....422 Hume Mansur Bldg. (4)
Daly, Joseph M.....234 E. Southern Ave. (25)
Daniel, John C.....1008 Hume Mansur Bldg. (4)
Dann, Morton W.....I. U. Medical Center (7)
Davidson, Dale A.....1802 N. Illinois St. (2)
Davidson, N. Cort.....3233 N. Meridian St. (8)
Davis, John A.....3720 N. Sherman Dr. (18)
Davis, Margaret M.....3202 N. Medford Ave. (22)
Davis, Sam J.....908 Hume Mansur Bldg. (4)
Deal, Eleanor H..4909 W. 15th St. Speedway (24)
Dearmin, Robert M.....3233 N. Meridian St. (8)
DeArmond, Murray...723 Hume Mansur Bldg. (4)
Deever, John W.....4131 Shelby St. (3)
Deitch, Robert D.....4214 Carrollton Ave. (5)
DeMotte, C. Bowen.....808 C. of C. Bldg. (4)
Dennison, Alfred D., Jr...3400 N. Meridian St. (8)
Denny, Forrest L.....3351 W. 10th St. (22)
Denny, James W.....25 N. Ritter Ave. (19)
Des Jean, Paul A.....4301 E. 38th St. (18)
DeWees, Dwight L.....302 N. Bradley Ave. (1)
Dickson, Carolyn L.....501 N. West St. (2)
Dill, Myron K.....3120 N. Meridian St. (8)
Dilts, Robert L.....2521 E. 38th St. (18)
Dintaman, Paul G.....703 Hume Mansur Bldg. (4)
Dluzansky, James J.....I. U. Medical Center (7)
Donahue, James M.
Marion Co. General Hospital (7)
Donato, Albert N.....1429 Shelby St. (3)
Doneff, Ronald H..Marion Co. General Hospital (7)
Donnelly, Everett F.....8651 Cholla Rd. (20)
Doran, J. Hal.....720 Hume Mansur Bldg. (4)
Dorman, Willis L.....6430 E. Washington St. (19)
Doss, Jerome F...Marion Co. General Hospital (7)
Doty, James R. Jr.
Marion Co. General Hospital (7)
Doughty, Samuel R., Jr.
5817 N. Dearborn St. (20)
Dowd, Joseph A.....6177 College Ave. (20)
Drew, Arthur L. Jr.....I. U. Medical Center (7)
Dryden, Gale E.....5835 N. Tacoma (20)
Dugan, William M.....410 Hume Mansur Bldg. (4)
Duncan, Stuart J.
Marion Co. General Hospital (7)
Dupes, Lowell E.
V. A. Regional Office, 36 S. Penn. St. (4)
Dupler, Lee F. W.....I. U. Medical Center (7)
Dyar, Edwin W.....3202 N. Meridian St. (8)
Dyke, Richard W..Marion Co. General Hospital (7)

E

Earp, Evanson B.....717 Hume Mansur Bldg. (4)
Eastman, Joseph R., Jr.
514 Merchants National Bank Bldg. (4)
Eaton, Edwin R.....5505 N. Keystone Ave. (20)
Eaton, Lyman D.....5505 N. Keystone Ave. (20)
Ebert, J. Wayne.....1125 Southview Dr. (27)
Eberwein, John H. (S).....2322 Wheeler Ave. (18)
Egbert, Herbert L.....5317 E. 16th St. (18)
Eicher, Palmer O.....3400 N. Meridian St. (8)
Eikenberry, Hugh W...616 Bankers Trust Bldg. (4)
Eldridge, Gail E.....1440 E. 46th St. (5)
Elkins, James P.....234 E. Southern Ave. (25)
Ellis, William N.....1402 N. Olney St. (1)
Emhardt, John T.....1621 S. East St. (25)
Emhardt, John W. A. (S)
5424 Washington Blvd. (20)
Ensminger, Leonard A. (S)
1321 N. Meridian St. (2)
Evans, Frederick H.....2140 N. Capitol (2)
Evans, Paul V.....Marion Co. General Hospital (7)
Everly, Ralph V.....668 E. 38th St. (5)

F

Failey, Robert B.....I. U. Medical Center (7)
Farrell, Joseph T.....2807 E. Michigan St. (1)
Fausset, C. Basil.....2901 N. Meridian St. (8)
Ferry, Francis A.....1429 Shelby St. (3)
Fiedler, Howard W.....I. U. Medical Center (7)
Fields, Donald L.....I. U. Medical Center (7)
Fine, Nathaniel J.....764 S. Emerson Ave. (3)
Finneran, Joseph C.....1802 N. Illinois St. (2)
Fisch, Charles....Marion Co. General Hospital (7)
Fischer, Albert A.....1745 Howard St. (21)
Fisher, Frank C...Marion Co. General Hospital (7)
Fitzgerald, William J.
303 Fountain Square Theatre Bldg. (3)
Flanagan, Paul M.....3311 N. Meridian St. (8)
Flanders, Robert J.....3202 N. Meridian St. (8)
Flanigan, Meredith B.....3305 Rutledge (8)
Fleischl, Herbert.....Central State Hospital (22)
Flick, John J.....1443 N. Pennsylvania St. (2)
Flora, Joseph O.....4317 W. Washington St. (21)
Folkening, Norval C.....234 E. Southern Ave. (25)
Forbes, Robert S.....3043 S. Holt Rd. (4)
Forry, Frank (S).....I. U. Medical Center (7)
Fortuna, Frank W.....5602 S. Madison Ave. (27)
Fosgate, Harold L.....1131 N. Lesley (19)
Foster, Lee N.....St. Vincent's Hospital (7)
Foster, Ray D.....1944 N. Capitol Ave. (2)
Fouts, Dallas B.....I.U. Medical Center (7)
Fouts, Paul J.....623 Hume Mansur Bldg. (4)
Franklin, William L....508 Hume Mansur Bldg. (4)
Freed, Carl A.....2966 Kessler Blvd., N. Dr. (22)
Freeman, Jerry A.
Marion Co. General Hospital (7)
Freeman, Leslie W.....I. U. Medical Center (7)
Freeman, Max E.....1745 Howard St. (21)
French, Richard N.....I. U. Medical Center (7)
Fromhold, Willis A....611 Bankers Trust Bldg. (4)
Fry, Robert D.....517 Hume Mansur Bldg. (4)
Funkhouser, Elmer (S).702 Underwriters Bldg. (4)

G

Gabovitch, Edward R.
Marion Co. General Hospital (7)
Gachaw, Gabra S.
V. A. Hospital, 1481 W. 10th St. (7)
Gaddy, Euclid T.....2602 W. Washington St. (22)
Gaddy, Nelson D.....2602 W. Washington St. (22)
Gambill, William D.....1633 N. Capitol Ave. (2)
Gammieri, Robert L.....661 E. 49th St. (5)
Garber, J. Neill.....806 Hume Mansur Bldg. (4)
Garceau, George J.....508 Hume Mansur Bldg (4)
Gard, Daniel A...Ford Motor Co., Box 19106 (19)
Gardiner, Sprague H.....I. U. Medical Center (7)
Gardner, Austin L.
Marion Co. General Hospital (7)
Gardner, Buckman.....St. Vincent's Hospital (7)
Garfield, Martin D.....3705 College Ave. (5)
Garner, W. Stanley..... 2911 E. 10th St. (1)
Garrett, John D. (S).....2523 Central Ave. (5)
Garrett, Robert A.....I. U. Medical Center (7)
Gatch, Willis D. (S)..605 Hume Mansur Bldg. (4)
Geider, Roy A.....1525 Prospect St. (3)
Genna, Mary E. Miller..I. U. Medical Center (7)
Genovese, Pasquale
V. A. Hospital, 1481 W. 10th St. (7)
George, Charles L.....I.U. Medical Center (7)
Gibson, Alois E.....St. Vincent's Hospital (7)
Gibson, Greta Maxine.5744 Broadway Terrace (20)
Gick, Herman H. (S)....2705 E. Michigan St. (1)
Gifford, Fred E.....710 Hume Mansur Bldg. (4)
Gillespie, Charles F.....3400 N. Meridian St. (8)
Gillespie, Jacob E.....523 Hume Mansur Bldg. (4)
Gillim, Parvin D.....I. U. Medical Center (7)
Ginsberg, Stewart T.....1315 W. Tenth St. (7)
Glendening, John L. (S)
7202 N. Meridian St. (20)
Godwin, Donald W.....Methodist Hospital (7)
Goldenberg, Norman S.....Coleman Hospital (7)
Goldman, Samuel.....1204 Oliver Ave. (21)
Gormley, Joseph J.....2369 Goodlet (23)
Gosman, James H.....2901 N. Meridian St. (8)
Graham, Edward W.
V. A. Hospital, 1481 W. 10th St. (7)
Graham, John D.....1802 N. Illinois St. (2)
Graham, William E.....St. Vincent's Hospital (7)

Gratz, Ray J. .....7899 Ridge Road (20)
Green, Morris .....Riley Hospital (7)
Green, Oscar .....504 Hume Mansur Bldg. (4)
Greene, Morgan E. .....1621 S. East St. (25)
Gregory, Robert L. .....Methodist Hospital (7)
Greist, John H. .....2901 N. Meridian St. (8)
Griffin, Leslie W. .....Allison Div., General Motors
Griffith, Richard S.
Lilly Clinic, Marion Co. General Hospital (7)
Griffith, Ross E. .....401 E. 34th St. (5)
Grimes, Hubert N. .....2809 E. Michigan St. (1)
Grisell, Ted L. .....5317 East 16th St. (18)
Gruber, Charles M.
Lilly Clinic, Marion Co. General Hospital (7)

H

Habegger, Elmer D. .....1802 N. Illinois St. (2)
Habich, Carl (S) .....703 Hume Mansur Bldg. (4)
Hadley, David .....702 Hume Mansur Bldg. (4)
Haggard, Edmund B. ....5914 N. Emerson Ave. (20)
Hall, Frank M. .....141 S. Meridian St. (25)
Hall, Jack H. .....Methodist Hospital (7)
Hall, William R. .....I. U. Medical Center (7)
Haller, Richard C. .....1727½ N. Talbott Ave. (2)
Hamer, Homer G. (S) ....1711 N. Capitol Ave. (7)
Hammond, James B.
Lilly Clinic, Marion Co. General Hospital (7)
Hampshire, Donald R. .1443 N. Pennsylvania St. (2)
Hancock, John G. .....2226 W. Michigan St. (22)
Hann, Eldon C. .....1633 N. Capitol Ave. (2)
Hanna, Thomas A. .....1608 N. Lynhurst Dr. (24)
Hansell, Robert M. ....6049 E. Washington St. (1)
Harcourt, Allan K. .....812 C. of C. Bldg. (4)
Harcourt, Robert S. .....I. U. Medical Center (7)
Harding, M. Richard ...308 Hume Mansur Bldg. (4)
Harding, Myron S. ....308 Hume Mansur Bldg. (4)
Hare, Earl H.
Indiana State Board of Health 1330 W. Michigan St. (7)
Hare, Laura .....404 Hume Mansur Bldg. (4)
Harger, Robert W. ....804 Hume Mansur Bldg. (4)
Harold, Albert H. (S) ...7510 Allisonville Rd. (20)
Harold, Norris E. (S) .....3545 N. Denny St. (18)
Harris, Carl B. .....319 Hume Mansur Bldg. (4)
Harris, Paul N.
Eli Lilly & Co., 740 S. Alabama St. (6)
Harshman, James A. .....I. U. Medical Center (7)
Harvey, Verne K., Jr.
Indiana State Board of Health 1330 W. Michigan (7)
Harvey, Verne K., Sr.
V. A. Hospital, 1481 W. Tenth St. (7)
Haslinger, Clarence J. ....2151 E. New York St. (1)
Hatfield, Jack J. .....5538 N. Keystone Ave. (20)
Hatfield, Nicholas W. .....2032 N. Rural St. (18)
Hawk, James H. .....3736 N. Delaware St. (5)
Hawtof, David B. .....I. U. Medical Center (7)
Hay, Gene R. .....1 Goya Court (24)
Haymond, George M.
Marion Co. General Hospital (7)
Haymond, Joseph L. .....301 E. 38th St. (5)
Haynes, John T. .....2626 W. Washington St. (22)
Hays, Everett L. .....2607 Manker Ave. (3)
Healey, Robert J. .....3602 N. Meridian St. (8)
Hedrick, Philip W. .....652 E. 54th St. (20)
Heimburger, Robert F. .....I. U. Medical Center (7)
Heinrichs, Harry H. (S) .....1225 Evison (3)
Helmen, Charles H. .....I. U. Medical Center (7)
Henderson, Francis G.
Eli Lilly & Co., 740 S. Alabama St. (6)
Henderson, Roscoe C. .3131 Northwestern Ave. (23)
Henderson, William P. .....I. U. Medical Center (7)
Hendricks, Fred A. .....6921 N. Keystone Ave. (20)
Hendricks, John W. .....911 Hume Mansur Bldg. (4)
Henry, Russell S. .....725 Hume Mansur Bldg. (4)
Hepburn, C. K. .....1633 N. Capitol Ave. (2)
Hetherington, Arthur M. (S)
4121 E. New York St. (1)
Hetherington, John A. ..1633 N. Capitol Ave. (2)
Heubi, John E. .....668 E. 38th St. (5)
Hickam, John B. .....I.U. Medical Center (7)
Hickman, Jack W. .....625 E. 38th St. (5)
Hickman, Walter F. (S) ....1210 Oliver Ave. (21)
Hicks, Murwyn L. .....1502 N. Emerson (19)
Hicks, Wilbur D. .....310 W. 40th St. (8)
Hill, James K. .....4701 W. 30th St. (24)
Hillery, Robert L. .....I. U. Medical Center (7)
Himler, James M. .....809 Underwriters Bldg. (4)
Hines, Don C.
Eli Lilly & Co., 740 S. Alabama St. (6)
Hodges, Fletcher (S) .....3160 N. Penn. St. (5)
Hoffman, Herman .....2439 Central Ave. (5)
Hofmann, J. William (S)
323 Hume Mansur Bldg. (4)
Holman, Jerome E., Sr. (S) ...3315 E. 10th St. (1)
Holman, Jerome E., Jr. .....3315 E. 10th St. (1)
Hood, Ainslee A. .....3205 Shelby St. (27)
Horwitz, Thomas .....421 Hume Mansur Bldg. (4)
Howard, William F. .....I. U. Medical Center (7)
Howell, Arthur .....2060 Boulevard Pl. (2)
Howell, Joseph D. .....760 Bankers Trust Bldg. (4)
Howell, Robert D. .....1802 N. Illinois St. (2)
Hoyt, Lester H. .....Methodist Hospital (7)
Hoyt, Millard L. .....612 Hume Mansur Bldg. (4)
Hubbard, Jesse D. .....I. U. Medical Center (7)
Huber, Carl P. .....I. U. Medical Center (7)
Huddle, John R. .....2963 N. Sherman Dr. (18)
Hudson, Foster J. .....3440 N. Meridian St. (8)
Hull, DeWayne L. .....I. U. Medical Center (7)
Hull, Ronald H. .....723 Hume Mansur Bldg. (4)
Hummons, Francis D. ..... 729½ N. West St. (2)
Hurt, Laverne B. .....635 E. Kessler Blvd. (20)
Hurteau, William W. .....Methodist Hospital (7)
Huse, William M. .....703 Hume Mansur Bldg. (4)
Hynes, Roy T. .....633 E. 38th St. (5)

I

Irwin, Glenn W., Jr. .....I. U. Medical Center (7)
Iske, Paul G. .....420 Hume Mansur Bldg. (4)

J

Jackson, Frederick E. (S) ..2125 N. Park Ave. (2)
Jackson, James W. (S) .....463 W. 32nd St. (8)
Jaeger, Alfred S. (S) ..3057 Washington Blvd. (5)
Jaquith, Orville S. (S) .....261 Blue Ridge Rd. (8)
Jay, Arthur N. .....3400 N. Meridian St. (8)
Jay, James .....I. U. Medical Center (7)
Jeffries, Kenneth I. (S) .....3433 Central Ave. (5)
Jenkins, Robert E. .....3311 N. Meridian St. (8)
Jennings, Frank L. (S)
V. A. Hospital, 1481 W. Tenth St. (7)
Jewett, Joe H. .....3120 N. Meridian St. (8)
Jobes, James E. .....110 N. Illinois St., #305 (4)
Jobes, Norman E. (S) .....4245 Knollton Rd. (8)
Johnson, Thomas W. .....1802 N. Illinois St. (2)
Jones, Allen W. .....6060 College Ave. (20)
Jones, David E. .....828 C. of C. Bldg. (4)
Jones, Francis P. .....4212 E. Michigan St. (1)
Jones, Gordon C. .....1517 N. Emerson (19)
Jones, Lawrence R. .....4525 W. 30th St. (24)
Joseph, Rex M. .....1615 S. East St. (25)
Jowitt, Richard H. .....1502 N. Emerson (19)
Judd, Donald R. .....I. U. Medical Center (7)
Judson, Walter E. .....I. U. Medical Center (7)

K

Kahler, Maurice V. .....2638 Kessler Blvd. (22)
Kahn, Alexander J. .....3120 N. Meridian St. (8)
Kahn, Howard L. .....3120 N. Meridian St. (8)
Kaiser, George C. .....I. U. Medical Center (7)
Kalb, Everett L. .....5934 E. 21st St. (18)
Kammen, Leo .....3202 W. 16th St. (22)
Kammen, Robert .....3202 W. 16th St. (22)
Karnafel, Eugene T.
Larue Carter Hospital, 1315 W. 10th St. (7)
Katterjohn, James C. ..313 Hume Mansur Bldg. (4)
Kauffman, Nelson N. .....2901 N. Meridian St. (8)

Keenan, George B. ..... 1743 Shelby St. (3)
Keenan, Reid L. ..... 615 Hume Mansur Bldg. (4)
Keever, Charles H. ..... 5214 College Ave. (20)
Keiser, Venice D. ..... 5709 Broadway (20)
Kelly, Don E. ..... 702 Underwriters Bldg. (4)
Kelly, Walter F. (S) .. 6049 E. Washington St. (19)
Kennedy, Hunter F. ..... 1105 Prospect St. (3)
Kennedy, Joseph T. ..... 1502 N. Emerson (19)
Kenney, David B. ..... 6032 E. 10th St. (19)
Kenzler, Jack ..... 205 Hume Mansur Bldg. (4)
Kerr, Harry R. ..... 2817 E. Washington St. (1)
Ketcham, Jane M. (S) ..... 3906 Ruckle St. (5)
Kilgore, Byron W. ..... 2002 E. 62nd St. (20)
Kilmer, Warren L.
Marion Co. General Hospital (7)
Kime, Edwin N. ..... 4800 E. 42nd St. (18)
King, Harold ..... I. U. Medical Center (7)
King, William E. ..... 811 Hume Mansur Bldg. (4)
Kingsbury, John K. (S)
5462 E. Washington St. (19)
Kinzel, Robert J. W. ..... 3120 N. Meridian St. (8)
Kirkhoff, Paul J. ..... 5317 E. 16th St. (18)
Kirklin, Oren L. ..... 1802 N. Illinois St. (2)
Kirtley, William R.
Eli Lilly & Co., 740 S. Alabama St.
Kissel, Wesley A.
LaRue Carter Hosp., 1315 W. Tenth St. (7)
Kitterman, Harry E. ..... 5317 E. 16th St. (18)
Klain, Benjamin V. ..... 4157 College Ave. (5)
Klatte, Eugene C. ..... I. U. Medical Center (7)
Kleopfer, Ronald G. ..... I. U. Medical Center (7)
Kneidel, John H. ..... 508 E. 38th St. (5)
Knowles, Charles Y. ..... 5317 E. 16th St. (18)
Knowles, Robert P. ..... 2901 N. Meridian St. (8)
Koch, Edwin F., Jr. ..... I. U. Medical Center (7)
Kohlstaedt, Karl C.
Eli Lilly & Co., 740 S. Alabama St. (6)
Kohlstaedt, Kenneth G.
Lilly Clinic, Marion Co. General Hospital (7)
Kooiker, John E. ..... 401 E. 34th St. (5)
Koons, Karl M. ..... 923 Hume Mansur Bldg. (4)
Kopecky, Robert R. ..... 4131 Shelby St. (27)
Kornafel, L. H. ..... 608 K. of P. Bldg. (4)
Kraft, Bennett ..... 760 Bankers Trust Bldg. (4)
Kriel, William B. ..... 5630 W. Washington St. (21)
Kuntz, Herman W. ... 611 Hume Mansur Bldg. (4)
Kurlander, Gerald J. ..... I. U. Medical Center (7)
Kurtz, Fred B. (S) ..... 5520 N. Illinois St. (8)
Kurtz, Philip L.
Eli Lilly & Co. 740 S. Alabama St. (6)
Kwitny, Isadore J. ..... 3400 N. Meridian St. (8)

L

LaDine, Clarence B. ..... 2508 Station St. (18)
Lalonde, Alban H. ..... 920 Hume Mansur Bldg. (4)
Lamb, Emmett B. ..... 205 Hume Mansur Bldg. (4)
Lamb, Russell W. ..... 205 Hume Mansur Bldg. (4)
Lamber, Chet K. ..... 914 Hume Mansur Bldg. (4)
Landwehr, Alfons ..... Sunnyside Sanitorium (26)
Lane, Charlotte E. ..... Methodist Hospital (7)
Langdon, Harry K. (S)
3264 N. Pennsylvania St. (5)
Lansford, Kenneth G. ..... I. U. Medical Center (7)
Laramore, Ward
V. A. Hospital, 1481 W. 10th St. (7)
Larkin, Bernard J. (S) .305 Hume Mansur Bldg. (4)
Lasich, Anthony R. ..... 820 C. of C. Bldg. (4)
Lawler, George F. ..... 5601 E. St. Clair St. (19)
Layman, Douglas C. ..... I. U. Medical Center (7)
Leasure, J. Kent ..... 3115 N. Meridian St. (8)
Leatherman, Harter L. ..... 1531 Broadway (2)
Leff, Abe H. ..... 3120 N. Meridian St. (8)
Leffel, James M. ..... 1633 N. Capitol Ave. (2)
Leffler, William T. ..... 2141 E. 52nd St. (5)
Lein, John ..... I. U. Medical Center (7)
LeMaster, Theodore R. .304 Hume Mansur Bldg. (4)
Leonard, Henry S. (S) .303 Hume Mansur Bldg. (4)
Leser, Ralph U. ..... 3233 N. Meridian St. (8)
Levi, Leon ..... 40 W. 38th St. (8)
Levin, Ralph T. ..... 3400 N. Meridian St. (8)
Lewis, Paul S. ..... 6357 Rockville Rd. (24)
Lewis, R. Earl ..... 1638 E. Raymond St. (3)
Lichtenberg, Melvin ..... 535 E. 38th St. (5)
Lidikay, Edward C. ..... 621 Hume Mansur Bldg. (4)
Lindenborg, Paul G. .. 3016 N. Arlington Ave. (18)
Lingeman, Raleigh E. ..... 1944 N. Capitol Ave. (2)
Lingeman, Roger E. ..... 2081 N. Emerson Ave. (18)
Link, Goethe (S) ..... 608 K. of P. Bldg. (4)
Little, John W. (S) ..... 2735 E. 10th St. (1)
Littlefield, Paul A.
4040 Crooked Creek Overlook (8)
Littlefield, Shirley D.
4040 Crooked Creek Overlook (8)
Lloyd, Frank P. ..... 1540 Columbia Ave. (2)
Lochry, Ralph L. ..... 6134 Norwaldo (20)
Loehr, William M. ..... I. U. Medical Center (7)
Loomis, Norman S. ..... 5230 N. Kenwood Ave. (8)
Lord, Glenn C. ..... 104 E. 38th St. (5)
Louden, Robert W. ..... 8545 Westfield Blvd. (20)
Loughlin, Lawrence L. ..... 3233 N. Meridian St. (8)
Love, George N. ..... 5331 Washington Blvd. (20)
Love, Jesshill ..... I. U. Medical Center (7)
Lozow, David ..... 3939 Meadows Dr. (5)
Lucas, Clarence A., Jr. ..... 2012 Boulevard Pl. (2)
Lukemeyer, George T. ..... I. U. Medical Center (7)
Lunsford, Thomas E. ..... I. U. Medical Center (7)
Lurie, Paul R. ..... I. U. Medical Center (7)
Luros, J. Theodore ..... 1633 N. Capitol Ave. (2)
Lybrook, William B. ... 3731 N. Keystone Ave. (18)

M

MacCollum, M. Speers .. St. Vincent's Hospital (7)
MacDougall, John D. ..... 3939 Meadows Dr. (5)
McAree, Francis E. ..... Methodist Hospital (7)
McBride, James S. ..... 810 Hume Mansur Bldg. (4)
McCallum, Donald C. ..... Methodist Hospital (7)
McCallum, Joseph T. C. ..... 237 W. 46th St. (8)
McCallum, Robert N.
1922 N. Capitol Ave., #5 (7)
McCartney, Donald H. .918 Hume Mansur Bldg. (4)
McCaskey, Carl H. (S) ..... 608 Guaranty Bldg. (4)
McClain, Edwin S. ..... 414 Hume Mansur Bldg. (4)
McCormick, Charles O., Jr.
621 Hume Mansur Bldg. (4)
McGrath, Michael F. ..... 1929 E. 38th St. (18)
McGuff, Paul E. ..... 4829 E. 38th St. (18)
McIntyre, Charles J. (S)
414 Hume Mansur Bldg. (4)
McIntyre, James M. ..... 2901 N. Meridian St. (8)
McKinley, A. David ..... I. U. Medical Center (7)
McLaren, David E. ..... 6302 Guilford (20)
McMillan, Frederick G. (S)
1110 Odd Fellows Bldg. (4)
McQuiston, Ralph J. ..... 608 Guaranty Bldg. (4)
McTurnan, Robert W. ..... 5646 N. Illinois St. (8)
Mackey, Harry S. (S) ..... 4309 Central Ave. (5)
Mackey, John E. ..... 3400 N. Meridian St. (8)
Madden, Robert J. ..... 4612 E. Tenth St. (1)
Madtson, A. Ricks ..... 822 Hume Mansur Bldg. (4)
Magennis, Herbert L. (S)
520 W. Washington St. (4)
Manalan, Maurice M. .. 5831 E. Washington St. (19)
Manders, Karl L. ..... 3400 N. Meridian (8)
Manion, Marlow W. ..... 601 Hume Mansur Bldg. (4)
Mann, Mortimer ..... 3602 N. Meridian St. (8)
Mann, Richard E. ..... 1315 W. Tenth St. (7)
Manning, K. Randolph .723 Hume Mansur Bldg. (4)
Manzie, Michael W. ..... 1633 N. Capitol Ave. (2)
Markovitch, Marilyn T. ... I. U. Medical Center (7)
Marks, Maurice I. ..... 2901 N. Meridian St. (8)
Marsh, Carl M. ..... 101 N. Shortridge Rd. (19)
Marsh, Myrle F. ..... I. U. Medical Center (7)
Marshall, Albert L., Jr.
Indiana State Board of Health,
1330 W. Michigan St. (7)
Marshall, Cavins R. (S) ..... 43 W. 30th St. (8)

Martin, Hugh E.
Pitman-Moore Co., 1200 Madison Ave. (6)
Martin, Loren H.....2626 W. Washington St. (22)
Martz, Bill L.
Lilly Clinic, Marion Co. General Hospital (7)
Martz, Carl D.....912 Hume Mansur Bldg. (4)
Marvel, Robert J.....3311 N. Meridian St. (8)
Masters, John M.....805 Hume Mansur Bldg. (4)
Masters, Robert J.....805 Hume Mansur Bldg. (4)
Matthew, W. Burleigh.520 Hume Mansur Bldg. (4)
Matthews, Bernard J.....4612 E. 10th St. (1)
Matthews, William M.....4612 E. 10th St. (1)
Maxam, B. T.....400 Hume Mansur Bldg. (4)
Megenhardt, Dennis S...1633 N. Capitol Ave. (2)
Meiks, Lyman T.....Riley Hospital (7)
Melin, John R.....3440 N. Meridian St. (8)
Melloh, Ardis F.....2821 E. 10th St. (1)
Mentendiek, Maurice H.
141 Buckingham Dr. (8)
Mericle, Earl W.....1633 N. Capitol Ave. (2)
Merrell, Paul .....420 Hume Mansur Bldg. (4)
Mershon, Jack B.....3508 W. 16th St. (22)
Mertz, John H. O.....1711 N. Capitol Ave. (7)
Michael, Isaac E....2966 Kessler Blvd., N. Dr. (20)
Middleton, Harvey N.....1828 N. Illinois St. (2)
Miller, Frank H.....201 Hume Mansur Bldg. (4)
Miller, Harold L.
V. A. Hospital, 1481 W. 10th St. (7)
Miller, Jerry R.....I. U. Medical Center (7)
Miller, John D.....Sunnyside Sanitorium (26)
Miller, John M.....I. U. Medical Center (7)
Miller, Raleigh S.....6211 College Ave. (20)
Miller, Roscoe E.....I. U. Medical Center (7)
Million, Rodney R.....Robert Long Hospital (7)
Miofsky, William E.....I. U. Medical Center (7)
Mitchell, Edward O....5704 N. Keystone Ave. (20)
Mitchell, George H...6049 E. Washington St. (19)
Moenning, John E.
Marion Co. General Hospital (7)
Moenning, Walter P.....618 K of P Bldg. (4)
Montgomery, William F.
904 Hume Mansur Bldg. (4)
Moore, Donald F.
LaRue Carter Hospital, 1315 W. 10th St. (7)
Moore, Harold T.....Methodist Hospital (7)
Moore, Richard B.....5005 N. Illinois St. (8)
Moore, William G.
Marion Co. General Hospital (7)
Morchan, Samuel.....3769 College Ave. (5)
Morgan, Margaret E.....3400 N. Meridian St. (8)
Moriarty, John R.....5602 Madison Ave. (3)
Morrison, Lewis E.....603 Hume Mansur Bldg. (4)
Morrow, Robert E.....I. U. Medical Center (7)
Morton, Joseph L.....St. Vincent's Hosp. (7)
Morton, Walter P.....3434 Fall Creek Blvd. (5)
Moser, Rollin H.....400 Hume Mansur Bldg. (4)
Moss, Bobby L.....1121 N. Arlington Ave. (19)
Moss, Herschel C.....401 E. 34th St. (5)
Mothersill, Mark H. (S).....3650 College Ave. (5)
Mouser, Robert W.....6201 Park Ave. (20)
Mueller, Lillian B. (S).....4026 Broadway (5)
Mullen, James B.....3120 N. Meridian St. (8)
Muller, Lullus P.....3120 N. Meridian St. (8)
Muller, Paul F.....3311 N. Meridian St. (8)
Muller, Victor H.....St. Vincent's Hosp. (7)
Mumford, E. Bishop (S).....812 C. of C. Bldg. (4)
Musser, A. Wendell.....I. U. Medical Center (7)
Myers, Charles W.....R. R. 18, Box 256 (24)
Myers, Roy V.....1904 N. Rural St. (18)

N

Nafe, Cleon A.....822 Hume Mansur Bldg. (4)
Nagan, Robert F.....606 Hume Mansur Bldg. (4)
Nay, Richard M.....1015 Hume Mansur Bldg. (4)
Nayyar, Som N.....I. U. Medical Center (7)
Need, Louis T.....1927 S. Meridian St. (25)
Neeley, Alonzo S. (S)
2324 E. Pleasant Run Prkwy., N. Dr. (3)
Nester, Henry G.....307 City Hall (4)
Nicholas, Dennis.....4456 N. Keystone Ave. (5)
Nie, Louis W.....2901 N. Meridian St. (8)
Nohl, John M.....975 N. Emerson Ave. (19)
Nolin, Richard T.....6007 Michigan Rd. (8)
Nolting, Henry F. (S).....261 W. 40th St. (8)
Norman, William H....908 Hume Mansur Bldg. (4)
Norris, Howard L..... 704 Hume Mansur Bldg. (4)
Norris, Max S.....510 Hume Mansur Bldg. (4)
Nourse, Myron H.....1711 N. Capitol Ave. (7)
Nugent, Edwin J.....Allison Div. GMC (6)
Nurnberger, John I.....I. U. Medical Center (7)

O

O'Brian, Earl J.....3041 Lafayette Rd. (22)
Ochsner, Harold C.....Methodist Hospital (7)
Offutt, Andrew C...Indiana State Board of Health,
1330 W. Michigan St. (7)
Olvey, Ottis N.....3769 Park Ave. (5)
O'Malley, Martha A.....Ind. St. Bd. of Health
1330 W. Michigan St. (7)
Orders, Clarks E. (S)
4954 W. 15th St., Speedway (24)
Ormiston, Michael W.
V. A. Hospital, 1481 W. 10th St. (7)
Otten, Claude F.....812 C. of C. Bldg. (4)
Ottinger, Ross C. (S).....Indianapolis
Overley, Toner M., Jr.
Larue D. Carter Hospital, 1315 W. 10th St. (7)
Owen, John E..... 605 Hume Mansur Bldg. (4)
Owens, Tracy C.....2823 N. Meridian St. (8)

P

Pagedas, Tom C.....Methodist Hospital (7)
Palmer, Charman F.
Larue D. Carter Hospital, 1315 W. 10th St. (7)
Palmer, Harley P.
Marion Co. General Hospital (7)
Palmer, Robert M.....I. U. Medical Center (7)
Palmer, Robert W.....3400 N. Meridian (8)
Pandolfo, Harry.....234 E. Southern Ave. (25)
Parker, George F., Jr...1502 N. Emerson Ave. (19)
Parker, John F.....1706 E. Washington St. (1)
Parker, L. Burton.Marion Co. General Hospital (7)
Parker, Portia.....2226 W. Michigan St. (22)
Parmenter, Harry B.....5940 Nash Lane (24)
Parr, Robert L.....3043 E. 38th St. (18)
Paskind, J.....Marion Co. General Hospital (7)
Patton, Martin T.....107 W. 30th St. (8)
Paulissen, George T.....741 Markwood Ave. (27)
Paz, Luis.....Methodist Hospital (7)
Pearson, John S.....American United Life Ins. Co.,
30 W. Fall Creek Parkway (6)
Pearson, Lyman R.....311 Hume Mansur Bldg. (4)
Pebworth, Aubrey C. (S)..1625 W. Morris St. (21)
Peck, Franklin B. Jr.
Lilly Clinic, Marion Co. General Hospital (7)
Peck, Franklin B. Sr.
Eli Lilly & Co., 740 S. Alabama St. (6)
Peirce, James D.
Eli Lilly & Co., 740 S. Alabama St. (6)
Pennington, Walter E. (S)
214 Hume Mansur Bldg. (4)
Perlov, Sylvan H.....5505 N. Keystone Ave. (20)
Permer, Erwin.....136 E. 30th St. (5)
Peterson, Deward D.
Marion Co. General Hospital (7)
Petranoff, Theodore V.....515 N. Tibbs Ave. (22)
Pettijohn, Fred L. (S).....2460 Central Ave. (5)
Pfaff, Dudley A.
V. A. Regional Office, 36 S. Pennsylvania St. (4)
Phillips, David L.....605 E. 38th St. (5)
Pickett, Robert D.....400 Hume Mansur Bldg. (4)
Pierce, Emmett, Jr.
Marion Co. General Hospital (7)
Pilcher, Jack E.....1802 N. Illinois St. (2)
Plasterer, Edward D...1833 Eisenhower Dr. (24)

Pontius, Edwin E.....Methodist Hosp. (7)
Popplewell, Arvine G.
Marion Co. General Hospital (7)
Porterfield, Hubert W.
408 Hume Mansur Bldg. (4)
Pribble, Robert H.
Marion Co. General Hospital (7)
Price, Francis W.....1002 E. Troy Ave. (3)
Price, James O.....512 Hume Mansur Bldg. (4)
Priebe, Fred H....Marion Co. General Hospital (7)
Pryor, Richard C.....6111 College Ave. (20)

Q

Quigley, Joseph B.....817 Hume Mansur Bldg. (4)

R

Rabb, Frank M.....915 E. 38th St. (5)
Rabb, Harry S.....3139 E. 10th St. (1)
Raber, Robert M.....1633 N. Capitol Ave. (2)
Rader, George S.....1010 Hume Mansur Bldg. (4)
Rafalski, Thomas A.....3120 N. Meridian St. (8)
Ragan, William D.....3400 N. Meridian St. (8)
Ralston, John D.....Central State Hosp. (22)
Ramsey, Frank B.....1802 N. Illinois St. (2)
Rapp, George F.....St. Vincent's Hosp. (7)
Rawls, George H.....1540 Columbia Ave. (2)
Reed, Philip B.....4131 N. Meridian St. (8)
Rees, Russel C.....6114 E. Washington St. (19)
Reid, Charles A.....2445 Shelby St. (3)
Reid, James D.....I. U. Medical Center (7)
Reid, Robert H.....Methodist Hospital (7)
Reisler, Simon (S)....318 Bankers Trust Bldg. (4)
Reuter, John W...Marion Co. General Hospital (7)
Rhamy, Robert K.....I. U. Medical Center (7)
Rice, Frederic A.....7017 Pendleton Pike (26)
Rice, Raymond M.
Eli Lilly & Co., 740 S. Alabama St. (6)
Richardson, Thad T.....513 S. Sherman Dr. (3)
Richter, Arthur B.....720 Hume Mansur Bldg. (4)
Ridgeway, Ora W. (S).....411 E. 16th St. (2)
Ridolfo, Anthony S.
Eli Lilly & Co., 740 S. Alabama (6)
Riner, Jack K.....Methodist Hospital (7)
Ritchey, James O.....608 Hume Mansur Bldg. (4)
Ritter, Wayne L.....404 Hume Mansur Bldg. (4)
Robb, John A.....238 Hume Mansur Bldg. (4)
Robertson, Ray B.....6118 E. Washington St. (19)
Rochlin, Isidore.....3202 N. Meridian St. (8)
Roesch, Ryland P.....I. U. Medical Center (7)
Roeske, Nancy A.....220 W. Beverly Dr. (5)
Rogers, Donald L.....3426 N. Meridian St. (8)
Rohn, Robert J.....I. U. Medical Center (7)
Roll, John W.....3628 N. Sherman Dr. (18)
Roller, Charles W. (S).....915 Hervey (3)
Romberger, Floyd T., Jr...3440 N. Meridian St. (8)
Rosenak, Bernard D...226 Hume Mansur Bldg. (4)
Rosenbaum, David
V. A. Hospital, 1481 W. 10th St. (7)
Rosenbaum, Irving, Jr.....401 E. 34th St. (5)
Roshe, Joseph.....I. U. Medical Center (7)
Ross, Alexander T.....I. U. Medical Center (7)
Roth, Bertram S.....6358 College Ave. (20)
Row, D. Hamilton.....906 Hume Mansur Bldg. (4)
Ruddell, Karl R. (S).....3202 N. Meridian St. (8)
Ruddell, Keith.....3202 N. Meridian St. (8)
Rudesill, Cecil L. (S)..405 Hume Mansur Bldg. (4)
Rudesill, Robert L.....405 Hume Mansur Bldg. (4)
Rudolph, Kenneth J.....1827 N. Norfolk (24)
Russell, John R.....315 Hume Mansur Bldg. (4)
Rust, Byron K.....3740 Central Ave. (5)
Rust, Roland B.....3939 Meadows Drive (5)
Ruth, Martin L.....4304 E. Washington St. (1)
Rutherford, Cyrus W. (S)
4601 N. Pennsylvania St. (5)
Ryan, Glen V.....2428 W. 16th St. (22)

S

Sabens, James A.....I. U. Medical Center (7)
Sage, Russell A.....1944 N. Capitol Ave. (2)
Salb, Max C.....826 C. of C. Bldg. (4)
Samter, Thomas G.....I. U. Medical Center (7)
Sanders, Harry M.....4829 E. 38th St. (18)
Sandorf, Marvin H.....1102 Prospect St. (3)
Schaefer, C. Richard (S)..1838 N. Meridian St. (2)
Schaffer, Edward V....806 Hume Mansur Bldg. (4)
Schechter, John S.....3400 N. Meridian St. (8)
Scheier, Emil W.....1542 Prospect St. (3)
Schell, Harry D.....I. U. Medical Center (7)
Schlaegel, Theodore F., Jr.
419 Hume Mansur Bldg. (4)
Schlegel, Donald M.....1802 N. Illinois St. (2)
Schmalhausen, Ansel W.....Methodist Hospital (7)
Schmidt, Loren F.....605 Hume Mansur Bldg. (4)
Schmoyer, Maurice R....Community Hospital (19)
Schneider, Carl J.....1008 N. Beville Ave. (1)
Schnute, Richard B.....I. U. Medical Center (7)
Schuchman, Abe.....3763 Broadway (5)
Schuchman, Gabriel.....3451 College Ave. (5)
Schulze, Hans A.....2424 Raymond St. (3)
Schuster, Dwight W...723 Hume Mansur Bldg. (4)
Schut, Almon L.....I. U. Medical Center (7)
Schwarz, Anton
Pitman-Moore Co., 1200 Madison Ave. (6)
Scott, George E.....3636 N. Layman Ave. (18)
Scott, I. Winfield.....3400 N. Meridian St. (8)
Scott, John R.....6214 Broadway (20)
Scott, Robert P.....209 Hume Mansur Bldg. (4)
Scott, Samuel L.....6325 Guilford Ave. (20)
Seaman, Charles F....1010 Hume Mansur Bldg. (4)
Sedam, Herbert L.....4548 College Ave. (5)
Segar, Louis H.....818 E. 48th St. (5)
Segar, William E.....Riley Hosp. (7)
Sellmer, George W.....8545 Westfield Blvd. (20)
Sexson, Hiram T.....3731 N. Keystone (18)
Shafer, Marion R.....614 Hume Mansur Bldg. (4)
Shanafelt, Donald K.....1802 N. Illinois St. (2)
Sheehan, Francis G....6049 E. Washington St. (19)
Shelley, Richard.....6016 E. Washington (19)
Sherster, Harry.....1135 S. Meridian St. (25)
Shipley, Edward
LaRue Carter Hospital, 1315 W. Tenth St. (7)
Shullenberger, Wendell A....3740 Central Ave. (5)
Shumacker, Harris B., Jr...I. U. Medical Center (7)
Sicks, Okla W.....606 Hume Mansur Bldg. (4)
Sidebottom, Earl W...507 Hume Mansur Bldg. (4)
Siderys, Harry.....3002 N. Tibbs Ave. (22)
Siebe, Jack C.....4829 E. 38th St. (18)
Siersdorfer, Theodore N. (S)
5559 W. Morris St. (21)
Sigmond, Harvey W...321 Hume Mansur Bldg. (4)
Silver, Richard A.....712 Hume Mansur Bldg. (4)
Simmons, James E.....I. U. Medical Center (7)
Simms, J. Leon.....2453 Northwestern Ave. (23)
Simpson, William D...6049 E. Washington St. (19)
Sims, J. Lawrence.....3400 N. Meridian St. (8)
Sisk, Phillip B.....I. U. Medical Center (7)
Slichenmyer, Jack E.....2418 Madison Ave. (25)
Sluss, David H.....808 C. of C. Bldg. (4)
Sluss, John W. (S).....808 C. of C. Bldg. (4)
Smith, David L.....2901 N. Meridian St. (8)
Smith, Edward B.....I. U. Medical Center (7)
Smith, E. Rogers.....822 Hume Mansur Bldg. (4)
Smith, Francis C.....983 N. Arlington Ave. (19)
Smith, Roy Lee.....707 Underwriters Bldg. (4)
Smith, William B.....2229 Northwestern Ave. (23)
Snider, Byron.....2717 S. East St. (3)
Solomon, Reuben A....414 Hume Mansur Bldg. (4)
Soper, Hunter A.....1015 Hume Mansur Bldg. (4)
Souter, Martha C.....3360 N. Meridian St. (8)
Southworth, John W.....1315 W. Tenth St. (7)
Sovine, Joe W.....922 Hume Mansur Bldg. (4)
Spahr, John F., Jr.....3440 N. Meridian St. (8)
Spalding, Joseph J.....706 Hume Mansur Bldg. (4)
Sparks, Alan L.....1024 Hume Mansur Bldg. (4)
Spears, John M.....5562 Madison Ave. (27)

Speckman, Glenn H.....2120 E. 10th St. (1)
Spivey, Russell J.....2616 N. Pennsylvania St. (5)
Spolyar, Louis W...Indiana State Board of Health, 1330 W. Michigan St. (7)
Sputh, Carl B., Jr.....301 Doctors' Bldg. (4)
Stadler, Harold E.....5508 E. Washington St. (19)
Staff, Robert A.....9880 W. 10th St. (24)
Stander, Richard W.....I. U. Medical Center (7)
Stansbury, William E....3628 N. Sherman Dr. (18)
Staten, Jesse C.....Chevrolet Body Div., GMC, 340 White River Pkwy., W. Dr. S. (22)
Stayton, Chester A., Jr. 313 Hume Mansur Bldg. (4)
Steinmetz, Edward F. Marion Co. General Hospital (7)
Stephens, Donald E.....6332 Guilford Ave. (20)
Stephens, Kuhrman H..501 Hume Mansur Bldg. (4)
Stevens, Sydney L.....303 Hume Mansur Bldg. (4)
Stoelting, Vergil K.....I. U. Medical Center (7)
Stone, Alvin T.....6202 College Ave. (20)
Storey, D. Edmund.....6225 Broadway (20)
Storey, Joseph L.....3454 N. Illinois St. (8)
Storms, Roy B. (S).....812 C. of C. Bldg. (4)
Streeter, Ralph T.....3131 E. 38th St. (18)
Strickland, Neil R.....Methodist Hospital (7)
Stroup, Tyler J.....216 K. of P. Bldg. (4)
Stucky, Elsworth K.....1349 Madison Ave. (25)
Stump, Loyd K.....3939 Meadows Dr. (5)
Stump, Thomas A. Marion Co. General Hospital (7)
Suelzer, John G.....I. U. Medical Center (7)
Summerlin, Jack D.....I. U. Medical Center (7)
Sutton, William E.....521 Hume Mansur Bldg. (4)
Swan, John R.....915 Hume Mansur Bldg. (4)
Symmes, Alfred T.....625 E. 38th St. (8)
Szumilas, Peter P.....I. U. Medical Center (7)
Szynal, John S.....633 E. 38th St. (5)

T

Talbott, Dan E.....1802 N. Illinois St. (2)
Tanner, Henry S.....321 Hume Mansur Bldg. (4)
Taube, Jack I.....1007 Hume Mansur Bldg (4)
Taylor, Clifford C.....Community Hospital (19)
Taylor, Cyril.....I. U. Medical Center (7)
Taylor, Frederic W....822 Hume Mansur Bldg. (4)
Taylor, Max T....Marion Co. General Hospital (7)
Teague, Frank W.....918 Hume Mansur Bldg. (4)
Teixler, Victor A.....224 Hume Mansur Bldg. (4)
Tepfer, Milton.....I. U. Medical Center (7)
Test, Charles E.....1002 Hume Mansur Bldg. (4)
Teter, George V.....401 E. 34th St. (5)
Tether, Joseph E.....510 Hume Mansur Bldg. (4)
Tharpe, Ray.....3202 N. Meridian St. (8)
Thatcher, Hugh K., Jr.....4548 College Ave. (5)
Thomas, Charles R.....Methodist Hosp. (7)
Thomas, Edward P.....917 W. 30th St. (23)
Thomas, Fred A.....St. Vincent's Hospital (7)
Thomas, Lowell I.....615 Hume Mansur Bldg. (4)
Thomas, Morris E.....1802 N. Illinois St. (2)
Thompson, John V.....7899 Ridge Rd. (20)
Thompson, Joseph F.....I. U. Medical Center (7)
Thompson, Paul D...404 Hume Mansur Bldg. (4)
Thompson, Wayne H.....1633 N. Capitol Ave. (2)
Thornburg, Kenneth E...1633 N. Capitol Ave. (2)
Thornton, Harold C.....301 E. 38th St. (5)
Throop, Frank B.....3400 N. Meridian St. (8)
Tindall, George T.....6002 Windsor Dr. (18)
Tinsley, Frank W.....3044 LaFayette Rd. (22)
Tinsley, Walter B., Jr.....3044 LaFayette Rd. (22)
Tinsley, Walter B.(S).....603 K. of P. Bldg. (4)
Tischer, E. Paul.....208 Hume Mansur Bldg. (4)
Tondra, John M.....408 Hume Mansur Bldg. (4)
Torrella, Jose A.....5324 W. 16th St. (24)
Tosick, William A. Marion Co. General Hospital (7)
Toumey, Fred L.....1802 N. Illinois St. (2)
Trusler, Harold M.....408 Hume Mansur Bldg. (4)
Tschetter, David J.....3202 N. Meridian St. (8)
Tuchman, Joseph H.....2040 E. 46th St. (5)
Tucker, Warren S.....414 Hume Mansur Bldg. (4)
Tyler, Edward A.....I. U. Medical Center (7)
Tyner, Harlan H.....3202 N. Meridian St. (8)

U-V

Ullom, Ralph B.....Methodist Hospital (7)
Vandivier, Robert M...209 Hume Mansur Bldg. (4)
Van Dorn, Myron J.....2165 Weslynn Dr. (8)
Van Fleet, Josephine.....Indiana State Board of Health, 1330 W. Michigan St. (7)
Van Meter, C. Powell.....3419 E. 10th St. (1)
Van Nuys, John D.....I. U. Medical Center (7)
Van Tassel, Charles J..709 Hume Mansur Bldg. (4)
Van Vactor, Helen D...226 Hume Mansur Bldg. (4)
Vellios, Frank.....I. U. Medical Center (7)
Vollrath, Victor J.....5202 N. Illinois St. (8)
Von Der Haar, Gerard....4016 E. Michigan St. (1)
Vore, Robert E....Marion Co. General Hospital (7)
Voyles, Charles F. (S)...4150 N. Meridian St. (8)

W

Wagner, Anabel R.....Methodist Hospital (7)
Wagner, Lindley H.....Methodist Hospital (7)
Wainscott, Clinton S.....I. U. Medical Center (7)
Waldo, J. Thayer.....610 Hume Mansur Bldg. (4)
Walker, Robert K.....413 E. 34th St. (5)
Walther, Joseph E.....3202 N. Meridian St. (8)
Walton, William M.....1802 N. Illinois St. (2)
Ward, Wesley C.....3 E. 46th St. (5)
Warfel, Frederick C. (S).....4817 Broadway (5)
Warman, Alvah P. (S).....1363 E. 38th St. (5)
Warriner, James B.....1012 N. Emerson Ave. (19)
Warshaw, Seymour.....I. U. Medical Center (7)
Warvel, John H.....614 Hume Mansur Bldg. (4)
Weaver, Marlin.....I. U. Medical Center (7)
Webster, Paul L.....I. U. Medical Center (7)
Wehrman, Jule O. (S).....410 N. Meridian St. (4)
Weigand, Clayton G.....Eli Lilly & Co., 740 S. Alabama St. (6)
Weinland, George C.....Larue D. Carter Hospital, 1315 W. 10th St. (7)
Weller, Charles A. (S)...3720 N. Delaware St. (5)
West, Joseph L. .....6714 Rockville Rd. (41)
Westfall, B. Kemper.....2901 E. 38th St. (18)
Westfall, John B... 1025 Hume Mansur Bldg. (4)
Wheeler, David E.....Community Hospital (19)
White, Donald J.....502 Bankers Trust Bldg. (4)
White, Douglas H...1015 Hume Mansur Bldg. (4)
White, John B.....806 Hume Mansur Bldg. (4)
White, Nicholas.....I. U. Medical Center (7)
White, Philip T.....I. U. Medical Center (7)
Wickstrom, Otto W.....98 N. Warman (22)
Widdifield, G. E.....2614 Madison Ave. (3)
Wilkens, Irvin W.....1743 Shelby St. (3)
Williams, Charles D.....2422 Station St. (1)
Williams, Clifford L....Central State Hospital (22)
Williams, Harold W...5839 E. Washington St. (19)
Williams, Howard S.....115 E. 16th St. (2)
Williams, Hugh L.....4829 E. 38th St. (18)
Willitts, Bruce K.....Methodist Hospital (7)
Wilmore, Ralph C. V. A. Hospital, 1481 W. 10th St. (7)
Wilson, Fred M.....I. U. Medical Center (7)
Wilson, Ned A.....I. U. Medical Center (7)
Wilson, Oliver R.....3440 N. Meridian St. (8)
Wise, William R.....120 E. 22nd St. (2)
Wishard, William N., Jr...1711 N. Capitol Ave. (7)
Witham, Robert L.....1502 N. Emerson (19)
Wolfe, John W.....I. U. Medical Center (7)
Wolfram, Don J.....208 Hume Mansur Bldg. (4)
Wood, Donald E.....6325 Guilford Ave. (20)
Wood, William H.....3120 N. Meridian St. (8)
Woodard, Abram S.....668 E. 38th St. (5)
Woolling, Kenneth R...718 Hume Mansur Bldg. (4)
Worley, Joseph P.....5839 E. Washington St. (19)
Worley, Richard H.....5317 E. 16th St. (18)
Wrege, Malcolm L.....1502 N. Emerson Ave. (19)

Wright, J. William, Jr. 301 Hume Mansur Bldg. (4)
Wyttenbach, John E. 503 Hume Mansur Bldg. (4)

Y

Yacko, Michael L. 1502 N. Emerson (19)
Yingling, Robert J. I. U. Medical Center (7)
Young, James W. 6302 Guilford Ave. (20)
Young, John E. 4829 E. 38th St. (18)
Young, John M. 1456 E. 46th St. (5)
Young, John T. 1540 Columbia Ave. (2)

Z

Zell, Evertson H. 812 C. of C. Bldg. (4)
Zerfas, Phyllis K. R. R. 1, Box 220 (27)
Zore, Joseph J. I. U. Medical Center (7)

Lewis, Robert J. Lawrence
Asher, Ernest O. (S) New Augusta
Asher, James W. New Augusta
Thrasher, John R. (S)
R. R. 1, Box 362, New Augusta
Freeborn, Warren S. Oaklandon
Miller, Joseph A. Oaklandon
Paynter, Morris B. Southport
Jones, George L. Wanamaker

Bailey, Orville T.
912 S. Wood St., Chicago, Illinois
Bobowski, Stan J. Letterman Army Hosp.,
San Francisco, California
Bohner, Caryle B. Huasca, Hidalog, Mexico
Brayton, John R., Jr.
1616 George St., Key West, Florida
Breneman, William L.
3415 USAF Hosp., Lowry AFB, Denver, Colo.
Bugh, Charles W.
1075 Riverview Dr., Fairbanks, Alaska
Burman, Leonard
9509 Glasgow Pl., Los Angeles 45, California
Burton, Philip B.
230 N. Daugherty, Ft. Bragg, N. C.
Call, William H.
University Hospital, Ann Arbor, Michigan
Clark, George A.
1664 Graefield, Birmingham, Michigan
Cullen, Paul K. Jr.
Mayo Clinic, Rochester, Minnesota
Dailey, James E.
527 S. Fourth St., Watseka, Illinois
Dickey, William M.
V. A. Hospital, Bay Pines, Florida
Dierdorf, Fred W.
Ind 7520th U. S. A. F. Hosp.,
APO 125, New York, N. Y.
Dirks, Kenneth R.
OUSARMA, Navy 100, FPO New York, N. Y.
Dixon, Fritz R.
2842 Tidewater Dr., Houston 25, Texas
Finfrock, James D.
VA Hospital, Fayetteville, Arkansas
Fisher, Gerald Ippy, French Equatorial Africa
Foust, Betty J.
Parkview Apts. #502 D, Collingswood 6, N. J.
Fulton, William H.
358 Sharon Amity Rd., Charlotte, N. C.
Gabe, William E.
61 Heather Lane, Orinda, California
Huffman, Galen C.
Columbus Psy. Inst. and Hosp., Columbus 10, Ohio
Irick, Robert L.
3910th USAF Disp. APO 179, New York, N. Y.
Jennings, F. Lamont
8607 S. University, Chicago, Illinois
Jones, Roland W.
USN Hospital, Bethesda, Maryland
Kenoyer, Wilbur L.
3700 USAF Hospital, Lackland AFB, Texas
Kurtz, Richard
2901 S. Parkway, Chicago, Illinois
Lambert, Ross W.
USN Hospital, Camp Pendleton, California
McLaughlin, William T.
1055 Pine St., Menlo Park, California
Marshall, Thomas R.
53 Maple St., Topsfield, Massachusetts
Marty, Sophocles
USN Hospital, Corpus Christi, Texas
Mertz, Henry O., Sr. (S)
R. R. 2, Box 1619, Nokomis, Florida
Meulbroek, Harvey J.
V. A. Hospital, Pittsburgh, Pennsylvania
Morrow, Dean H.
Nat'l. Institutes of Health, Bethesda, Maryland
Moss, Harlan B.
1122 E. College Avenue, Iowa City, Iowa
Murray James S.
606 N. Roxbury, Beverly Hills, Calif.
Nelson, Audrey H.
1719 Macaulay, Memphis, Tennessee
Nelson, John W.
1719 Macaulay, Memphis, Tennessee
Norris, Mary Alice,
c/o Col. J. F. Surratt, Quarters 3,
Ft. Sheridan, Illinois
Pinsky, Sheldon T. 4755 Noble, Bellaire, Ohio
Powell, Richard C.
USA Med. Res. Nut. Lab., Fitzsimmons Hospital,
Denver, Colorado
Reibel, Donald B.
Hosp. for Special Surgery, New York 21, N. Y.
Rhodes, Theodore D.
R.R. #2, Box 1595, Nokomis, Fla.
Rice, Reed 720 16th Ave. N.E., Rochester, Minn.
Ricketts, Joseph W.
136 Magnolia Drive, Orman Beach, Florida
Rigg, John F.
1279 N. E. 97th Street, Miami Shores, Florida
Robinson, Frank C. (S)
200 Via Mentone, Newport Beach, Calif.
Rogers, Thomas P. USN Hospital,
San Diego 33, Calif.
Rohrbacker, Donald M.
V. A. Hospital, Portland, Oregon
Rudolph, Stephen J., Jr.
832nd TAC Hosp., Cannon AFB
New Mexico
Rupel, Ernest
1841 Venetian Pt. Dr., Clearwater, Florida
Shoptaugh, A. Glenn Jr.
30750th USAF, Sheppard AFB
Wichita Falls, Texas
Sommers, Stephen D.
USAF Hosp., Wright-Patterson AFB,
Dayton, Ohio
Stanley, John S.
470 N. E. 25th St., Miami 37, Florida
Sprenger, Thomas R.
V. A. Hospital, New Orleans, La.
Steury, Ernest M.
Kenya Colony, British East Africa
Talarico, Leonard H.
219 Orlando Rd., Rochester 22, N. Y.
Thurston, Harrison S. (S)
1204 Earlham Drive, Dayton 6, Ohio
Tinney, William E. (S)
P. O. Box 1186, Pass-A-Grille, Florida
Wallace, Collins R.
Ireland Army Hosp., Ft. Knox, Ky.
Warvel, John H., Jr.
Womack Army Hosp., Fort Bragg, N. C.
Weber, Norbert J.
Hazelwood Sanitarium, Louisville, Ky.
Weisenberger, Brockton L.
USPHS Indian Hospital, Rosebud, S. Dakota

Williams, Russell S.
20th Station Hosp., A.P.O. 696, New York, N. Y.

Ziperman, H. Haskell
Box 108, Letterman Army Hosp., San Francisco, Calif.

MARSHALL COUNTY

Hampton, James N. ..... Argos
Kelly, Frank (S) ..... Argos
Connell, Vactor O. ..... Bourbon
Marshall, George L. (S) ..... Bourbon

Bremen

Bowen, Otis R. ..... 424 W. South St.
Burket, Cecil R. ..... 424 W. South St.
Cripe, Earl P. ..... 119 N. Center St.
Schreiner, John E. ..... 201 E. Plymouth
Stine, Marshall E. ..... 424 W. South St.

Baker, Milan D. ..... Culver
Norris, Ernest B. ..... Culver
Reed, Donald ..... Culver

Plymouth

Connell, Paul S. ..... 320 N. Center St.
Coursey, James O. ..... 109 N. Walnut St.
Klingler, Maurice O. ..... 213 W. LaPorte St.
Kubley, James D. ..... 304 N. Walnut St.
Peterson, Ronald L. ..... 121 E. Garro St.
Pomeroy, Rex K. ..... 1400 Park Ave.
Reed, Robert G., Jr. ..... 109 N. Walnut St.
Rimel, James F. ..... 213 W. LaPorte St.
Robertson, James S. ..... 304 N. Walnut St.
Vore, Louring W. ..... 121 E. Garro St.

Thompson, Alfred A. (S) ..... Tyner

MARTIN COUNTY

(See Daviess-Martin)

MIAMI COUNTY

Shrock, Ethan E. ..... Amboy
Hill, Lloyd ..... Denver
Malott, Fred R. ..... Converse
Sennett, William K. ..... Macy
Rendel, Harold E. ..... Mexico

Peru

Barnett, Ralph E. ..... 65 N. Miami St.
Boone, Max L. ..... 65 N. Miami St.
Burrous, E. Lee ..... 27 W. Sixth St.
Carlson, Edward A. (S) ..... 11½ W. Main St.
Ferrara, Donald W. ..... 18 W. Fifth St.
Ferrara, Samuel J. ..... 18 W. Fifth St.
Herd, Cloyn R. ..... 15 S. Wabash
Johnson, Owen ..... 15 S. Wabash
Malouf, Stephen D. ..... 53 S. Broadway
Snyder, Parker M. ..... 207 Senger-Mavrick Bldg.
Teaboldt, George ..... 18 W. Fifth St.
Wildman, Roscoe E. ..... 27 W. Sixth St.

Kimmel, George E.
U.S. Naval Hospital, Camp Lejeune, N. C.

MONROE COUNTY

(See Owen-Monroe)

MONTGOMERY COUNTY

Crawfordsville

Alexander, Stephen J. ..... 306 Ben-Hur Bldg.
Burks, Jess E. ..... 411 Ben Hur Bldg.
Cooksey, Thomas L. (S) ..... 109½ S. Washington St.
Cornell, Robert A. ..... 219 Ben Hur Bldg.
Daugherty, Fred N. ..... 120 W. Pike St.
Dodds, Wemple ..... Culver Hospital
Eggers, Richard ..... 120 W. Pike St.
Fisher, Frank L. ..... R. R. Donnelley & Sons Co.
Haller, Thomas C. ..... 411 Tinsley Ave.
Humphreys, John W. ..... 312 Jones Ave.
Kinnaman, Howard A. ..... 206 Ben Hur Bldg.
Kirtley, James M. ..... 416 Ben Hur Bldg.
Lingeman, Byron N. ..... 419 Ben Hur Bldg.
Mount, William M. ..... 411 Tinsley Ave.
Peacock, Norman F. ..... 219 Ben Hur Bldg.
Pierson, Robert H. ..... 305 E. Main St.
Shannon, Wesley ..... 901 Cottage Ave.
Sharp, John L. ..... 1403 E. Main St.
Wallace, Hawthorne C. ..... 411 Tinsley Ave.

Otten, Ralph E. ..... Darlington
Blix, Fred M. ..... Ladoga
Wong, Norman F. ..... Linden
Davis, William H. ..... New Market
Kindell, Hurschell D. ..... New Richmond
Thompson, Claude N. ..... Waynetown
Parker, Carl B. ..... Wingate

MORGAN COUNTY

Martinsville

Brubeck, Robert E. ..... 215 E. Washington St.
Eisenberg, David A. ..... 310 N. Main St.
Gibbs, Joseph W. ..... Home Lawn Sanitarium
Gray, Leon ..... 171 E. Washington St.
Johnston, Alan ..... R. R. #6
Miller, Ray D. ..... 290 E. Washington St.
Pitkin, McKendree C. ..... 440 E. Washington St.
Taylor, Loren F. ..... 60½ E. Morgan St.
Van Wienen, John ..... 60 W. Morgan
Willan, Horace R. ..... 109 S. Jefferson St.
Winter, William P. ..... 60½ E. Morgan St.

Murphy, Maurice G. (S) ..... Morgantown

Mooresville

Bivin, James H. ..... 31 S. Indiana
Comer, Kenneth E. ..... 130 N. Indiana
Karpel, Bernard ..... Medical Arts Bldg.
Kendrick, William ..... 130 N. Indiana
Van Bokkelen, Robert W. ..... 320 N. Indiana

Farr, James C. ..... Paragon

NEWTON COUNTY

(See Jasper-Newton)

NOBLE COUNTY

Bowman, Charles M. ..... Albion
Nash, Justin R. ..... Albion
Mattmiller, Everette D. ..... Avilla
Sneary, Kenneth D. ..... Avilla
Sneary, Max E. ..... Avilla

Kendallville

Bryan, Robert E. ..... 129 E. Main St.
Carey, Willis W. (S) ..... Lutheran Home
Gutstein, Richard R. (S) ..... 120 Diamond
Hepner, Herman ..... 101½ N. Main St.
Lawson, Isaac H. (S) ..... 125½ S. Main St.
Messer, Frank W. ..... 115 E. Rush St.
Slough, O. Thomas ..... 112 W. Mitchell
Stallman, Carl F. ..... 409 E. Wayne St.

Ligonier

Chase, James A. ..... 104 S. Main St.
Stone, Robert C. ..... 401 S. Main St.
Stultz, Quentin F. ..... 401 S. Cavin St.

Fipp, August L. ..... Rome City
Pulskamp, Bertrand H. ..... Wolcottville
Luckey, James ..... Wolf Lake
Luckey, Robert C. ..... Wolf Lake
Roth, James R. ..... Wolf Lake

OHIO COUNTY

(See Dearborn-Ohio)

ORANGE COUNTY

Keseric, N. E. ..... French Lick Springs
Sugarman, Benjamin E. ..... French Lick Springs
Hodgin, Philip T. ..... Orleans
Schoolfield, William E. ..... Orleans
Clark, Ivan A. ..... Paoli
Hammond, Keith ..... Paoli
Manship, Stanley ..... Paoli
McCalla, Charles X. ..... Paoli
Spears, John K. ..... Paoli
Miller, Henderson L. (S) ..... West Baden Springs

OWEN-MONROE COUNTIES

Bloomington

Baxter, Neal E. ..... 306 E. Fifth St.
Bidney, Evelyn B. ..... 321 S. Jordan Ave.
Borland, Raymond M. ..... R. R. 3
Buckingham, Richard E. ..... 344 College Ave.
Cochran, John F. ..... Indiana University
Creek, Jean A. ..... 312 N. Walnut St.
Estes, Ambrose C. ..... 121 E. Kirkwood Ave.
Fowler, Richard R. ..... 104 N. Grant St.
Geiger, Dillon D. ..... 300 E. Kirkwood
Hardtke, Eldred F. ..... 509 E. Fourth St.
Hepner, Herman S. ..... 312 N. Walnut St.
Holland, Deward J. (S) ..... 313 N. College Ave.
Holland, Philip T. ..... 108 W. 7th St.
Holtzman, Paul W. ..... 615 N. College
Hrisomalos, Frank N. ..... 306 E. Fifth St.
Link, William C. ..... 110 E. Fourth St.
Lundblad, Wilfred M. ..... 1805 E. Tenth St.
Lyons, Robert E. ..... 321 E. Fifth St.
Manifold, Harold M. ..... 114 N. Lincoln St.
Marchant, Clarence H. ..... 350 S. College Ave.
McIntire, Clarence B. ..... Bloomington Hospital
Middleton, Thomas O ..... 404 E. Seventh St.
Milan, Joseph F. ..... 106 N. Grant St.
Miller, John M. ..... Indiana University
Owen, Margaret A. ..... 200 S. Washington St.
Pizzo, Anthony ..... Bloomington Hospital
Poolitsan, George C. ..... 407 N. Walnut St.
Quarles, E. Bryan ..... Indiana University
Ramsey, Hugh S. ..... 307 E. Fifth St.
Reed, William C. ..... 307 E. Fifth St.
Rieger, I. Taylor ..... 102 N. Grant St.
Rogers, Otto F., Jr. ..... 210 N. Washington St.
Rollins, Thomas K. ..... 114 E. Seventh St.
Ross, Ben R. ..... 314 E. Seventh St.
Ross, James B. ..... 314 E. Seventh St.
Schuman, Edith B. ..... Indiana University
Sibbitt, Joseph W. ..... 300 E. Fifth St.
Smith, Herschel S. ..... 110 S. Lincoln
Smith, Rodney D. (S) ..... 115 N. Washington St.
Spencer, Beaufort A. ..... 114 N. Lincoln
Stangle, William J. ..... 640 S. Rogers
Taraba, Ralph W. ..... Indiana University
Topolgus, James N. ..... 403 N. Walnut St.
Wenzler, Paul J. ..... 110 S. Washington St.
Wilson, Talmage L. ..... 301 E. Kirkwood

Stouder, Charles E. ..... Ellettsville
Mitchell, George L. (S) ..... Smithville
Brown, Marcel S. ..... Spencer
Kay, Oran E. ..... Spencer
Smith, Frederick R. ..... Spencer

PARKE-VERMILLION COUNTIES

Greene, Frederick G. (S) ..... Bloomingdale
Goodrum, William R. ..... Cayuga

Clinton

Evans, Frederick J. ..... 242 S. Third St.
Gerrish, Wakefield D. (S) ..... 125 S. Fifth St.
Herzberg, Milton ..... 222 Elm St.
Kercheval, John M. ..... 819 S. Third St.
White, Isaac D. (S) ..... 427 S. Fourth St.

Lauer, Dorothy B. ..... Dana
Britton, Welbon D. ..... Montezuma
De Renne, William L. ..... Newport
Johnson, William A. (S) ..... Perrysville

Rockville

Bloomer, Richard S. ..... 115 N. Market St.
Dowell, Emil H. ..... Parke Hotel Bldg.
Harstad, Casper ..... 216 W. High St.
Kempf, Gerald F. ..... Indiana State Sanitarium
Merrell, Basil M. ..... 110 E. York St.
Noblitt, James S. (S) ..... Rockville
Pace, Jerome V. ..... Indiana State Sanitarium
Pirkle, Hubert B. ..... Indiana State Sanitarium
Zierer, Reubon O. ..... Indiana State Sanitarium
Fell, Robert M. ..... Rosedale
White, Chester S. (S) ..... Rosedale

Pickett, Paul ..... 3140 Silverton, Dallas 29, Texas

PERRY COUNTY

Bush, Hargis R. ..... Cannelton

Tell City

Dome, Hardin S. (S) ..... 704 Ninth St.
Dukes, David A. ..... 521 Main St.
Gilbert, Robert G. ..... Perry Co. Mem. Hosp.
Glenn, Fred C. (S) ..... 436 Main St.
Herr, John W. ..... 622 Main St.
James, John M. ..... 746 Ninth St.
James, Nicholas A. (S) ..... 746 Ninth St.
Lohoff, Lewis C. ..... 507 Main St.
Neifert, Noel L. ..... 507 Main St.
Smith, Fred, Jr. ..... 507 Main St.

Snyder, Earl R. (S) ..... Troy

PIKE COUNTY

Petersburg

Hall, Donald L. ..... 7th & Poplar Sts.
Omstead, Milton ..... 110 S. Sixth St.

DeTar, George B. (S) ..... Winslow

Higgins, James L.
551st USAF Hospital, Otis AFB, Mass.

PORTER COUNTY

Chesterton

Griffin, Joseph P. ..... 139 S. Calhoun
Hall, Thomas C. ..... 621 Broadway
Harless, Clarence M. ..... 123 Indiana Ave.
Read, John E. ..... 114 S. 11th St.
Robertson, William C. ..... 600 E. Morgan

Kleinman, Francis J. ..... Hebron

Valparaiso

Brown, James C. ..... 101 Lincolnway
Covey, Thomas J. ..... 552 Lincolnway
Davis, Carl M. ..... 202 Indiana Ave.
DeGrazia, Eugene J. ..... 810 LaPorte Ave.
Dittmer, Jack E. ..... 23 Lincolnway
Dittmer, Thomas L. ..... 23 Lincolnway
Eades, Ralph C. ..... 6 Napoleon St.
Frank, John R. (S) ..... 23 Lincolnway
Green, Leonard J. ..... 8 N. Garfield
Griffin, Charles G. ..... 813 La Porte Ave.
Koenig, Robert L. ..... 810 La Porte Ave.
Makovsky, Theodore ..... 808 Lincolnway
O'Neill, Martin ..... 810 LaPorte Ave.
Sacks, Leonard Z. ..... Porter Memorial Hosp.
Scheimann, Lois ..... 702 Lincolnway
Schmidt, Richard H. ..... Porter Memorial Hospital
Stoltz, Robert M. ..... 501 Lincolnway
Vietzke, Paul C. F. ..... 60 Jefferson St.

Gordon, Joseph L. ..... Wheeler

POSEY COUNTY

Montgomery, Samuel B. (S) ..... Cynthiana
Ropp, Harold E. ..... New Harmony
Boren, Paul ..... Poseyville
Boren, Samuel W. (S) ..... Poseyville
Boyle, Carroll ..... Poseyville
Woods, Arba L. (S) ..... Poseyville

Mount Vernon

Challman, William B. ..... 431 W. Third St.
Crist, John R. ..... 105 E. Sixth St.
Hirsch, Herman L. ..... 126 W. Fifth St.
Oliphant, Frank W. ..... 701 Mulberry St.
Vogel, L. John ..... 131 W. Third St.

PULASKI COUNTY

Dublin, Madeline P. ..... Francesville
Sullivan, Francis J. ..... Francesville
Lacy, John D., Jr. ..... Medaryville
Eshelman, Henry R. ..... Monterey

Winamac

Carneal, Thomas E. (S) ..... 111 N. Monticello
Halleck, Harold J. ..... 119 W. Main St.
Hollenberg, Edward L. ..... 210 S. Market St.
Karns, John D. ..... 105 N. Franklin
Thompson, William R. ..... 111 N. Monticello

PUTNAM COUNTY

Veach, Lester W. ..... Bainbridge
Veach, Richard L. ..... Bainbridge
Gray, Clyde C. (S) ..... Cloverdale

Greencastle

Dester, Herbert E. ..... Box 76
Dettloff, Frederick ..... Alamo Bldg.
Fuson, Wenfred J. ..... Alamo Bldg.
Johnson, James B. ..... 105 E. Washington St.
Nichols, Anne Sackett ..... 707 E. Seminary St.
Reigle, Frederick C. ..... 105 E. Washington St.
Schauwecker, Cleon M. ..... 239 Hillsdale Ave.
Smith, A. Wilson ..... DePauw University
Steele, Dick J. ..... Alamo Bldg.
Tennis, George T. ..... Alamo Bldg.
Tipton, William R. ..... 110 S. Vine St.
Wiseman, V. Earle ..... 239 Hillsdale Ave.

Byrne, Louis E. ..... Roachdale
Richards, Edgar E. ..... Russellville

RANDOLPH COUNTY

Nixon, Byron ..... Farmland
White, Harvey E. ..... Farmland
Harmon, Wayne ..... Lynn
Jordan, Leo E. ..... Lynn
Martin, Charles E. (S) ..... Lynn
Shallenberger, Henry R. ..... Modoc
Hinchman, Jean F. ..... Parker
Potter, Richard M. ..... Ridgeville

Union City

Birum, Patricia ..... 334 W. Oak St.
Chambers, Carol R. ..... Chambers Medical Clinic
Chambers, Leroy B. ..... Chambers Medical Clinic
Landon, David J. ..... R.R. #2
McClure, Morris E. ..... 334 W. Oak St.
Phipps, Leland K. ..... 227 W. Oak St.
Reid, Robert W. (S) ..... 726 W. Division St.
Wagoner, B. D. ..... 232 W. Oak St.

Winchester

Brenner, Andrew M. ..... 129 N. Meridian
Dininger, William S. ..... 102 E. South St.
Engle, Russell B. ..... 210 S. Main St.
Koch, Howard W. ..... 208 E. Washington St.
Painter, Lowell W. ..... 124 E. Franklin St.
Slick, Crystal R. ..... 457 Elm St.
Sparks, Paul W. ..... 214 S. Main St.

Ruby, Fred McK. (S)
8128 Brookside Pl., Wauwatosa, Wis.

RIPLEY COUNTY

Hisrich, Lloyd W. ..... Batesville
Freeland, Bill E. ..... Batesville
Warn, William J. ..... Milan
Lippoldt, Charles L. ..... Oldenburg
Row, George S. ..... Osgood
Smith, R. Lee ..... Osgood
McConnell, William C. ..... Sunman
Fletcher, Charles F. (S) ..... Sunman

RUSH COUNTY

McNabb, George B.....Carthage
McNabb, Richard C.....Carthage
Sheets, Charles E.....Manilla
Worth, C. Willard.....Milroy

Rushville

Atkins, Clarence C.....225 N. Morgan St.
Corpe, Kenneth F.....R. R. No. 4
Dean, Donald I.....4th & Main
Denny, Melvin H.....127 W. Third St.
Ellis, Davis W.....229 N. Morgan St.
Green, Frank H.....134 E. Second St.
Johnson, Robert B.....229 N. Morgan St.
Lee, John M. (S).....914 N. Morgan St.
McKee, Harry G.....335 N. Main St.
Norris, Marvin G.....134 E. Second St.
Nutter, Wyndham H.....1003 N. Morgan

ST. JOSEPH COUNTY

How, John T. (S).....Lakeville

Mishawaka

Barone, Carmelo V.....307 W. Fourth St.
Christophel, Verna.....109 W. Third St.
Farner, James E.....114 Lincolnway E.
Fujawa, Matthew J.....721 Lincolnway E.
Ganser, Richard A.....111 S. Race St.
Goethals, Charles J.....602 Lincolnway W.
Mahank, Camiel C.....223 S. Spring St.
Martin, Charles F.....322 S. Mill St.
Reed, Robert F.....316 Lincolnway E.
Rosenwasser, Jacob.....225 Lincolnway E.
Sirlin, Edward M.....109 S. Church St.
Spalding, Wendell L.....427 Lincolnway E.
Templeton, Ames R.....522 Calhoun St.
Van Rie, Leo P. (S).....116 S. West St.
Walerko, Frank.....124 S. Race St.
Walters, Charles E.....319 S. Spring St.
Whitlock, Francis C.....110 N. Race St.
Whitlock, Merle E.....123 W. Fourth St.
Wixted, John F.....314 Lincolnway E.
Wixted, Julia F.....314 Lincolnway E.
Wurster, Herbert C.....221 E. Third St.
Zimmer, Henry J.....119½ Lincolnway W.

Luzadder, John E.....New Carlisle
Hardy, John J. (S).....North Liberty
Randall, Thomas A.....North Liberty
Warrick, Homer L.....Osceola

South Bend

A

Acker, Robert B. (S)....418 Sherland Bldg. (1)
Arisman, Ralph K.....607 Odd Fellows Bldg. (1)

B

Backs, Alton J.....1401 Lincolnway W. (28)
Baran, Charles.....404 Sherland Bldg. (1)
Bartsch, Harvey L.....424 Sherland Bldg. (1)
Bechtold, Samuel E.....730 Sherland Bldg. (1)
Bell, Horace D.....420 N. Hill St. (17)
Bennett, Jene R.....531 N. Main St. (1)
Berke, Robert D.....1118 Lincolnway E. (18)
Biasini, Benedict A.....403 Dixie Way North (17)
Bickel, David A.....515 Odd Fellows Bldg. (1)
Birmingham, Peter J. (S)..426 Sherland Bldg. (1)
Bishop, Charles A.....122 N. Lafayette Blvd. (1)
Bixler, Louis C.....615 Sherland Bldg. (1)
Blackburn, Erwin.....402 Sherland Bldg. (1)
Bodnar, Leslie M.....525 N. Michigan (1)
Booth, Franklin M.....530 Sherland Bldg. (1)
Borough, Lester D.....710 J. M. S. Bldg. (1)
Brechtl, Harvey J.....728 W. Colfax Ave. (1)
Bryan, Robert J.....1002 Lincolnway W. (16)
Buchanan, Wallace D.....825 Sherland Bldg. (1)
Buechner, Frederick W.....116 N. Main St. (1)
Buslee, Roger M.....531 N. Main Street (1)
Bussard, Clifford F. (S)
202 Whitcomb-Keller Bldg. (1)
Bussard, Frank....202 Whitcomb-Keller Bldg. (1)
Butts, Milton A.....118 N. Walnut St. (28)

C

Carter, F. R. Nicholas....605 Sherland Bldg. (1)
Cassady, James V.....921 Lincolnway E. (18)
Cassady, John R.....921 Lincolnway E. (18)
Chamblee, Roland W.....336 N. Notre Dame (17)
Clark, Stanley A. (S) .1242 E. Jefferson Blvd. (17)
Clark, William H.....520 Sherland Bldg. (1)
Colip, George D.....514 Sherland Bldg. (1)
Colosey, Frederick J...3121 Mishawaka Ave. (15)
Condit, David H.....122 N. Lafayette Blvd. (1)
Conklin, Raymond L...215 Swanson Circle W. (15)
Cook, Gordon C.....719 N. Main St. (1)
Cooper, Harry L. (S)....410 Sherland Bldg. (1)
Crowley, Joseph B.....Notre Dame Univ.
Culbertson, Carl S.....531 N. Main St. (1)
Custer, Edward W.....Healthwin Hospital (17)

D

Denham, Robert H.....401 Sherland Bldg. (1)
Devoe, Kenneth.....418 N. Michigan St. (1)
Dietl, Ernest L.....820 Sherland Bldg. (1)
Dodd, Robert D.....2311 Miami St. (14)
Dolezal, Bernard J.....119 S. Eddy St. (17)
Dunlap, D. Logan.....203 J. M. S. Bldg. (1)

E

Eades, R. Charles.....527 Colfax (17)
Ebin, Judah L.....816 Odd Fellows Bldg. (1)
Edwards, Bernard E.....704 N. Main St. (1)
Egan, Sherman.....203 J. M. S. Bldg. (1)
English, John P.....122 N. Lafayette Blvd. (1)
Ericksen, Lester G.....615 Sherland Bldg. (1)
Erickson, Gustaf W...122 N. Lafayette Blvd. (1)

F

Feferman, Martin E.....315 Sherland Bldg. (1)
Feldman, Max.....1921 Miami St. (14)
Filipek, Walter J.....311 Odd Fellows Bldg. (1)
Firestein, Ben Z.....703 J. M. S. Bldg. (1)
Firestein, Ray.....416 Sherland Bldg. (1)
Fish, Edson C.....326 Sherland Bldg. (1)
Fisher, Lawrence F.....1717 E. Colfax (17)
Frank, Herbert.....3610 W. Western Ave. (25)
Frank, Lyall L., Jr.....224 W. Navarre (1)
Frank, Lyall L.....224 W. Navarre (1)
Frash, DeVon W.....1910 Miami (14)
Frey, William B.....316 N. Ironwood Dr. (15)
Friedman, Morris S.....503 Sherland Bldg. (1)
Frith, Louis G.....521 W. Washington Ave. (1)

G

Gaffney, Raymond.....535 W. Colfax Ave. (1)
Ganser, Ralph V.....302 Sherland Bldg. (1)
Gates, George E.....122 N. Lafayette Blvd. (1)
Geisler, Hans E.....710-B E. Cedar St. (17)
Gilman, Marcus M.....403 Odd Fellows Bldg. (1)
Godersky, George E...512 Odd Fellows Bldg. (1)
Graf, John P.....326 Sherland Bldg. (1)
Green, George F.....822 Sherland Bldg. (1)
Green, Norval E.....704 N. Main St. (1)
Grillo, Donald.....723 Sherland Bldg. (1)
Grorud, Alton C.....122 Lafayette Blvd. (1)
Grove, James H.....825 Sherland Bldg. (1)

H

Haley, Paul E.....816 Sherland Bldg. (1)
Hall, James M.....230 Sherland Bldg. (1)
Hamilton, Charles O.....602 N. Michigan (1)
Hanley, Harriet F.....316 N. Ironwood Dr. (15)
Hartwick, John P.....St. Joseph's Hosp. (17)
Haugseth, Ellsworth K...122 Lafayette Blvd. (1)
Hawkins, Glen E.....602 N. Michigan (1)
Helman, Harry W. (S)..120 Franklin Place (1)
Helmer, John F.....826 Sherland Bldg. (1)
Hilbert, John W.....410 W. Washington Ave. (1)
Hildebrand, John O.....1307 E. Ewing Ave. (14)
Hill, Theodore A.....107 N. Eddy (17)
Hill, Wallace C.....430 Sherland Bldg. (1)
Hillman, Marion W.....206 E. Bartlett St. (1)
Hillman, William H. (S)
1317 Marquette Blvd. (16)
Holdeman, Richard W..404 N. Lafayette Blvd. (1)
Holtzman, Norman N.....3123 S. Michigan (14)
Hord, Luther J., Jr.....Curtiss-Wright Corp.
Houser, D. Stanley.....2314 Miami (14)
How, Louis E.....60649 S. Michigan (14)
Hyde, Carroll C.....122 N. Lafayette Blvd. (1)

J-K

Johns, Nicholas C.....718 Sherland Bldg. (1)
Kamm, Bernard A.....526 Sherland Bldg. (1)
Karn, John W.....326 Sherland Bldg. (1)
Knapp, Arthur L. (S) .2215 Mishawaka Ave. (15)
Knode, Kenneth T.....729 Sherland Bldg. (1)
Krueger, John E.....326 Sherland Bldg. (1)
Kuhn, Frederick L.....1215 S. Michigan (18)

L

Lamb, J. Leonard.....706 J. M. S. Bldg. (1)
Lane, William H.....418 N. Main St. (1)
Lang, Joseph E.....318 Sherland Bldg. (1)
Lester, Vern L.....825 Sherland Bldg. (1)
Levatin, Bernard I.....711 Odd Fellows Bldg. (1)
Levkoff, Abner H.....119 S. Eddy St. (17)
Lionberger, John R.....615 Sherland Bldg. (1)
Lockhart, Philip B.....825 Sherland Bldg. (1)

M

MacLeod, John K.....120 N. Lafayette Blvd. (1)
Marquis, Gordon.....120 N. Lafayette Blvd. (1)
Martinov, William E.....822 Sherland Bldg. (1)
Mason, Bernard A.....122 N. Lafayette Blvd. (1)
Mather, Glenn B.....1229 Chimes Blvd. (15)
McCraley, William J.....406 Sherland Bldg. (1)
McDonald, Ralph M.....410 J. M. S. Bldg. (1)
McFarland, Corley B...122 N. Lafayette Blvd. (1)
Metcalfe, Grant E.....319 Odd Fellows Bldg. (1)
Miller, Milo K. (S).....122 N. Lafayette Blvd. (1)
Mott, Cassell A...1301½ W. Washington St. (16)
Mueller, Hilbert M...122 N. Lafayette Blvd. (1)
Murphy, Eugene C.....122 N. Lafayette Blvd. (1)
Murphy, Josephine F.....111 W. Bartlett St. (1)
Myers, Philip R.....St. Joseph's Hospital (17)

N-O

Nelson, F. Dale.....704 N. Main St. (1)
Nelson, Raymond E.....206 E. Bartlett St. (1)
Olson, Donald T.....713 W. LaSalle St. (1)
Olson, Kenneth L.....615 Sherland Bldg. (1)
Oren, William F.....530 Sherland Bldg. (1)
Orr, W. Robert .....525 N. Michigan St. (1)

P

Parsons, Robert L.....424 Odd Fellows Bldg. (1)
Pauszek, Thomas B...704 W. Washington St. (16)
Petrass, Andrew.....516 Sherland Bldg. (1)
Phelps, Stephen R.....818 Sherland Bldg. (1)
Plain, George.....122 N. Lafayette Blvd. (1)
Proudfit, Charles H...525 Odd Fellows Bldg. (1)
Pyle, Harold D.....119 S. Eddy St. (17)

R

Rasmussen, Ruth F...122 N. Lafayette Blvd. (1)
Reinhardt, Charles F.....621 N. Main St. (1)
Rigley, Edward L.....408 Sherland Bldg. (1)
Roberts, Billy J.....3123 Mishawaka Ave. (15)
Rodin, Herman H.....714 Whitehall Dr. (15)
Rosenheimer, George M...418 N. Michigan St. (1)
Rubens, Eli.....2314 Miami (14)
Rudolph, Carl J.....110 W. Bartlett St. (1)

S

Sanderson, Robert B.....730 Sherland Bldg. (1)
Sandock, Isadore.....819 E. Napoleon St. (17)
Sandock, Louis F.....428 Sherland Bldg. (1)
Sandoz, Harry H.....612 Odd Fellows Bldg. (1)
Schaphorst, Richard A.....1124 Whitehall Dr. (15)
Schiller Herbert A.....226 Sherland Bldg. (1)
Scott, Frank M.....122 N. Lafayette Blvd. (1)
Selby, Keith E.....407 Lincolnway W. (1)
Sellers, Francis M.....3209 Mishawaka Ave. (15)
Sensenich, Roscoe L. (H) ....128 S. Scott St. (25)
Sharp, Merle C.....717 N. Main St. (1)
Shelley, Edward S.....207 S. Taylor (25)
Shriner, Richard L...319 Odd Fellows Bldg. (1)
Sisson, Norvel D.....531 N. Main St. (1)
Skillern, Penn G. (S)
1014 E. Fox St. (14)
Skillern, Scott D.....422 Sherland Bldg. (1)
Slominski, Harry H...708 Odd Fellows Bldg. (1)
Spenner, Raymond W.....726 Sherland Bldg. (1)
Staunton, Henry A.....3016 Mishawaka Ave. (15)
Stiver, Daniel D.....822 Sherland Bldg. (1)
Stogdill, William J.....525 Sherland Bldg. (1)

T

Thompson, John M.....921 Lincolnway E. (18)
Thompson, Robert A.
913 S. Twyckenham Dr. (15)
Thornton, Maurice J.....825 Sherland Bldg. (1)
Tirman, Wallace S.....615 Sherland Bldg. (1)
Traver, Perry C. (S)....1010 Riverside Dr. (16)

V-W-X-Y-Z

Vagner, S. Bernard
1303½ W. Washington Ave. (16)
Van Campen, Warren M.....Memorial Hospital (1)
Vurpillat Francis J...132 N. Lafayette Blvd. (1)
Walker, Edwin M., Jr.....326 Sherland Bldg. (1)
Ward, James W.....19248 Summers Dr. (17)
Weiss, Eugene.....2521 S. Michigan (14)
White, Donald G.....1721 E. Altgeld St.
Wilhelm, Agatha M..1832 E. Wayne at Eddy. (15)
Wilson, James M.....621 J. M. S. Bldg. (1)
Zeiger, Irvin.....3123 Mishawaka Ave. (15)

Carter, William D...506 Roosevelt Rd., Walkerton
Rohrer, Bryce B.....506 Roosevelt Rd., Walkerton
Skeen, Earl D. (S).....Walkerton
Cline, Kenneth L.....Wyatt

Backs, Mark F.
228 Cowbell Rd., Willow Grove, Pa.
Bassler, Carl R. (S).....R. #4, Niles, Michigan
Ellison, Alfred...7304 Encelia Dr., La Jolla, Calif.
Fish, Clyde M. (S)
1533 S. E. Sixth St., Deerfield, Florida
Liss, Emanuel C.
112-20 72nd Dr., Forest Hills, New York
Stratigos, Joseph S.
2048 Pratt Court, Evanston, Ill.

SCOTT COUNTY

Bogardus, Carl R. ..... Austin
Boneta, Thomas L. ..... Scottsburg
McClain, Marvin L. ..... Scottsburg
Napper, Floyd S. ..... Scottsburg

SHELBY COUNTY

Nigh, Rufus M. ..... Fairland
Davis, John A. ..... Flat Rock

Shelbyville

Arata, Lucian A. ..... 327 W. Broadway
Dalton, Wilson L. ..... 117 W. Washington St.
Gehres, Robert W. ..... 15 S. Tompkins St.
Inlow, Herbert H. ..... 103 W. Washington St.
Inlow, William D. ..... 103 W. Washington St.
Miller, Richard C. ..... 17 Mechanic St.
Richard, Norman F. ..... 103 W. Washington St.
Scott, V. Brown ..... 103 W. Washington St.
Spindler, Robert D. ..... 165 W. Mechanic St.
Tindall, Paul R. (S) ..... 20 N. Pike St.
Tindall, William R. ..... 505 S. Harrison St.
Tower, James H., Jr. ..... 120 W. Jackson St.
Travis, Floyd D. ..... 103 W. Washington St.
Whitcomb, Roger F. ..... 302 Methodist Bldg.

Alden, John O.
111 Westmont, West Hartford 17, Conn.

SPENCER COUNTY

Gailey, Ivan ..... Chrisney
Barrow, John H. ..... Dale
Medcalf, Norman L. (S) ..... Lamar
Jolly, Wesley P. (S) ..... Richland
Atchison, Kenneth C. (S) ..... Rockport
Glackman, John C., Jr. ..... Rockport
Monar, Michael ..... Rockport

STARKE COUNTY

Leinbach, Earl ..... Hamlet

Knox

DeNaut, James F. ..... 4 N. Heaton St.
Henry, Howard J. ..... 107 S. Main St.
Ingwell, Guy B. ..... 201 S. Heaton St.
McClure, Clark ..... 107 S. Main St.

North Judson

Matthew, John R. ..... 420 S. Lane St.

STEUBEN COUNTY

Angola

Artz, Richard W. ..... 416 E. Maumee
Barton, Robert ..... 416 E. Maumee
Cameron, Don F. ..... 416 E. Maumee
Cameron, Mary H. ..... 416 E. Maumee
Crum, Marion M. ..... 301 E. Maumee
Hartman, John J. ..... 209 W. Felicity
Kissinger, Knight L. ..... Elmhurst Hospital
Mason, Donald G. ..... 416 E. Maumee
Rausch, Norman W. ..... 416 E. Maumee

Blosser, Blaine A. (S) ..... Fremont
McCormack, Lloyd L. ..... Fremont
Alford, James A. ..... Hamilton
Schrepferman, Wayne ..... Hamilton

SULLIVAN COUNTY

Brown, John S. ..... Carlisle
Whipps, Charles E. (S) ..... Carlisle
Dukes, Betty ..... Dugger
Dukes, Frederic M. (S) ..... Dugger
Dukes, Joe E. ..... Dugger
Bethea, Robert O. ..... Farmersburg

Sullivan

Bedwell, Marion H. ..... 16 N. Court St.
Crowder, James H. ..... 112 N. Section St.
Eskew, Kenneth W. ..... 117 W. Washington St.
Higbee, Paul (S) ..... 4 E. Washington St.
Maple, James B. (S) ..... 117 W. Washington St.
McClure, Glenn ..... 342 S. Main St.
Scott, Irvin H. ..... 117 W. Washington St.

Taylor, John R. ..... 105 N. Main, Palestine, Ill.
Daugherty, William L. ..... Hutsonville, Ill.

SWITZERLAND COUNTY

(See Jefferson-Switzerland)

TIPPECANOE COUNTY

Lafayette

Ade, Charles H. ..... 2211 South St.
Ade, Mary Keller ..... 2211 South St.
Baker, John R. ..... 405 Lafayette Life Bldg.
Balkema, Catherine M. ..... 3 N. 18th St.
Bayley, William E. ..... Home Hospital
Bolin, Robert C. ..... 308 N. Eighth St.
Buhrmester, Harry C., Jr. ..... 308 N. Eighth St.
Burkle, John C. (S) ..... 133 N. Fourth St.
Burns, John T. ..... 2502 South St.
Calvert, Raymond R. ..... 314 N. Sixth St.
Canganelli, Vincent G. ..... 2433 South Ninth St.
Carpenter, James B. ..... 15 N. 25th St.
Cole, Ira ..... 2315 South St.
Coyner, Alfred B. ..... 509 Lafayette Life Bldg.
Davis, Howard B. ..... 308 N. Eighth St.
Deur, Julius ..... 1011 Columbia
Donahue, George R. ..... 718 Lafayette Life Bldg.
Dubois, Ramon B. ..... 23 N. 25th St.
Eaton, Marion J. ..... 214 Lafayette Life Bldg.
Elliott, Paul W. ..... 35 N. 25th St.
Engeler, James E. ..... 308 N. Eighth St.
Ferguson, William B. ..... 2211 South St.
Fields, Donald C. ..... 312 N. Eighth St.
Flack, Russell A. ..... 1005 Lafayette Life Bldg.
Frasch, Mahlon G. ..... 300 Lafayette Life Bldg.
Frey, Harley B. ..... 405 Lafayette Life Bldg.
Gery, Richard E. ..... 308 N. Eighth St.
Gripe, Richard P. ..... 308 N. Eighth St.
Haas, Charles F. ..... 2211 South St.
Harden, Murray E. ..... 903 Lafayette Life Bldg.
Harter, Eli B. ..... 312 N. Eighth St.
Herrold, George W. ..... 20 N. 24th St.
Hogle, Frank D. ..... Wabash Valley Sanitarium
Holladay, Lloyd J. ..... 411 Lafayette Life Bldg.
Hughes, Richard R. ..... 31 N. 25th St.
Hull, James E. ..... 2211 South St.
Hunsberger, Walter G. ..... St. Elizabeth Hospital
Hunter, Frank P. (S) ..... 617 Lafayette Life Bldg.
Johnson, Herbert S. ..... 312 N. Eighth St.
Johnson, Lowell R. ..... 2315 South St.
Jones, David ..... 24 N. 24th St.
Karberg, Richard J. ..... 2420 Ferry St.
Klatch, Ben Z. ..... 2211 South St.
Klepinger, Harry E. ..... 824 Lafayette Life Bldg.
Kohne, Robert W. ..... 3010 Underwood

Landis, Charles B.....2211 South St.
Laws, Kenneth F.....501 Lafayette Life Bldg.
Levering, Guy P. (S).....2113 S. Eighth St.
Loop, Frederick A.....2211 South St.
McAdams, Hugh B.....2011 Kossuth St.
McAdams, Robert.....2011 Kossuth St.
McClelland, Donald C. (S).....312 N. Eighth St.
McFadden, James M.....35 N. 25th St.
McKinley, Joseph.....312 Lafayette Life Bldg.
McKinney, Daniel H.....301 Lafayette Life Bldg.
Marsh, George W.....1216 Howell
Marvel, Howard R.....308 N. 8th St.
Mather, Charles R.....20 N. 24th St.
Mather, Robert L.....609 Lafayette Life Bldg.
Miller, Roland E.....2200 Scott St.
Neumann, Kenneth O.....618 Lafayette Life Bldg.
Onorato, Joseph J.....2433 S. Ninth St.
Pearlman, Samuel S. (S).....107 N. Sixth St.
Peterson, Joel A.....609 Lafayette Life Bldg.
Peyton, Frank W.....15 N. 25th St.
Ratcliff, Frank W.....405 Lafayette Life Bldg.
Rothrock, Philip W.....2200 Scott St.
Ruschli, Edward B. (S)..510 Lafayette Life Bldg.
Shively, John L.....2211 South St.
Sholty, William M.....405 Lafayette Life Bldg.
Smith, Lowell C.....637 Ferry St.
Stahl, Edward T.....308 N. Eighth St.
Stansell, Gilbert B.....St. Elizabeth Hosp.
Steele, Hugh H.....308 N. Eighth St.
Strayer, Joseph W.....612 Lafayette Life Bldg.
Trout, Carl J.....314 N. Sixth St.
Tubbs, George R. (S).....2503 Main St.
Underwood, George M.
Jefferson Sq. Shopping Center
Van Buskirk, Edmund L.....308 N. Eighth St.
Van Den Bosch, Wallace R.....2216 South St.
Vermilya, Robert W.....405 Lafayette Life Bldg.
Weaver, Richard J.....St. Elizabeth Hosp.
Williams, Robert E.....15 N. 25th St.

Mitchell, Edgar T. (S).....Romney
Babb, Forrest J.....Stockwell

West Lafayette

Ash, Harold H.....712 Bexley Rd.
Carroll, Bertha Rose.....Purdue University
Crockett, Franklin S. (H).....424 Littleton St.
Hass, Caroline E.....402 Northwestern Ave.
Hass, Thomas W.....402 Northwestern Ave.
MacLeod, Donald F.....Purdue University
McCabe, James E.....Soldiers Home
Meikle, Louise J. (S).....606 Terry Lane
Rommel, Clarence H.....456 Northwestern
Schmiedicke, Paul H.....Purdue University
Wilms, John H.....Purdue University

TIPTON COUNTY

Haller, Robert L.....Kempton
Stouder, Albert E.....Kempton
Tranter, William F.....Sharpsville

Tipton

Burkhardt, Boyd A.....202 S. West St.
Carter, Jean V.....130 N. Main St.
Compton, George.....219 N. Independence
Gossard, Meredith B.....308 N. Independence
Kincaid, Raymond K.....202 S. West St.
Kurtz, William A.....202 S. West St.

Ericson, Harold L.....Windfall
Moser, Elmer B. (S).....Windfall

UNION COUNTY

(See Wayne-Union)

VANDERBURGH COUNTY

Evansville

A

Acre, Robert R.....706 Walnut St. (8)
Adler, Raymond N.....714 Second Ave. (10)
Adye, Wallace M.....1307 N. Stringtown Rd. (11)
Alexander, John E.....609 Hulman Bldg. (8)
Anderson, Milton H...Evansville State Hosp. (2)
Antes, Earl H.....420 Cherry St. (13)
Arendell, Robert E.....1400 Cass Ave. (14)
Austin, Eugene W.....3700 Belle Meade(15)
Austin, M. A. (S)....3900 Washington Ave. (15)

B

Baker, Herman M. (S).....402 Hulman Bldg. (8)
Baker, Mason R.....1008 S. Evans Ave. (13)
Barclay, Irvin C.....114 S. E. Second St. (8)
Barnhart, Willard T.....701 Chestnut St. (13)
Baylor, Edward M.....501 E. Cherry St. (13)
Beck, Robert E.....600 Mary St. (10)
Begley, Joseph W. Jr..314 S. E. Riverside Dr. (13)
Bender, Martin J.....912 Hulman Bldg. (8)
Bennett, Abner P.....412 S. E. Fourth St. (13)
Bissonnette, Roger P.....420 Cherry St. (13)
Boone, Robert D.....420 Cherry St. (13)
Boswell, Robert W. C.....2351 Division St. (14)
Boyd, Stella N.....502 Hulman Bldg. (8)
Brakel, Frank J.....420 Cherry St.
Britt, Robert.....420 Cherry St. (13)
Brockmole, Arnold W.....201 S. E. Third St. (13)
Brown, George W.....2404 W. Penn (12)
Bryan, Stanton L.....607 Hulman Bldg. (8)
Buehner, Donald F.....3700 Bellemeade (15)
Burger, Thomas C.....3700 Bellemeade (15)
Burnikel, Ray H.....527 Sycamore St. (8)
Burress, Clyde R.....723 Mary St. (10)

C

Cacia, John J.....609 Hulman Bldg. (8)
Caldwell, William C. (S)
504 Old National Bank Bldg. (8)
Carlson, Ralph F.....517 Sycamore St. (8)
Cheydleur, Eleanor P.
314 S. E. Riverside Dr. (13)
Clark, Thomas W.....420 Cherry St. (13)
Clouse, Paul A.....613 S. Weinbach Ave. (14)
Cockrum, William M.....908 Hulman Bldg. (8)
Cole, William L.....10 N. Weinbach (11)
Coleman, Joseph E.....3700 Bellemeade (15)
Combs, Herman T.....807 W. Indiana (10)
Combs, John H.....412 S. E. Fourth St. (13)
Combs, Pearl B. (S).....4109 Lincoln (15)
Cooper, Waller W.....Deaconess Hospital (10)
Corcoran, Patrick J. V.....3700 Bellemeade (15)
Crawford, James H.....221 Chestnut St. (13)
Crevello, Albert J.....3700 Bellemeade (15)
Crimm, Paul D.....Boehne Hospital (12)
Crudden, Charles H...Clearview Sanitarium (10)
Cullnane, Chris W.....2312 W. Franklin St. (12)
Cymbala, Bohdan.....St. Mary's Hospital (10)

D

Daugherty, Silas C.....420 Cherry St. (13)
Daves, William L.
608 Old National Bank Bldg. (8)
Davidson, Harold H.....420 Cherry St. (13)
Deems, Myers B.....314 S. E. Riverside Dr. (13)
Denzer, Edward K.....108 S. E. Second St. (8)
Denzer, William O.....108 S. E. Second St. (8)
Dieckman, Herbert S.....3700 Bellemeade (15)

Diefendorf, Charles F. (S)
2100 W. Virginia St. (12)
Dodd, Roberts K.....2605 Lincoln Ave. (14)
Downer, Luther H.....521 Oak Street (13)
Drake, Dale W.....St. Mary's Hospital (10)
Dunham, Henry H.....715 First Ave. (10)
Durkee, Melvin S.....3700 Bellemeade (15)
Dycus, Walter A.....319 N. St. Joseph Ave. (12)
Dyer, Wallace K.....221 Chestnut St. (13)

E

Ehrich, William S. (S)
Evansville State Hospital (2)
Eisterhold, John A.....5300 New Harmony Rd. (12)
Engel, Edgar L.....126 S. E. Seventh St. (8)

F

Faith, Ira L.....805 Old Nat'l. Bank Bldg. (8)
Faul, Henry J.....815 Hulman Bldg. (8)
Faw, Melvin L.....420 Cherry St. (13)
Fenneman, Robert J...402 S. E. Seventh St. (8)
Fickas, Dallas.....704 Hulman Bldg. (8)
Fisher, William C.....413 First Ave. (10)
FitzGerald, Maurice D.
924 Bayard Park Dr. (13)

G

Garland, Edgar A.....606 S. Weinbach (14)
Gaul, L. Edward.....509 Hulman Bldg. (8)
Getty, William H.....420 Cherry St. (13)
Giorgio, Douglas J.....916 S. Burkhardt Rd. (15)
Gow, Robert C.....Mead Johnson & Co. (21)
Griep, Arthur H.....5414 Madison Ave. (15)
Guckien, Joseph L.....609 Hulman Bldg. (8)

H

Hammond, R. Case.....701 Chestnut St. (13)
Hare, Daniel M.....706 Walnut St. (8)
Harlin, William L.....3700 Bellemeade (15)
Harned, Ben K.....420 Cherry St. (13)
Hart, L. Paul.....3700 Bellemeade Ave. (15)
Hartley, Clarence A., Jr.....221 Chestnut St. (13)
Hartz, F. Minton.....123 S.E. Second St. (8)
Hawk, Edgar A.....Mead Johnson & Co. (21)
Heard, Albert.....322 E. Cherry St. (13)
Heinrich, Weston A...314 S. E. Riverside Dr.(13)
Hendershot, Eugene L...412 S. E. Fourth St. (13)
Hermayer, Stephen....220 S. E. Seventh St. (13)
Herrmann, Gordon T.....3700 Bellemeade (15)
Herzer, Clarence C.....322 N. Fulton (10)
Himebaugh, Gilbert.....3700 Bellemeade (15)
Hobbs, Arthur A.....600 Mary St. (10)
Hoopes, Jane M.....3700 Bellemeade (15)
Hoover, J. Guy.....517 Sycamore St. (8)
Hovda, Richard B.....St. Mary's Hospital (15)
Huggins, Victor S.
703 Citizens Nat'l Bank Bldg. (8)
Hyatt, Gilbert T.....1106 W. Franklin St. (10)

J

Johnson, Gardner C. (S)..1412 Parkside Dr. (14)
Johnson, Harold V.....2114 W. Franklin St. (12)
Johnson, Stephen L.....521 Sycamore St. (8)

K

Kauffman, Harley M.....219 Walnut St. (8)
Kelly, John B.....420 Cherry St. (13)
Kessler, Robert B.....1338 Division St. (14)
Kiechle, Frederich L.....726 S. E. First St. (13)
Kincaid, Robert S.....1000 N. Spring St. (11)
Kleindorfer, Roscoe L...819 W. Franklin St. (10)

L

Laubscher, Clarence....6621 Kratzville Rd. (10)
Lawrence, Joseph C.....413 First Ave. (10)
Leibundguth, Henry.....221 Chestnut St. (13)
Leich, Charles F.....124 S. E. First St. (8)
Lyman, Frank L.....Mead Johnson & Co. (21)
Lynch, Harold D.....216 S. E. Riverside Dr. (13)

M

McCool, Joseph H.....314 S. E. Riverside Dr. (13)
McCoy, Melvin H.....1717 S. Norman
McDonald, Joseph D.....517 Sycamore St. (8)
MacKenzie, Pierce.....126 S. E. Seventh St. (8)
Mason, Everett E.....118 S. E. First St. (8)
Mathews, James R.....118 S. E. First St. (8)
Maxson, Roy V.....401 Mary St. (10)
Mayberry, Alton.....3700 Bellemeade (15)
Miller, Laverne B.....714 N. Main St. (11)
Miller, Milton.....15 W. Franklin St. (10)
Miller, Robert J.....1905 Division St. (14)
Mills, Fred E.....Deaconess Hospital (10)
Mino, Robert A.....723 Mary St. (10)
Moehlenkamp, Charles E.
614 N. Governor St. (11)
Moulton, Lillian G.....1 North Barker (12)
Muelchi, Adeline F.....518 Hulman Bldg. (8)
Murphy, Edward U.....901 Hulman Bldg. (8)
Myre, Theodore T.....517 Sycamore (13)

N

Nenneker, Henry (S)....1912 Harmonyway (12)
Newman, Alvin E.....912 Hulman Bldg. (8)
Newsome, C. K.....415 E. Mulberry (13)
Nicholson, Ray W.....3700 Bellemeade (15)
Niedermayer, Alfred J..960 Washington Ave. (13)
Nisenbaum, Harold...312 Old Nat'l Bank Bldg. (8)
Nonte, Leo R.....1218 Lincoln Ave. (14)

O

Oswald, Robert H.....126 S. E. Seventh St. (8)

P

Pastor, Julius W.....3700 Washington Ave. (15)
Pemberton, Jack J...319 N. St. Joseph Ave. (12)
Pollard, Walter S. (S)..115 S. E. Second St. (8)
Porro, Francis W.....3700 Washington Ave. (15)
Present, Julian.....113 S. E. Second St. (8)
Price, Shirley G.....420 Cherry St. (13)
Pugh, Willis L.....413 First Ave. (10)

R

Ratcliffe, Albert W.....510 S. E. First St. (13)
Reich, Clarence E.....1209 N. Fulton (10)
Rietman, H. Jerome
Evansville State Hospital (2)
Ritchie, William D.....555 Herndon Dr. (11)
Rittelmeyer, Louis F., Jr.
Mead Johnson & Co. (21)
Robinson, Earle U.....615 Bellemeade (13)
Rosenblatt, Bernard B.....709 Hulman Bldg. (8)
Royster, George M. (S)
401 Citizens Nat'l. Bank Bldg. (8)
Royster, Robert A.
401 Citizens Nat'l. Bank Bldg. (8)
Rusche, Henry J.....313 W. Iowa (10)
Russell, Richard H.....3700 Washington Ave. (15)

S

Schimmelpfennig, Robert W.
1013 Parrett St. (13)
Schirmer, Robert H.....1118 W. Franklin St. (12)
Schneider, Charles P...2211 W. Franklin St. (12)
Schriefer, Victor V.....1120 N. Main St. (11)
Sinn, Charles M.....402 Hulman Bldg. (8)
Slaughter, Howard C.....908 Hulman Bldg. (8)
Slaughter, John C.....3700 Bellemeade (15)
Slaughter, Owen L.....3700 Bellemeade (15)
Smith, Roy M.....1307 Stringtown Rd. (11)

Snively, William D., Jr.
Mead Johnson and Co. (21)
Sprecher, Herman C.....527 Sycamore St. (8)
Springstun, Walter R.....601 Hulman Bldg. (8)
Steele, Paul W.....1218B Lincoln Ave. (14)
Sterne, John H.....221 Chestnut St. (13)
Stork, Urban.....420 Cherry St. (13)
Strueh, Paul E.....220 S. E. Seventh St. (13)

T

Tager, Stephen N.....3700 Bellemeade (15)
Thompson, Naiad Mason....420 Cherry St. (13)
Tilden, Margaret H.....700 Mary St. (10)
Tisserand, John B. Jr.....3700 Bellemeade (15)
Tuholski, James M.....Mead Johnson & Co. (21)
Turner, Isabel B.....2208 E. Walnut St. (14)
Tweedall, Daniel C.....527 Sycamore St. (8)

U-V

Viehe, Robert W.....207 S. E. First St. (13)
Visher, John W..805 Old National Bank Bldg. (8)
VonderHaar, Thomas E.....402 Hulman Bldg. (8)

W

Walker, William F.....420 Cherry St. (13)
Walter, Robert F.....1514 S. Kentucky Ave. (14)
Warner, Charles L.....420 Cherry St. (13)
Waters, George W..Evansville State Hospital (2)
Watson, James L.....1158 Lincoln Ave. (14)
Weber, Edgar H.....123 S. E. Second St. (8)
Weiss, Henry G.....614 Hulman Bldg. (8)
Welborn, Mell B.....420 Cherry St. (13)
Wilhelmus, C. Kenneth..115 S. E. Seventh St. (8)
Wilhelmus, Gilbert M.....1028 Washington (15)
Willis, Charles F.....1100 S. Bedford Ave. (13)
Willison, George W.....3700 Bellemeade (15)
Wilson, David.....517 Mary St. (10)
Wilson, John D.....3700 Bellemeade (15)
Wilson, Ralph.....517 Mary St. (10)
Woods, William P. (S)....5050 Lincoln Ave. (15)
Wynn, Justice F.....905 Hulman Bldg. (8)

X-Y-Z

Young, C. Curtis.....126 S. E. Seventh St. (8)
Zeier, Francis G.....420 Cherry St. (13)
Zimmerman, Harold.....6 S. E. Second St. (8)
Ziss, Robert C.....216 S. E. Riverside (13)
Zwickel, Ralph E.....906 Hulman Bldg. (8)

Buchholz, Ransom R.....Georgetown, Texas
Jernigan, William R.
4135 Barron, Memphis, Tenn.
Nicholl, Willard
Warner-Lambert Res. Inst., Morris Plains, N. J.
Oppenheimer, Ernst
V. A. Hosp., 408 First Ave., New York 10, N. Y.
Steckler, Robert J.
9871 Aldgate, Garden Grove, Calif.

VERMILLION COUNTY

(See Parke-Vermillion)

VIGO COUNTY

Loving, Jury B.....New Goshen
McIntosh, Wilbert .....Riley
Jett, Clyde W.....Seelyville

Terre Haute

A

Allen, Orris T. (S).....422 Rose Dispensary Bldg.
Anderson, Walter C.....2235 Wabash Ave.
Ault, Roy.....3050 Poplar St.

B

Baldridge, William O...12 Points State Bank Bldg.
Bannon, William G.....416 Rose Dispensary Bldg.
Benages, Anthony G.....221 S. Sixth St.
Blum, Leon L.....210 Rose Dispensary Bldg.
Bopp, Henry, Jr.....221 S. Sixth St.
Bopp, James.....236 S. 21st St.
Boyd, H. Clark.....221 S. Sixth St.
Bradley, Stephen C. (S).....916 S. 25th St.
Bristol, Henry M. S.....1218½ Wabash Ave.
Bronson, Paul J.....3050 Poplar St.
Brown, Robert R.....221 S. Sixth St.

C

CaJacob, Melville E.....1000 S. Sixth St.
Caldwell, Milton V.....721 Wabash Ave.
Cavins, Alexander W.....221 S. Sixth St.
Combs, Stuart R.....3050 Poplar St.
Congleton, George C. (S)
308 Merchants National Bank Bldg.
Conforti, Victor P.....221 S. Sixth St.
Conklin, James O.....500 Rose Dispensary Bldg.
Conway, Thomas J.....221 S. Sixth St.
Crockett, Wayne A.....416 Rose Dispensary Bldg.

D

Davis, Merle J.....221 S. Sixth St.
Decker, Harvey.....14 Rea Bldg.
Denny, E. Rankin.....3050 Poplar St.
Drummy, W. W. .....221 S. Sixth St.
Dyer, George W.....2235 Wabash Ave.

E

Edwards, Henry G.....221 S. Sixth St.

F

Freed, John E., Jr.....1030 S. Sixth St.
Freed, John E. (S).....1030 S. Sixth St.

G

Gerrish, Donald A.....R. R. 7
Gilbert, Ivan.....505 Rose Dispensary Bldg.
Goodman, Hubert T...410 Rose Dispensary Bldg.
Gossom, Donn R.....Rose Dispensary Bldg.
Grindrod, John M.....Ind. State Teachers College

H

Harkness, Robert G.....301 Rose Dispensary Bldg.
Haslem, Ezra R.....401 Rose Dispensary Bldg.
Haslem, John R.....221 S. Sixth St.
Hogan, Thomas W.....627 Cherry St.
Hoover, Dewey A.....14½ N. Third St.
Humphrey, Paul E.....1235 Ohio Blvd.
Hunt, Edgar J.....R. R. 1

J

Johnson, Paul D.....822 N. Fifteenth St.
Justin, Renate G.....901 S. 25th St.

K

Kabel, Robert N.....3050 Poplar St.
Krieble, William W.....221 S. Sixth St.
Kunkler, Arnold W.....1700 N. Seventh St.
Kunkler, Joseph (S).....408 Chestnut
Kunkler, William C.
212 Merchants Nat'l Bank Bldg.

L

LaBier, C. Russell.....1630 Wabash Ave.
Lancet, Robert O.....2101 Wabash Ave.
Lee, James.....St. Anthony Hospital
Loewenstein, Werner L.....1537 S. Seventh St.
Luckett, Coen L.....211 Fairbanks Bldg.
Lyons, L. Mason.....59 S. 18th St.

M

McAleese, George B.....1030 S. Sixth St.
McBride, Noel S...407 Merchants Nat'l Bank Bldg.
McCrea, Fred R.....221 S. Sixth St.
McEwen, James W.....670 Cherry St.
McLaughlin, Gordon C.....608 Tribune Bldg.
Mahoney, Charles L.....221 S. Sixth St.
Malone, Leander A.....721 Wabash Ave.
Mankin, William J.....402 Tribune Bldg.
Mason, Lester M....312 Merchant Nat'l Bank Bldg.
Mattox, Don M.....1700 N. Seventh St.
Meyn, Werner P.....221 S. Sixth St.
Miklozek, John E.....1461 S. Seventh St.
Milleson, Ann L. M.....826 S. Center St.
Musselman, Glen G.....7222 Wabash Ave.

N-O

Nay, Ernest O.....221 S. Sixth St.
Neudorff, Louis G.....221 S. Sixth St.
Oliphant, Robert W.....1603 S. 7th St.

P

Pearce, Roy V.....1440 S. 25th St.
Pierce, Harold J. (S).....627 Cherry St.

R

Reed, Robert C.....1933 S. Center St.
Reynolds, Richard J.....2250 Wabash Ave.
Richart, James V.....414 Rose Dispensary Bldg.
Riggs, Floyd C.....2216 Wabash Ave.
Rogers, R. Shirrell.....26 N. Sixth St., West Terre Haute
Rubin, Milton M.....221 S. 19th St.

S

Sayers, Frank E. (S).....436 Bluebird Dr.
Scherb, Burton E.....104 N. Seventh St.
Schott, Edward J. (S).....653 Oak St.
Schumaker, Robert A.....3050 Poplar St.
Selsam, Etta B. (S) 203 Merchants Nat'l Bank Bldg.
Shanklin, Vernon A. (S).....672½ Wabash Ave.
Showalter, John R.....1233 Maple Ave.
Siebenmorgen, Louis (S).....1200 S. Eighth St.
Siebenmorgen, Paul.....1200 S. Eighth St.
Silverman, Norman M.....1634 S. Seventh St.
Smoots, Samuel A. (S).....1307 Maple Ave.
Speas, Robert C.....402 Tribune Bldg.
Stewart, Walter E. (S).....721 Wabash Ave.
Stoelting, J. Lewis.....507 Rose Dispensary Bldg.
Strecker, William L.....2006 Wabash Ave.
Strong, Daniel S. (S).....2618 Lafayette Ave.
Sullivan, John M.....1712 Franklin St.

T-U-V

Taylor, Donald J.....423 Rose Dispensary Bldg.
Thom, Julia S.....912 Chestnut St.
Topping, Malachi C.....3050 Poplar St.
Ulmer, David R. (S).....2500 Wabash Ave.
Van Arsdall, Clarence R.....17 S. Ninth St.
Veach, William L.....1235 Ohio St.
Voges, Edward C.....702 College Ave.

W

Weber, Joseph G. S.....723 Wabash Ave.
Weinbaum, Jack G.....206 Rose Dispensary Bldg.
White, James V.....721 Wabash Ave.
Wiedemann, Frank E. (S) 222 Rose Dispensary Bldg.
Wilson, Fred L.....1501 S. Third St.
Wyeth, Charles (S).....1100 S. Seventh St.

X-Y-Z

Zwerner, Paul F.....12 Points State Bank Bldg.

LaBier, Clarence R. (S) 230 N. E. 28th Rd., Boca Raton, Fla.

WABASH COUNTY

Walker, James L. (S).....Lafontaine

North Manchester

Balsbaugh, George.....107 W. Seventh St.
Brubaker, Ora G. (S).....111 N. Market St.
Bunker, Ladoska Z.....North Manchester
Cook, Charles E.....114 W. Main St.
Keller, Frank G. (S)....Peabody Memorial Home
Seward, George W.....111 E. Main St.
Smith, Lloyd H.....1118 N. Wayne St.
Venable, George L.....106 W. Main St.
Warvel, Joseph L. (S).....North Manchester

Wabash

Dannacher, William D.....284 N. Wabash
Elward, Carl J.....1280 Columbus
Hanneken, Vincent J.....86 N. Comstock
LaSalle, Richard M.....55 West Market St.
LaSalle, Robert M. Jr.....55 West Market St.
LaSalle, Robert M. Sr.....55 W. Market St.
Mills, John F.....24 E. Main St.
Pearson, William E.....290 N. Wabash
Rauh, Robert A.....284 N. Wabash
Steffen, Arthur J.....70 W. Hill
Steffen, Julius T.....443 N. Wabash
Stoops, Jean T.....280 N. Wabash
Whisler, Frederick M. (S).....10 W. Hill

Black, Edgar K..209 Linden Lane, Circleville, Ohio
Kidd, James G. (S)....Veterans Hosp., Wood, Wis.

WARREN COUNTY

(See Fountain-Warren)

WARRICK COUNTY

Boonville

Hoover, Peter B.....223 W. Locust St.
Stover, Wendell C.....125½ S. Second St.
Terry, Robert H.....117 S. Second St.
Wilson, Paul E. (S).....126 N. Third St.
Woodson, Dan E.....117 S. Second St.

Nelson, Dudley.....Chandler
Colvin, Robert C.....Newburgh
Rogers, Arthur R.....Newburgh
Wilhelmus, Charles M. (S).....Newburgh

Dimmett, Robert P. 149 Rosewood Dr., Metairie, La.

WASHINGTON COUNTY

Tower, Thomas K.....Campbellsburg
Paynter, William.....Pekin

Salem

Apple, Eddie R.....501 W. Market St.
Coleman, Henry G.....Mitchell Bldg.
Episcopo, Arsenius R.....308 N. Main St.
Fultz, Roy L.....304 E. Market St.
Huckleberry, Irvin E.....502 W. Mulberry St.

WAYNE-UNION COUNTIES

Clark, Marion E.....Cambridge City
Hill, Paul G.....Cambridge City
Kenyon, Charles E.....Cambridge City

Barton, Willoughby M.....Centerville
Hutchison, Donald R.....Fountain City
Donahue, Francis E.....Dublin
Charles, Henry L.....Hagerstown
Hollenberg, Alfred E.....Hagerstown
Miller, William A.....Hagerstown

Liberty

Clarkson, Clarence G.....304 E. Union St.
Lewis, James F.....28 E. Union St.
McWilliams, William B.....207 N. Market St.

Richmond

Adney, Frank B.....215 Medical Arts Bldg.
Ake, Loren.....410 First National Bank Bldg.
Allen, Hubert E. (S).....21 S. Eighth St.
Allen, Robert T.....34 S. Seventh St.
Ballenger, William E.....309 Medical Arts Bldg.
Blossom, Paul W.....825 S. A St.
Brown, Richard J.....310 Colonial Bldg.
Buche, Frederick P. (S).....106 S. Seventh St.
Coble, Frank H.....51 S. Eighth St.
Cook, Norman R...303 First National Bank Bldg.
Cox, Leon T.....1210 E. Main St.
Daggy, B. T.....Medical Arts Bldg.
Daggy, James R.....35 S. Eighth St.
Dingle, Paul E.....216 Medical Arts Bldg.
Dreyer, Ralph W.....2 S. W. 17th St.
Ebbinghouse, Tom.....98 W. Main St.
Ensey, Philip L.....512 W. Main St.
Griffis, Vierl C. (S).....201 S. 23rd St.
Guthrie, James R.....25 S. Eighth St.
Hadley, Harvey (S).....627 S. 14th St.
Hagie, Frank E.....1110 S. A St.
Harmon, Carl J.....407 Medical Arts Bldg.
Herring, George N.....Richmond State Hospital
Hill, Gladys Marie.....407 Medical Arts Bldg.
Hill, Harold D.....412 Medical Arts Bldg.
Hunt, Gayle J.....Reid Memorial Hospital
Johnson, George M.....136 Medical Arts Bldg.
Johnson, Paul S. (S).....200 S. 18th St.
Kime, Charles E.....810 S. A St.
Klepfer, Jefferson.....Richmond State Hospital
Kreitl, Dorothy R.....Richmond State Hospital
Lee, Glen Ward.....139 Medical Arts Bldg.
Ling, John F.....505 First National Bank Bldg.
Logan, James Z.....2 N. Eighth St.
Loomis, Charles H.....1203 S. A St.
Mader, John H.....2000 E. Main St.
Malcolm, Russell.....127 Medical Arts Bldg.
Meredith, Elwood J.....203 Medical Arts Bldg.
Millis, Arthur B.....505 First Nat'l. Bank Bldg.
Park, Byron J.....418 Medical Arts Bldg.
Passino, James.....Reid Memorial Hospital
Ramsdell, Glen A.....407 First Nat'l. Bank Bldg.
Ross, Harry P.....410 Second National Bank Bldg.
Ross, James S.....321 S. 14th St.
Runge, Paul W.....1426 E. Main St.
Sage, Charles V.....48 S. 11th St.
Sherer, Kenneth E.....422 Medical Arts Bldg.
Shields, Tom S.....47 S. 11th St.
Snyder, Morris C.....130 Medical Arts Bldg.
Stamper, Lucian A.....402 Medical Arts Bldg.
Stepleton, John D.....Reid Memorial Hospital
Stillwell, William R.....2607 South C Place
Sweet, Howard E.....35 S. Eighth St.
Taylor, William R.....308 Medical Arts Bldg.
Vance, William C.....1008 South A St.
Wanninger, Horace...408 Second Nat'l Bank Bldg.
Warrick, Francis B.....1426 E. Main St.
Weinstein, Edwin B.....204 Colonial Bldg.
Wertenberger, Morris D...Reid Memorial Hospital
Whallon, Arthur J. (S).....29 S. 10th St.
Wiland, Olin K.....Reid Memorial Hospital
Wisener, Guthrie H. (S)....213 Medical Arts Bldg.
Yencer, Martin W. (S).....22 N. 14th St.
Zeps, E. Frances.....701 S. 16th St.

Hiatt, Russell L. .....VA Hospital, Louisville, Ky.
Shepard, Fred F.....College Corner, Ohio

WELLS COUNTY

Bluffton

Bishop, Robert E.....303 S. Main St.
Boonstra, Charles E.....303 S. Main St.
Bradley, Louis F.....303 S. Main St.
Brickley, Harry D. (S).....227 S. Main St.
Buckner, Joy F.....116 E. Walnut St.
Caylor, Charles H. .....303 S. Main St.
Caylor, Harold D.....303 S. Main St.
Caylor, Truman E.....303 S. Main St.
Cook, Robert G.....303 S. Main St.
Dorrance, Thomas O.....303 S. Main St.
Eisaman, Jack L.....303 S. Main St.
Gitlin, Max M.....121 E. Market St.
Gitlin, William A.....121 E. Market St.
Hamilton, Orville G.....227 S. Main St.
Jackson, Charles E.....303 S. Main St.
Kephart, S. Bruce.....303 S. Main St.
Mead, Clarence H. (S).....227 S. Main St.
Meier, Donald W.....303 S. Main St.
Milroy, Robert A. .....303 S. Main St.
Nachman, Elias.....303 S. Main St.
Panos, Constantine G. .....227 S. Main St.
Pietz, David G.....303 S. Main St.
Priest, Edward M.....303 S. Main St.
Rudy, Donald B.....303 S. Main St.
Symon, William E.....303 S. Main St.
Talbert, Pierre C.....303 S. Main St.
Yanson, Mannfredo R. S.....303 S. Main St.
Yoder, Richard P.....303 S. Main St.

Gingerick, Charles M.....Liberty Center
Davidoff, Manuel A.....Ossian
Hardin, Wayne E.....Ossian

Brewer, Robert A. .....Hqs. Co. 1st Bn. 2nd AC
APO 114, New York, N.Y.

WHITE COUNTY

Galbreth, Jesse P. (S).....Burnettsville
Derhammer, George L.....Brookston
Gish, Howard M. .....Brookston
Henderson, Robert N. .....Brookston
Netherton, Clyde R. (S) .....Chalmers
Houser, Wayne W.....Monon
McClure, Stanley E.....Monon

Monticello

Beck, David C.....135 S. Illinois St.
Carney, John C.....116 N. Illinois St.
Dickerson, W. Martin .....120 S. Illinois St.
Fullerton, Robert L.....201 Beach Dr.
Hibner, Nolan A.....110 S. Main St.
Morris, Warren V.....115 Court St.

Mayfield, Clifford H. (S).....Reynolds
Baynes, Frank L.....Wolcott
Forbes, Violet Crabbe.....Wolcott

WHITLEY COUNTY

Hershey, Ernest A. (S) .....Churubusco
Minick, Linus J.....Churubusco

Columbia City

Brandt, William E. .....Columbia City
Hamilton, Thomas.....Columbia City
Heritier, C. Jules.....116 S. Chauncey
Langohr, John.....215 E. Van Buren St.
Lehmberg, Otto F. C.....118 E. Van Buren St.
Niccum, Warren L.....215 E. Van Buren St.
Nolt, Ernest V. (S) .....103 N. Line
Reid, Donald B.....118 E. Van Buren
Thompson, Frank M.....112 N. Main St.
Vogel, John L.....215 E. Van Buren St.
Wait, Jerome H.....115 S. Main St.
Wilson, John .....116 S. Chauncey

Huffman, Verlin P.....South Whitley

WOMAN'S AUXILIARY
to the
INDIANA STATE MEDICAL ASSOCIATION

OFFICERS

PRESIDENT	Mrs. Joseph Black	671 Braewick Rd. Sunset Parkway	Seymour
PRESIDENT-ELECT	Mrs. Edward L. Rigley	1704 Ridgedale Rd.	South Bend
FIRST-VICE-PRESIDENT	Mrs. Burton Kintner	3520 E. Jackson	Elkhart
SECOND VICE-PRESIDENT	Mrs. R. Case Hammond	6820 Arcadian Hwy.	Evansville
THIRD VICE-PRESIDENT	Mrs. Richard Gripe	1623 S. Fifth	Lafayette
FOURTH VICE-PRESIDENT	Mrs. Paul Merrell	5367 Kenwood	Indianapolis
RECORDING SECRETARY	Mrs. George Wagoner		Delphi
CORRESPONDING SEC'Y	Mrs. Jack Shields	721 W. Spring	Brownstown
TREASURER	Mrs. Kenneth Brown	1654 Hedden Park	New Albany
HISTORIAN	Mrs. Philip Holland	1001 S. Jordan Ave.	Bloomington
PARLIMENTARIAN	Mrs. Wm. R. Tindall	616 S. Harrison	Shelbyville
DISTRICT COUNCILOR CHAIRMAN	Mrs. M. O. Scamahorn	Pittsboro	

COMMITTEE CHAIRMEN

A.M.E.F.	Mrs. Eli Rubens	1240 E. Irvington Ave.	South Bend
TREASURER	Mrs. D. H. Condit	1521 E. Wayne St.	South Bend
BULLETIN	Mrs. Fielding Williams		Huntingburg
CIVIL DEFENSE	Mrs. Kenneth Schneider		Nashville
EDITORIAL	Mrs. Frank Green	516 N. Morgan	Rushville
FINANCE	Mrs. Wendell Stover	20 Lake Shore Dr.	Boonville
LEGISLATION	Mrs. Otis Bowen		Bremen
MENTAL HEALTH	Mrs. Frank Hogle	Logansport State Hosp.	Logansport
ORGANIZATION	Mrs. E. L. Rigley	1704 Ridgedale Rd.	South Bend
TODAY'S HEALTH	Mrs. H. R. Swihart	1621 E. Jackson	Elkhart
MEDICAL CARE INSURANCE	Mrs. Joseph Dudding		Hope
PROGRAM	Mrs. Albert Marshall, Jr.	7802 Allisonville Rd.	Indianapolis
PUBLICITY	Mrs. Dwight Schuster	4503 Washington Blvd.	Indianapolis
PUBLIC RELATIONS	Mrs. I. S. Hostetter	300 Winthrop	Muncie
RECRUITMENT	Mrs. Russell Palmer	2006 W. Fourth Place	Gary
RULES	Mrs. Harry Harvey	2228 Crescent Ave.	Ft. Wayne
RURAL AND COMMUNITY HEALTH	Mrs. Sam Campbell		R. R. 1, Noblesville
SAFETY	Mrs. Robert Acher		Greensburg

MEMBERSHIP ROSTER—BY COUNTIES

ADAMS COUNTY

Berne

Beaver, Mrs. N. E. ..... 866 Columbia Dr.
Bose, Mrs. Robert L. ..... 255 Dearborn
Luginbill, Mrs. Howard ..... 817 W. Main St.

Decatur

Burk, Mrs. J. M. ..... 221 S. Third St.
Freeby, Mrs. William C. ..... 1022 Mercer Ave.
Girod, Mrs. A. H. ..... 1004 W. Monroe St.
Kohne, Mrs. G. J. ..... 304 W. Adams
Parrish, Mrs. Richard K. ..... 242 S. 2nd St.
Rich, Mrs. Norval S. ..... R. R. 4
Terveer, Mrs. John B. ..... 1721 W. Monroe St.
Zwick, Mrs. H. F. ..... 401 E. Rugg

Cutshaw, Mrs. James A. ..... Monroeville
Harless, Mrs. Fred O. ..... Monroeville
Schetgen, Mrs. Joseph V. ..... R. R., Geneva

ALLEN COUNTY

Bluffton

Brickley, Mrs. Harry D. ..... 227 S. Main St.
Buckner, Mrs. J. F. ..... 116 E. Walnut
Hamilton, Mrs. O. G. ..... 203 E. Central Dr.
Mead, Mrs. C. H. ..... 211 W. Washington

Fort Wayne

A

Adams, Mrs. E. Wade ..... 1902 Forest Park Blvd.
Adams, Mrs. J. R. ..... 2538 Fairfield Vw. Pl.
Aiken, Mrs. Arthur F. ..... R. R. #1, Waterswold Dr.
Aiken, Mrs. Nevin E. ..... 5540 Leo Rd.
Arata, Mrs. Justin E. ..... 224 Ludwig Rd.

B

Bailey, Mrs. Paul ..... 1840 Pemberton
Ball, J. R. ..... 4112 S. Harrison
Baltes, Mrs. Joseph H. ..... 1309 Sunset Dr.
Barch, Mrs. John W. ..... 1715 Poinsette Dr.
Bash, Mrs. W. E. ..... 1201 Korte Lane
Beams, Mrs. Ralph ..... 3710 Wawonaissa
Beierlein, Mrs. Karl M. ..... 2716 Butler Road
Bergendahl, Mrs. Emil ..... 1202 Illsey
Berghoff, Mrs. Raymond ..... 2009 Forest Park
Beutler, Mrs. Theodore ..... 3505 S. Washington Rd.
Blichert, Mrs. Peter A. ..... 4501 Fairfield
Blosser, Mrs. H. V. ..... 1122 W. Washington
Bolman, Mrs. R. M. ..... Hamilton Rd.
Borders, Mrs. Theodore R. ..... 1802 Nevada St.
Bossard, Mrs. John W. ..... 1712 California
Bowers, Mrs. G. T. ..... 2609 East Dr.
Brandt, Mrs. William ..... 1717 Tilden
Bromley, Mrs. L. W. ..... 4216 Drury Lane

Brosius, Mrs. Robert H.....3302 Garland
Brown, Mrs. Frederic W.....4129 S. Harrison
Bruggeman, Mrs. H. O.....1202 W. Washington
Bryan, Mrs. Franklin A.....1439 Edgewater
Buckner, Mrs. Doster.....Bass Rd., R. R. 5
Buckner, Mrs. George D.....4327 Hampshire Drive

C

Carlo, Mrs. Ernest.....4633 Crestwood
Cartwright, Mrs. E. L.....3718 Hiawatha Blvd.
Chambers, Mrs. Alan.....4135 S. Harrison
Clark, Mrs. Wm. R.....4002 S. Harrison
Cochran, Mrs. H. A., Jr.....420 W. Sherwood Tr.
Connelly, Mrs. Richard.....3331 Webester
Cooney, Mrs. Charles C.....1168 Westover Rd.
Cottrell, Mrs. Robert F.....205 McKinnie
Craig, Mrs. Richard.....1002 Passadena
Culp, Mrs. John E.....2421 Paulding Rd.

D

Dieter, Mrs. William.....1002 Summerset
Dunstone, Mrs. H. C.....2433 Paulding Road

E

Eberly, Mrs. Karl C.....1240 W. Rudisill
Emenhiser, Mrs. John L.....1411 Reed Road

F

Ferguson, Mrs. Arthur N.....328 W. Sherwood
Flaherty, Mrs. Robert.....1835 Forest Park Blvd.
Foy, Mrs. H. W.....1816 Forest Park
Franke, Mrs. Gordon.....4452 Sandridge Dr.
Frankhouser, Mrs. Chas. M..7245 Winchester Rd.
Fullam, Mrs. Richard.....4159 Woodstock

G

Garton, Mrs. Harry W.....Hamilton Rd., R. R. 6
Gastineau, Mrs. David C.....8203 Westridge Rd.
Gerding, Mrs. W. J.....1721 Forest Park Blvd.
Glassley, Mrs. Stephan.....6950 Stellhorn Rd.
Glock, Mrs. Maurice E.....1502 Hawthorne Rd.
Glock, Mrs. Wayne R.....Tonkel Road
Goebel, Mrs. Carl W.....4102 So. Harrison
Graham, Mrs. George M.....1126 W. Rudisill
Greenlee, Mrs. Robert L.....3344 Sanibel Dr.
Griest, Mrs. Walter D.....4809 Arlington
Griffith, Mrs. H. R.....1913 Forest Park Blvd.

H

Hackett, Mrs. Walter G.....5220 Crandon Lane
Haffner, Mrs. Herman G.....3606 Mulberry Rd.
Haley, Mrs. Alvin J.....3720 Stellhorn Rd.
Hamilton, Mrs. Emory D.....2405 Florida Dr.
Harvey, Mrs. Harry G.....2228 Crescent
Hasewinkle, Mrs. A. M.....3544 Kirkland Lane
Hastings, Mrs. Warren C.....1822 Kensington
Hattendorf, Mrs. A. P.....4041 Old Mill Rd.
Havens, Mrs. Russell E.....1845 Kensington
Hershberger, Mrs. Phillip G....5525 Covington Rd.
Hickman, Mrs. D. M.....1815 Kensington
Higgins, Mrs. Kenneth E.....3460 Sandpoint Rd.
Hipskind, Mrs. Richard E.....3929 Wenonah Lane
Hoffman, Mrs. Arthur F.....3619 Harris Rd.
Holsinger, Mrs. Robert E.....4617 Indiana
Horning, Mrs. R. R.....3017 Kenwood
Howe, Mrs. Fordyce L.....2540 Springfield
Humphreys, Mrs. John L...3701 S. Washington Rd.

J

Jackson, Mrs. John F.....4922 Indiana
Jontz, Mrs. Joseph.....514 Shadyhurst Dr.
Juergens, Mrs. Richard.....6825 Ludwig Circle
Jurgenson, Mrs. Walter T.....5009 Indiana

K

Karol, Mrs. Herbert J.....1725 Ardmore
Keck, Mrs. Carleton A.....4633 Crestwood
Kent, Mrs. Richard N.....2717 East Dr.
Keyes, Mrs. Robert C.....1226 Illsey Drive
Kidder, Mrs. O. T.....Lima Rd.
Kimbrough, Mrs. Robert.....4601 Beaver Ave.
Kleifgen, Mrs. W. A.....4602 Tacoma
Klooze, Mrs. Kenneth W.....723 W. Packard
Knight, Mrs. L. W.....1220 Kensington
Krueger, Mrs. J. E.....4418 Bradwood Terrace
Kruse, Mrs. Edward.....4001 Old Mill Rd.
Kruse, Mrs. Walter E.....1242 Maxine Dr.

L

Ladig, Mrs. Donald S.....2720 Fairfield
Lampe, Mrs. Elfred H.....1018 Kinnaird
Land, Mrs. Francis L.....4520 Beaver
Laycock, Mrs. Richard.....5019 Stellhorn Rd.
Leming, Mrs. Ben L.....3005 N. Anthony
Lenk, Mrs. George G.....E. State St. Ext. 5507
Lloyd, Mrs. Robert P.....3609 S. Anthony
Lohman, Mrs. Robert M.....2138 Owaissa
Lorman, Mrs. James G.....3401 Kirkwood
Loudermilk, Mrs. J. L.....1732 Pemberton

M

McArdle, Mrs. Edward G....1133 W. Rudisill Blvd.
McBride, Mrs. W. O.....610 Beechwood Circle
McCallister, Mrs. John W.....4215 Drury Lane
McCoy, Mrs. Roy R.....4101 S. Harrison
McDowell, Mrs. G. A.....2322 Forest Park Blvd.
McEeachern, Mrs. Cecil.....4242 Old Mill Rd.
McKeeman, Mrs. D. H.....1615 Ardmore
Manning, Mrs. George.....4115 Indiana Ave.
Marshall, Mrs. Caesar L.....1215 McCulloch
Mercer, Mrs. S. R.....3235 W. Washington
Meyer, Mrs. Hans.....2615 Trier Rd.
Meyer, Mrs. T. O.....3728 Kirkwood
Michaelis, Mrs. S. C.....1255 Korte Lane
Miller, Mrs. Carl G.....457 Oakdale Dr.
Miller, Mrs. Edward D.....2615 East Drive
Miller, Mrs. H. Paul.....6408 S. Calhoun
Miller, Mrs. Mahlon.....1115 Illsley Dr.
Miller, Mrs. Orval J.....1810 Kensington
Miller, Mrs. Richard.....5125 Old Mill Road
Miller, Mrs. Wm. J.....2620 Capitol
Moats, Mrs. Carl F.....3210 N. Washington Rd.
Moeller, Mrs. Victor C.....4723 St. Joe Center Rd.
Moravec, Mrs. Arthur.....4711 Old Mill Rd.
Mortenson, Mrs. Leland J....1310 N. Foster Pkwy.
Mueller, Mrs. Lawrence W., 3423 S. Washington Rd.
Murdock, Mrs. Harry L.....1212 Kensington

N-O

Nahrwold, Mrs. E. W.....3314 Irvington Dr.
Nill, Mrs. John H.....440 W. Fleming
Nolan, Mrs. Gerald R.....1102 Kensington
O'Brian, Mrs. John F.....1215 N. Anthony Blvd.
O'Rourke, Mrs. Carroll.....Covington Road
Oyer, Mrs. J. H.....2206 Wawonaissa

P

Painter, Mrs. Donald S.....R. R. 1, Southridge Rd.
Parker, Mrs. C. B.....2215 Paulding Rd.
Parrot, Mrs. Donald J.....1809 Kensington
Pearson, Mrs. Huey.....1801 S. Clinton
Perrin, Mrs. Kermit F.....2828 Lake Ave.
Perry, Mrs. Frederick G.....709 Kinnaird
Philbert, Mrs. Richard N.....2503 Drexel Ave.
Pickett, Mrs. Merle E.....4509 Atwood Dr.
Ponzcek, Mrs. Edward J.....6515 S. Calhoun
Popp, Mrs. Milton F.....3148 Parnell Ave.
Powell, Mrs. M. Jack.....7412 Ridgeknoll Rd.
Priddy, Mrs. Marvin.....2909 Belfast Dr.

R

Ranke, Mrs. Henry....2301 Fairfield
Rhamy, Mrs. B. W....4312 Beaver
Rissing, Mrs. Walter J....3200 Irvington
Rodriquez, Mrs. Juan....4720 Crestwood Dr.
Roser, Mrs. Arthur J....3559 Leesburg Rd.
Rossiter, Mrs. D. L....724 Oakdale Dr.
Rothberg, Mrs. Maurice....4319 Hartman Rd.
Rousseau, Mrs. John W....3913 Mound Pass

S

Sahlman, Mrs. Hans....2402 Woodward
Salon, Mrs. Harry W....4017 Hiawatha Blvd.
Salon, Mrs. Joel....4935 Old Mill Road
Salon, Mrs. N. L....7939 Scottwood Court
Sarver, Mrs. Francis E....4629 Tacoma
Savage, Mrs. A. R....South Ridge Road, R. R. 1
Schellhouse, Mrs. Earl M....3610 Mulberry Rd.
Schlademan, Mrs. K. R....4029 Weisser Park
Schloss, Mrs. Robert....3518 Algonquin Pass
Schmidt, Mrs. Eugene E....1119 Maxine Dr.
Schmoll, Mrs. Robert J....5214 Woodhurst
Schneider, Mrs. Louis A....1351 W. Sherwood Tr.
Schoen, Mrs. Fred....5128 S. Wayne
Schubert, Mrs. J. C....4716 Lillie
Scoins, Mrs. W. H....4301 Taylor
Scott, Mrs. H. Vaughn....5224 Fairfield Ave.
Senseny, Mrs. Eugene F....3112 Beaver
Shaw, Mrs. James E....3932 Rosewood Drive
Sidell, Mrs. James....1228 Powers
Singer, Mrs. Elmer C....825 W. Oakdale Dr.
Smith, Mrs. Phillip L....2701 Fairfield
Smith, Mrs. Richard B....709 E. Oakdale
Smith, Mrs. Roger....1722 Pemberton
Snyderman, Mrs. S. C....3222 N. Washington Rd.
Somers, Mrs. G. H....1253 W. Rudisill
Spencer, Mrs. C. Herbert....2106 Paulding Road
Stanley, Mrs. Robert G....411 W. Concord Lane
Stauffer, Mrs. Richard....4120 S. Harrison
Steigmeyer, Mrs. D. J....1503 Kensington
Stellner, Mrs. Howard A....3323 Butler Court
Stier, Mrs. Paul....13120 Ravine Trail, R. R. 6
Stucky, Mrs. Jerry L....2524 Belfast Dr.
Stump, Mrs. Edwin E....1118 Elm St.
Sullivan, Mrs. Robert E....4145 Woodstock

T

Taylor, Mrs. Robert G....3104 Alexander Dr.
Tennant, Mrs. D. L....3513 Kirkland Lane
Terrill, Mrs. Richard....4727 Old Mill Rd.
Thornton, Mrs. W. E....601 Oakdale Dr.

U-V

Underwood, Mrs. Ella....2301 Fairfield
Van Buskirk, Mrs. E. W....920 Maxine Dr.
Vogel, Mrs. Lloyd A....7137 Roseann Pkwy.

W

Wade, Mrs. R. W....4105 Dalewood Dr., R. R. 9
Walker, Mrs. Floyd....1202 Forest Ave.
Ward, Mrs. Gerald....2014 Curdes
Warfield, Mrs. C. H....3924 Harris Rd.
Weber, Mrs. John R....1215 Sheridan Ct.
Welty, Mrs. S. G....8416 Stellhorn Road
Wilkins, Mrs. Robert W....914 Prange Dr.
Williams, Dr. (Berniece)..3526 N. Washington Rd.
Wilson, Mrs. Leslie....2810 S. Wayne Ave.
Wilson, Mrs. Roland B....4100 Abbott
Wright, Mrs. William C....1834 Pemberton Dr.

Z

Zehr, Mrs. Noah....301 W. Creighton
Zweig, Mrs. Elmer S....2015 Pemberton

New Haven

Dahling, Mrs. C. Wallace..Carefree Farms, R. R. 2
Emenhiser, Mrs. Don C....1040 Lincoln Highway
Hoetzer, Mrs. Emil M....Doyle Rd.
Smith, Mrs. G. A....2313 Florida

Emme, Mrs. Richard W....R. R. 2, Grabill
Saylors, Mrs. Roger D....R. R. 2 Grabill
Mackel, Mrs. Frederick....R. R. 1, Huntertown
Harless, Mrs. O. Fred....Monroeville

BARTHOLOMEW-BROWN COUNTIES

Columbus

Adler, Mrs. David L....931 Fifth St.
Beggs, Mrs. Lowell F....2733 Riverside Dr.
Davis, Mrs. Marvin R....2300 N. Washington St.
Echsner, Mrs. Herman J....Tipton Lane
Fisher, Mrs. Walter S....906 Franklin St.
Hart, Mrs. Robert B....1203 16th St.
Hawes, Mrs. Marvin E....2975 Franklin Dr.
Henry, Mrs. Alvin L....1926 Lafayette Avenue
Knotts, Mrs. Stanley....2740 Washington St.
Krueger, Mrs. Robert B....2102 Lafayette Ave.
Macy, Mrs. George W....2623 Riverside Dr.
Marr, Mrs. Griffith....Marr Rd.
McCullough, Mrs. Henry....Old Indianapolis Rd.
Mohler, Mrs. Floyd....Sunset Dr.
Norton, Mrs. Harold J....909 Pearl St.
O'Bryan, Mrs. Richard B....1602 Washington St.
Overshiner, Mrs. Lyman....1715 Franklin St.
Rank, Mrs. B. A....615 25th St.
Rau, Mrs. C. A....2424 Lafayette
Reid, Mrs. Robert....2712 Lafayette Avenue
Ryan, Mrs. Wm. J....Grove Parkway
Schmitt, Mrs. R. K....2639 Riverside Dr.
Sigmund, Mrs. Wm. B....Davis Road
Snapp, Mrs. R. A....1927 Home Ave.
Williams, Mrs. E. W....1902 Franklin St.
Yoder, Mrs. Dewey D....713 Lafayette Ave.
Zaring, Mrs. Byron K....2419 Riverside

Knotts, Mrs. Slater....Elizabethtown
Dudding, Mrs. Joseph E....Hope
Jacobs, Mrs. E. Robert....Hope
Schneider, Mrs. Kenneth....Nashville
Seibel, Mrs. Robert....Nashville

BENTON COUNTY

Leak, Mrs. Robert....Boswell
Coddens, Mrs. A. L....Earl Park
Miller, Mrs. Dan T....Fowler
Turley, Mrs. Verne L....Fowler
Scheurich, Mrs. Virgil....Oxford
Rutherford, Mrs. C....Otterbein

BLACKFORD COUNTY

Hartford City

Dodd, Mrs. J. U....The Oaks
Dudgeon, Mrs. Charles A....421 E. North St.
Jackson, Mrs. Dean D....401 W. Washington St.
Owsley, Mrs. Guy A....The Oaks
Park, Mrs. George O....State Rd. 26W
Weldy, Mrs. Brice P....227 W. Franklin St.
Wierzalis, Mrs. Edward....520 N. Jefferson St.

Burns, Mrs. Paul E....119 W. High St., Montpelier
Douglas, Mrs. William T.
205 E. Monroe St., Montpelier

BOONE COUNTY

Schaaf, Mrs. Alvin D.....Jamestown

Lebanon

Coons, Mrs. John D.....121 Ulen Blvd.
Coons, Mrs. Ritchie.....138 Ulen Blvd.
Grigsby, Mrs. Bland.....904 Northfield Drive
Headley, Mrs. Lloyd M.....137 Ulen Blvd.
Honan, Mrs. Paul.....202 East Dr.
Lenox, Mrs. Jack.....205 East Dr.
Weddle, Mrs. Charles O.....1210 N. East
Wiseheart, Mrs. Robert H.....123 Ulen Blvd. Dr.

Gregg, Mrs. Edwin.....320 E. Main, Thorntown
Lovett, Mrs. Harvey D.....Zionsville
Bailey, Mrs. Lawrence S.....Zionsville

CARROLL COUNTY

Van Kirk, Mrs. John.....Burlington
Maggart, Mrs. Ralph.....Camden

Delphi

Baker, Mrs. Eldon E.....816 S. Hamilton
Crampton, Mrs. Chas. C.....218 East Monroe
Petry, Mrs. Thomas N.....211 W. North St.
Seese, Mrs. Robert M.....201 W. North St.
Wagoner, Mrs. Geo. W.....305 W. Summit St.

Adams, Mrs. Max R.....Flora
McLaughlin, Mrs. James R.....Flora

CASS COUNTY

Dutchess, Mrs. Charles T.....Galveston

Logansport

Adamski, Mrs. M. S.....614 17th
Bailey, Mrs. Earl W.....2522 North
Ballard, Mrs. Charles A.....R. R. 4
Bean, Mrs. Joseph S.....R. R. 1
Burnett, Mrs. Paul C.....Logansport State Hosp.
Caffrey, Mrs. James F.....Logansport St. Hosp.
Cobb, Mrs. Clarence M.....R. R. 4, Box 8
Davis, Mrs. John.....2119 North
Eckert, Mrs. Russell A.....R. R. 1
Fitzgerald, Mrs. Brice.....1930 High
Fogel, Mrs. Ernest J.....Logansport St. Hospital
Gatzimos, Mrs. Christos D.....3116 High St. Rd.
Glendening, Mrs. Richard L.....2300 May Fair Dr.
Hall, Mrs. Bernard R.....3100 E. Broadway
Harrington, Mrs. James F.....2316 Rolling Ridge
Hedde, Mrs. E. L.....2304 Chase Rd.
Hillis, Mrs. L. J.....2508 E. Broadway
Holmes, Mrs. Will W.....2537 East Broadway
King, Mrs. Jay M.....2319 May Fair Dr.
Maschmeyer, Mrs. R. H...Logansport St. Hospital
Mikan, Mrs. V. Robert.....R. R. 5
Morrical, Mrs. R. J.....415 Highland
Schenck, Mrs. Foss.....97 21st St.
Viney, Mrs. Charles L.....26th and High St.
Wilson, Mrs. Paul H.....R. R. 5
Winter, Mrs. Donald K.....R. R. 5

Flanagan, Mrs. E. P.....106 May, Walton
Lybrook, Mrs. D. E.....Young America

CLARK COUNTY

Charlestown

Goodman, Mrs. Eli .....802 Market St.
Jones, Mrs. David.....State Rd. 403
Shina, Mrs. Haskel.....State Rd. 403

Clarksville

Mudd, Mrs. Joseph.....103 W. Rosewood Dr.
Wilner, Mrs. Alan.....214 Rosewood Dr.
Wolverton, Mrs. George.....115 Rosewood Dr.

Carr, Mrs. Joseph.....Pine Rd., Henryville
Greene, Mrs. W. R.....Henryville

Jeffersonville

Adair, Mrs. Sam.....50 Wildwood Rd.
Bizer, Mrs. Mier.....155 Forrest Dr.
Bruner, Mrs. George R.....804 E. Court Ave.
Buckley, Mrs. Ernest.....14 Blanchel Terrace
Buehler, Mrs. George.....192 Forest Dr.
Carlberg, Mrs. Dale L.....2 Blanchel Terrace
Carney, Mrs. J. T.....2602 Hollywood Dr.
Clark, Mrs. Wm. B., Jr.....Blackston Mill Road
Dare, Mrs. Lee.....215 Sparks Ave.
Graham, Mrs. O. P.....713 E. Maple St.
Havens, Mrs. Alfred Lyle.....203 Sparks Ave.
Havens, Mrs. Thomas.....400 Chippewa
Huoni, Mrs. John.....6 Blanchel Terrace
Isler, Mrs. Nathaniel.....901 Morningside Dr.
Reed, Mrs. Edsel.....4 Pawnee Dr.
Roby, Mrs. A. L.....2708 Hollywood Dr.
Shaw, Mrs. Houston.....209 Maplewood Dr.
Weems, Mrs. Mallory P.....Hopkins Lane

Regan, Mrs. George.....303 Indiana, Sellersburg
Sturgis, Mrs. Donald G...542 Linnwood, Sellersburg
Vandevert, Mrs. Arthur, 202 Highland, Sellersburg

DEARBORN-OHIO COUNTIES

Aurora

Baker, Mrs. Leslie M.....204 Fifth
Frable, Mrs. Frank.....412 Sunnyside Ave.
Irmscher, Mrs. George .....422 Sunnyside Ave.
Jackson, Mrs. Kenneth.....Mechanic St.
Olcott, Mrs. Charles W.....422 Sunnyside
Treon, Mrs. James F.....505 Fifth St.

McNeeley, Mrs. Matthew J.....Dillsboro

Lawrenceburg

Aldred, Mrs. Allen W.....803 Bode Ave.
Conrad, Mrs. Henry.....370 Bielby Rd.
Fagaly, Mrs. William J.....57 Oakley
Houston, Mrs. Fred D.....533 Ludlow St.
Hunter, Mrs. Lowell.....370 Bielby Rd.
Morrison, Mrs. George.....Billups
Pfeifer, Mrs. James M.....550 Ludlow
Streck, Mrs. Francis A.....547 Ridge Ave.
Vail, Mrs. George A.....Ridge Ave.

DECATUR COUNTY

Tremain, Mrs. M. A.....Adams

Greensburg

Acher, Mrs. Robert P.....446 E. Washington
Callaghan, Mrs. W. C.....R. R. 1, Lincoln Park
Dickson, Mrs. Dale D.....700 N. East
Dietz, Mrs. Richard A.....Box 27
Miller, Mrs. James C.....178 N. Michigan Ave.
Morrison, Mrs. J. Trevor....161 N. Michigan Ave.
Overpeck, Mrs. Charles.....R. R. 8
Shaffer, Mrs. William R.....214 N. Franklin
Walker, Mrs. Louis A.....R. R. 5

Porter, Mrs. Edward.....Westport

DELAWARE COUNTY

Puterbaugh, Mrs. Karl.....Albany
Hurley, Mrs. John.....Daleville
Montgomery, Mrs. Lall G.
Box 149A, RFD 1, Gaston

Muncie

A

Adams, Mrs. William B.....W. Jackson St. Pike
Alvey, Mrs. Charles R.....515 Greenbriar Rd.
Anthony, Mrs. Harvey M.....822 W. Charles

B

Ball, Mrs. Clay A.....1015 Linden Ave.
Ball, Mrs. Philip.....3201 Oaklyn Ave.
Benken, Mrs. Lawrence.....1511 Riley Rd.
Bergwall, Mrs. Warren .....1507 Riley Rd.
Bibler, Mrs. Henry.....2625 Parkway Dr.
Botkin, Mrs. Clyde G.....2904 Riverside Ave.
Botkin, Mrs. Thomas.....2500 Bethel Pike
Brown, Mrs. Leland.....605 Waid Ave.
Brown, Mrs. Stewart D.....R. R. 3, Hamilton Pk.
Brown, Mrs. Thomas.....Isanogel Road
Burwell, Mrs. Stanley W.....3124 Gilbert
Butterfield, Mrs. Robert.....222 Winthrop Rd.
Butz, Mrs. Ralph.....2920 Godman Ave.

C

Christie, Mrs. Robert..... 321 N. Manning Ave.
Clauser, Mrs. Eldo .....1 Briar Rd.
Clevenger, Mrs. Joseph H.....3124 University Ave.
Cooper, Mrs. John F.....2820 Glenwood Ave.
Covalt, Mrs. Wendell E.....120 Berwyn Rd.
Cure, Mrs. Elmer T..... 913 University Ave.

D

Deutsch, Mrs. Wm.....2100 Petty Rd.
Dunn, Mrs. Farrell W.....1417 Wheeling Ave.
Dunning, Mrs. Thos.....3627 Clover Lane

E-F

Eissman, Mrs. Eugene.....211 Alden Rd.
Funk, Mrs. John.....3700 Peachtree Lane

G

Garling, Mrs. L. C.....37 Briar Rd.
Geckler, Mrs. Charles E.....1007 W. North St.
Gill, Mrs. Tom.....45 Warwick Rd.
Greiber, Mrs. Marvin.....310 Riley Rd.
Gustafson, Mrs. Milton H.....230 Stradling Rd.

H-I

Hall, Mrs. O. A.....2302 Lanewood
Hall, Mrs. Robert.....701 Brentwood
Hayes, Mrs. T. R.....19 Warwick Road
Henderson, Mrs. Ramon.....75 Warwick Rd.
High, Mrs. Ralph.....2825 University Ave.
Hill, Mrs. Howard..... 106 Berwyn Rd.
Hostetter, Mrs. I. S.....300 Winthrop Rd.
Hurley, Mrs. Anson .....101 Berwyn Rd.
Imhof, Mrs. J. D.....307 Granville Ave.

K-L

Kammer, Mrs. Walter F.....1005 W. Parkway Dr.
Kirshman, Mrs. F. E.....41 Briar Rd.
Ko, Mrs. Richard.....R. R. 7
Koss, Mrs. Wm. K.....1504 Winthrop Rd.

M-N

Mathewson, Mrs. R. C.....Benton Rd.
McClellan, Mrs. John .....206 McKenzie Rd.
McClintock, Mrs. James A...3121 University Ave.
McCoy, Mrs. George.....516 Waid Ave.
McDowell, Mrs. Fletcher W.....1721 N. Tillotson
Moore, Mrs. Tom C.....1011 E. Parkway Dr.
Morris, Mrs. J. W.....222 Stradling Rd.
Moss, Mrs. M. J.....1010 W. Parkway Dr.
Nelson, Mrs. Harold E.....3216 Torquay Rd.

O

Owens, Mrs. Richard R.....3011 Oaklyn Ave.
Owens, Mrs. Thomas.....608 E. Charles

P-Q

Peacock, Mrs. Robert.....R. R. 3
Pippinger, Mrs. W. G.....1200 N. Tillotson
Quick, Mrs. Wm. .....Moore Rd.

R

Rettig, Mrs. Arthur.....614 N. McKinley Ave.
Rivers, Mrs. Glynn.....307 Alden Rd.

S

Schulhof. Mrs. M. G.....921 W. Parkway Dr.
Smith, Mrs. J. S.....1006 E. First St.
Speck, Mrs. Carlson.....1205 Brentwood
Stanley, Mrs. John R.....1515 N. Tillotson Ave.
Starks, Mrs. William O.....2820 W. Main St.
Steele, Mrs. F. M.....421 Bittersweet
Stibbins, Mrs. Warren E.....2908 Torquay Rd.
Stout, Mrs. Francis E.....1003 University Ave.

T

Taylor, Mrs. Donald.....8 Wildwood Lane
Taylor, Mrs. James A.....1613 Riley Rd.
Tomlin, Mrs. Hugh M.....2920 Beechwood Ave.

W

Walker, Mrs. Jack.....R. R. 6, Box 385A
Ware, Mrs. Herbert .....1700 Glen Ellyn

Y

Young, Mrs. G. S.....114 Berwyn Rd.

Hinchman, Mrs. Jean.....Parker
Lutz, Mrs. Robert.....215 E. Washington, Eaton
Hill, Mrs. Robert.....Yorktown
Moore, Mrs. Will C...White Oak Farm, Yorktown
Rutledge, Mrs. Jean.....R. R. #1, Yorktown

DUBOIS COUNTY

Barrow, Mrs. John.....Dale, Box 55
Backer, Mrs. Henry George..Ohio St., Ferdinand

Huntingburg

Amini, Mrs. Sohrab.....R. F. D. #2
Bretz, Mrs. John.....Orchard Road
Heaton, Mrs. Elton.....Cedar Heights
Scales, Mrs. Alfred B.....R. R. 2
Scales, Mrs. Allen 511 4th
Steinkamp, Mrs. Emil..... 302 Walnut
Stork, Mrs. Harvey K.....523 First St.
Williams, Mrs. Fielding.....511 Geiger

Jasper

Bevan, Mrs. John..... R. R. 2
Casper, Mrs. Joseph.....205½ West 7th St.
Gootee, Mrs. Thomas.....Dorbett Street
Heck, Mrs. Martin C.....388 W. 15th
Held, Mrs. George A.....716 W. Ninth
Klamer, Mrs. Charles H.....616 W. 13th St.

Ploetner, Mrs. Edward.....Dorbett Street
Salb, Mrs. J. P.....R. R. #5
Wagner, Mrs. Arthur.....R. R. 5, Box 188

ELKHART COUNTY

Bristol

Neidballa, Mrs. E. G.....R. R. 1
Patrick, Mrs. Glen P.....R. F. D. 1
Schlosser, Mrs. H. C.....Seven Gables

Elkhart

Atwood, Mrs. Wm. H., Jr.....1217 Bower St.
Bender, Mrs. R. L.....125 N. Riverside Dr.
Benson, Mrs. James E.....1501 Fulton St.
Billings, Mrs. Elmer R.....2022 E. Jackson Blvd.
Bloom, Mrs. George R.....1100 E. Jackson Blvd.
Bowdoin, Mrs. George E.....3809 Greenleaf Blvd.
Campbell, Mrs. Patrick B.....1618 Cone St.
Classen, Mrs. Pete R. C.....635 W. Wolf Ave.
Compton, Mrs. Walter A.....2225 Greenleaf Blvd.
Conklin, Mrs. R. L.....215 Swanson Circle West
Cormican, Mrs. Herbert L...2002 E. Jackson Blvd.
Crandall, Mrs. L. A., Jr.....3600 W. Indiana Ave.
DeDario, Mrs. Leonard M.....1418 Greenleaf Blvd.
Dovey, Mrs. E. G., Jr.....1430 Ervin St.
Elliott, Mrs. Thomas A.....2001 Stevens Ave.
Fleming, Mrs. Claude F.....229 W. Jackson Blvd.
Futterknecht, Mrs. James C...2313 Morehouse Ave.
Gattman, Mrs. G. Beach.....1319 Lawn Ave.
Hannah, Mrs. Jack W.....1906 E. Jackson Blvd.
Hemingway, Mrs. Norman L.
1700 Rainbow Bend Blvd.
Horswell, Mrs. R. G.....1629 E. Jackson Blvd.
Hull, Mrs. A. W.....3333 Greenleaf Blvd.
Hunn, Mrs. M. F.....202 W. Beardsley Ave.
Hurley, Mrs. James William.....1705 Roys Ave.
Ivy, Mrs. John H.....1311 Kilbourn St.
Keating, Mrs. John U.....1416 Strong Ave.
Kintner, Mrs. Burton E.....3520 E. Jackson Blvd.
Kistner, Mrs. Arthur W.....R. F. D. 3, Box 81
Koehler, Mrs. Elmer George....615 N. Riverside Dr.
Krause, Mrs. Frederick.....1001 St. Clair St.
Leasure, Mrs. Kenneth E.....1128 Kenmore Ave.
Lundt, Mrs. Milo O.....519 S. Second St.
Markel, Mrs. I. J.....215 W. Franklin St.
Martin, Mrs. Floyd S.....2301 S. Main St
Martin, Mrs. Paul H.....1519 Strong Ave.
McArt, Mrs. Bruce A.....905 Strong Ave.
Mendez, Mrs. Carlos.....1109 Baker Dr.
Miller, Mrs. Galen R.....2229 Thorndale Ct.
Miller, Mrs. Hugh A., Jr.....417 Prospect St.
Miller, Mrs. Samuel T.....174 Witmer Ave.
Mininger, Mrs. Edward P...1118 E. Jackson Blvd.
Mishkin, Mrs. Irving.....1809 Rainbow Bend Blvd.
Paff, Mrs. Wm. A.....1745 Rainbow Bend Blvd.
Paine, Mrs. George E.....329 Meisner Ave.
Pancost, Mrs. Vernon K.....160 Riverview Ave.
Parshall, Mrs. Dale B.....3538 Gordon Rd.
Rouen, Mrs. Robert L.....1919 E. Jackson Blvd.
Rupe, Mrs. L. O.....R. R. #4, Oakland Ave. Rd.
Sears, Mrs. M. Maywood....4806 W. Indiana Ave.
Slabaugh, Mrs. Jancy S.....258 N. Main St.
Sobel, Mrs. Z. W.....433 East Blvd.
Spray, Mrs. Page E.....658 Kilbourn St.
Stout, Mrs. R. B.....1501 Greenleaf Blvd.
Stubbins, Mrs. William.....15 St. Joseph Manor
Swihart, Mrs. Danny D.....1219 Greenleaf Blvd.
Swihart, Mrs. Homer R.....1621 E. Jackson Blvd.
Swihart, Mrs. Leonard F.....3213 Calumet Ave.
Wilson, Mrs. O. E.....2505 Greenleaf Blvd.
Work, Mrs. James A., Jr.....4 St. Joseph Manor
Yoder, Mrs. C. Richard.....409 Prospect St.

Goshen

Bender, Mrs. C. K.....624 S. Fifth St.
Bosler, Mrs. Howard A.....211 Egbert Road
Bowser, Mrs. Herschel P.....203 S. 6th St.
Bowser, Mrs. Philip G.....707 S. 7th St.
Chandler, Mrs. L. H.....412 S. Fifth St.
Freeman, Mrs. F. M.....309 E. Washington St.
Graber, Mrs. Virgil R.....R. R. #2
Hostetler, Mrs. C. M.....1602 S. Eighth St.
Krabill, Mrs. Willard S.....420 Westwood Rd.
Nelson, Mrs. D. Chester.....1210 S. Eighth St.
Quilty, Mrs. Thomas J.....801 S. 7th St.
Troyer, Mrs. Dana O.....1727 South 13th St.
Turner, Mrs. John P.....507 Greene Road
Vander Bogart, Mrs. Harry E...1411 S. Eighth St.
Wagner, Mrs. D. G.....307 S. Seventh St.
Westfall, Mrs. George S.....2422 S. Main St.
Yoder, Mrs. Albert C.....816 S. Sixth St.
Yoder, Mrs. Jonathan G.....1204 S. Eighth St.
Miller, Mrs. Donald G...105 Brown St., Middlebury
Rheinheimer, Mrs. Floyd L.....Box 142, Milford
Massanari, Mrs. Walter S.....Millersburg

Nappanee

Fleetwood, Mrs. R. A.....555 N. Nappanee St.
Kendall, Mrs. F. M.....654 Woodland
Price, Mrs. Douglas W.....607 E. Van Buren

DeFries, Mrs. John J.....New Paris
Clark, Mrs. Jack P.....Syracuse
Fosbrink, Mrs. E. L...218 S. Huntington, Syracuse
Guttman, Mrs. John Beck.....109 Wabash Ave.,
Zimmerman, Mrs. William H.....R. R. 2, Syracuse

Wakarusa

Abel, Mrs. Robert.....105 E. Harrison
Amick, Mrs. Charles L.....118 E. Waterford St.
Syracuse

FAYETTE-FRANKLIN COUNTIES

Brookville

Foreman, Mrs. Walter A.....617 Main
Smith, Mrs. H. N.....812 Main
Seal, Mrs. Perry F.....901 Main

Connersville

Ashworth, Mrs. Juanita.....2027 Indiana Ave.
Brookman, Mrs. Robert E.....2750 Grand Ave.
Ellis, Mrs. George M.....108 East 10th St.
Gregg, Mrs. Albert F.....835 Lincoln Ave.
Hudson, Mrs. Arlington.....80 East Drive
Kemp, Mrs. W. Alfred.....403 W. 28th St.
Leffel, Mrs. Glen.....1810 Indiana Ave.
Lockhart, Mrs. Jack M.....54 West Drive
Morrow, Mrs. Roy D.....629½ Eastern Ave.
Mountain, Mrs. Francis B.....1720 Virginia Ave.
Sanders, Mrs. Bertram W.....1533 Virginia Ave.
Steinem, Mrs. Joseph L.....R. F. D. #3
Watterson, Mrs. Gerald T.....1704 Virginia Ave.

Poston, Mrs. C. L.....R. R. 2, Laurel

FLOYD COUNTY

Jeffersonville

Baxter, Mrs. S. M.....Centralia Ct.
Gentile, Mrs. John P.....3405 Centralia Ct.
McCullough, Mrs. J. Y.....3500 Centralia Ct.
Sloan, Mrs. Herbert.....Lincoln Heights

New Albany

Baker, Mrs. A. M.....2523 Glenwood Ct.
Baxter, Mrs. J. W., Jr.....426 Woodrow Ave.
Best, Mrs. Maurice.....1233 Vance Ave.

Bird, Mrs. J. E.....1308 E. Spring St.
Briscoe, Mrs. C. E.....1413 E. Spring St.
Brown, Mrs. K. H.....1654 Hedden Park
Byrn, Mrs. Howard.....330 Beharrel Ave.
Cannon, Mrs. Daniel H.....1203 E. Spring St.
Davis, Mrs. Parvin M.....Paoli Pike
Edwards, Mrs. W. F.....615 Beharrel Ave.
Garner, Mrs. Wm. H.....922 E. Spring St.
Garner, Mrs. William H., Jr.....Silver Hills
Geyer, Mrs. Joseph H.....Old Vincennes Rd.
Harris, Mrs. Robert W.....1923 Ekin Avenue
Hauss, Mrs. A. P.....Silver Hills
Hess, Mrs. P. Patrick.....Silver Hills
Higgins, Mrs. John R.....Old Vincennes Rd.
LaFollette, Mrs. Donald R.....Crestview
Leuthart, Mrs. C. P.....1410 E. Spring
Paris, Mrs. John M.....2003 Lindberg Ct.
Robertson, Mrs. A. N.....323 E. Ninth St.
Sonne, Mrs. Irvin.....1607 Hedden Court
Streepey, Mrs. Jefferson.....1919 DePauw Ave.
Voyles, Mrs. Harry.....425 Beharrel Ave.
Wallace, Mrs. Elmer.....1804 DePauw Ave.
Weaver, Mrs. W. W.....Crestview
Wolfe, Mrs. Nelson A.....Graybrook Lane

Wohlfeld, Mrs. Gerald
Waverly Hills, Waverly Hills, Ky.

FULTON COUNTY

Miller, Mrs. Virgil C.....Akron
Stinson, Mrs. Arthur E.....Athens
Glackman, Mrs. John C.....Culver
Kraning, Mrs. Kenneth K.....Culver

Rochester

Dielman, Mrs. Franklin C.....920 Jefferson St.
Herendeen, Mrs. Elbie V.....317 W. Seventh St.
Johnson, Mrs. F. P.....1100 Washington St.
King, Mrs. Milo O.....110½ E. Eighth St.
Richardson, Mrs. Chas. L.....506 Pontiac St.
Rowe, Mrs. Howard H.....417 W. Ninth St.
Stinson, Mrs. Dean K.....1318 Main St.

GIBSON COUNTY

Geick, Mrs. R. G.....207 N. Main, Ft. Branch
Marchand, Mrs. Edwin V.....Haubstadt

Oakland City

Clark, Mrs. Carl M.....123 Vine St.
Dye, Mrs. William.....518 S. Jackson St.
Wood, Mrs. Russell W.....High St.

Princeton

Carpentier, Mrs. H. F.....319 E. State
Folck, Mrs. J. K.....528 N. Main St.
Graves, Mrs. O. M.....125 W. Walnut
McCarty, Mrs. Virgil.....403 W. Spruce
McElroy, Mrs. R. S.....404 W. Walnut
Peck, Mrs. J. F.....Outer W. Monroe
Weitzel, Mrs. R. E.....309 W. Spruce
Wells, Mrs. William R.....Broadview Addition

GRANT COUNTY

Malott, Mrs. Fred.....Converse
Grant, Mrs. Arthur.....Fairmount
Yale, Mrs. Charles.....Fairmount
Garrison, Mrs. L. J., 305 E. South "C" St., Gas City
Koontz, Mrs. William A.....334 E. Main, Gas City
Baskett, Mrs. R. J.....Jonesboro

Marion

Abell, Mrs. Charles F.....915 Wabash Ave.
Alderfer, Mrs. Henry .....919 Euclid Ave.
Ansbacher, Mrs. Stefan.....R. R. 1
Ayres, Mrs. W. W.....920 Jeffras Ave.
Bailey, Mrs. Douglas.....R. R. 6, Hickory Hills
Bloom, Mrs. A. Ward.....610 River Rd.
Braunlin, Mrs. Robert.....315 N. Hill St.
Brown, Mrs. Robert M.....825 Euclid Ave.
Comeau, Mrs. Wm. J.....Shady Hills
Cunningham, Mrs. Robert.....1017 Euclid Ave.
Davis, Mrs. Joseph.....121 No. Washington St.
Davis, Mrs. Merrill S.....723 Euclid Ave.
Davis, Mrs. Richard.....Shady Hills
Diamond, Mrs. Leo .....710 Jeffras Ave.
Dunbar, Mrs. Fred.....Plantonian Apts.
Fisher, Mrs. Henry.....R. R. 4, Swayzee Rd.
Ganz, Mrs. Max.....904 Jeffras Ave.
Goldsmith, Mrs. David.....1225 Jeffras Ave.
Hockett, Mrs. Harry G.....34 Veterans Hosp.
Hover, Mrs. Galen M.....27 A Veterans Hosp.
Hummel, Mrs. R. M.....Shady Hills
Jarrett, Mrs. John.....113 W. 5th St.
Lahr, Mrs. Richard E.....1627 Broadview Dr.
Lavengood, Mrs. Russell W.....Charles Rd. R. R.
Langrall, Mrs. Harrison M.....Hickory Hills
Lonngren, Mrs. Dudley.....307 Kem Rd.
Miller, Mrs. H. Allison.....1010 W. 4th Street
Miller, Mrs. John R.....33 A Veterans Hosp.
Oatman, Mrs. Jack.....1610 E. Parkview Dr.
Pattison, Mrs. John D.....Hickory Hills
Powell, Mrs. J. P.....127 River Dr.
Price, Mrs. Ambrose M.....2938 S. Branson St.
Radzyminski, Mrs. J.....Veterans Hospital
Rhamy, Mrs. Arthur.....1230 Euclid Ave.
Rhomy, Mrs. Donald .....Broadview Dr.
Rhorer, Mrs. John G.....711 Wabash Ave.
Richardson, Mrs. Jos.....911 River Dr.
Sandy, Mrs. William,.....32 Veterans Hosp.
Schroeder, Mrs. R. W.....2123 S. Boots St.
Shoemaker, Mrs. Richard L.....211 E. South A St.
Simmons, Mrs. F. H.....Shady Hills
Skomp, Mrs. C. E.....1123 Euclid Ave.
Snowhite, Mrs. Arthur B.....508 S. Whites Ave.
Thompson, Mrs. B. Jay.....123 River Dr.
Warren, Mrs. Carroll.....1211 Euclid Ave.
Weinberg, Mrs. Samuel .....905 Euclid Ave.
Woodbury, Mrs. J. W.....712 S. "G" St.
Young, Mrs. Robert.....Northwood Dr.

King, Mrs. P. C.....Swayzee
Beck, Mrs. Thomas.....Swayzee
Taylor, Mrs. E. C.....Upland
Rifner, Mrs. E. S.....Van Buren
McIlwain, Mrs. Robert...Methodist Home, Warren

HAMILTON COUNTY

Karlick, Mrs. J. R.....Arcadia
Donahue, Mrs. C. M.....Carmel
Thomas, Mrs. W. Clayton
716 First St., N. E., Carmel
Havens, Mrs. Oscar.....Cicero

Noblesville

Ambrose, Mrs. J. C.....298 N. Ninth
Campbell, Mrs. Sam.....R. R. 1
Hash, Mrs. J. S.....R. R. 4
Haywood, Mrs. John.....1260 Lincoln Dr.
Kraft, Mrs. Haldon.....R. R. #5
Lanning, Mrs. R. Adrian.....R. R. 3
Lloyd, Mrs. Joe.....560 N. 14th St.
Shanks, Mrs. Ray.....R. R. 5
Shonk, Mrs. H. W.....408 North Ninth St.

Newby, Mrs. Eugene.....Sheridan
Waitt, Mrs. Paul.....Sheridan
Connoy, Mrs. Andrew.....Westfield
Connoy, Mrs. Leo.....139 N. Union St., Westfield

HANCOCK COUNTY

Johnston, Mrs. W. R. ..... Charlottesville
Scott, Mrs. Robert ..... Charlottesville
Garrison, Mrs. James ..... Cumberland
Naven, Mrs. W. K. ..... Fortville

Greenfield

Allen, Mrs. Joseph ..... 210 E. Lincoln
Beeson, Mrs. Wilbur ..... 209 N. Penn.
Endicott, Mrs. Wayne ..... 115 McClellen
Farrell, Mrs. John J., Jr. ..... 304 W. McKenzie Rd.
Gill, Mrs. D. D. ..... 328 Park St.
Kinneman, Mrs. R. E. ..... McClelland Dr.
Kirby, Mrs. Ted C. ..... 122 Grandison Rd.
Smith, Mrs. John H. ..... 919 Maple Dr.
Vingis, Mrs. Bronie A. ..... 705 N. State

Cagle, Mrs. Robert ..... New Palestine
Miller, Mrs. Joseph A. ..... R. R. 12, Box 230 Y, Oaklandon
Kuhn, Mrs. Robert ..... Wilkinson
Trees, Mrs. Nellie ..... Wilkinson
Freeborn, Mrs. Warren ..... Oaklandon

HENDRICKS COUNTY

Abel, Mrs. Walter ..... Brownsburg
Black, Mrs. James ..... Brownsburg
Foltz, Mrs. Lloyd ..... Brownsburg
Scudder, Mrs. A. N. ..... Brownsburg

Danville

Hibner, Mrs. Kermit Q. ..... St. Rd. 36 East
Koch, Mrs. Elmer ..... 301 S. Bowen
Kirtley, Mrs. Robert W. ..... 138 W. Marion
Terry, Mrs. Lloyd ..... 292 W. Marion

Ellis, Mrs. L. Hall ..... Lizton
Scamahorn, Mrs. Malcolm ..... Pittsboro
Scamahorn, Mrs. Oscar T. ..... Pittsboro

Plainfield

Aiken, Mrs. Milo M. ..... 140 N. Center
Cohen, Mrs. Irvin ..... 645 E. Main St.
Haggard, Mrs. David B. ..... Lake Shore Dr., R #2
Stafford, Mrs. J. C. ..... 223 Avon Ave.
Stafford, Mrs. William C. ..... 625 S. East St.
Warbinton, Mrs. Fred ..... R. R. 2

HENRY COUNTY

Wiatt, Mrs. Leonard ..... 108 N. Washington St., Knightstown
Murray, Mrs. William ..... 100 Van Nuys Rd., Knightstown
Stauffer, Mrs. George E. ..... Moreland
Marshall, Mrs. L. C. ..... Mt. Summit

New Castle

Balcom, Mrs. Francis ..... New Castle
Bledsoe, Mrs. J. G. ..... 319 S. 14th St.
Burnett, Mrs. A. B. ..... 801 Melody Lane
Craig, Mrs. Alex F. ..... 711 Crescent Dr.
Fisher, Mrs. John L. ..... 1135 Woodlawn Dr.
Foster, Mrs. Ray T. ..... 420 N. Main St.
Harrison, Mrs. B. L. ..... 233 Bundy Ave.
Heilman, Mrs. William C. ..... 1111 Audubon Rd.
Heilman, Mrs. Wm. C., Jr. ..... 120 N. 24th St.
Hill, Mrs. Kenneth G. ..... 100 Leland St.
Hollenberg, Mrs. A. E. ..... 105 N. Franklin St.
Iterman, Mrs. G. E. ..... 925 Mourer St.
Kennedy, Mrs. W. U. ..... 701 S. 14th St.
Life, Mrs. Homer L. ..... 1101 St. James Dr.
McDonald, Mrs. Frank C. ..... 527 S. Main St.
McKee, Mrs. Roy G. ..... 1417 Church St.
Saint, Mrs. Wm. K. ..... Park Place
Smith, Mrs. Mark ..... 4205 S. Main St.
Steussy, Mrs. Calvin N. ..... Hoosier Dr.
Stout, Mrs. Walter M. ..... 1103 Audubon Rd.
Thorne, Mrs. Charles E. ..... 1225 Audubon Rd.
Vivian, Mrs. Donald E. ..... 2715 Fair Oaks

Charles, Mrs. Henry ..... Hagerstown
Lowery, Mrs. G. E. ..... Box 96, Mt. Summit
Robertson, Mrs. Wm. ..... 213 W. Main St., Spiceland

HOWARD COUNTY

Denton, Mrs. Larkin ..... S. Meridian, Greentown
Shoup, Mrs. E. M. ..... N. Meridian, Greentown

Kokomo

Adams, Mrs. C. J. ..... 1216 W. Superior
Alward, Mrs. J. H. ..... 401 W. Walnut
Ault, Mrs. C. H. ..... 3015 Dellwood Drive
Behn, Mrs. Walter ..... 1208 Highland
Belding, Mrs. Ray T. ..... 3210 Janice Dr.
Boughman, Mrs. J. D. ..... 1515 W. Jefferson
Bowers, Mrs. C. C. ..... 1530 W. Taylor
Bowers, Mrs. Garvey B. ..... 421 Morningside
Bowers, Mrs. J. A. ..... 1535 W. Jefferson
Brown, Mrs. Earl R., Jr. ..... 2000 S. Buckeye
Bruegge, Mrs. T. J. ..... 1414 Kingston
Cattell, Mrs. Lee M. ..... R. R. #1
Clarke, Mrs. Elton R. ..... 1400 W. Sycamore
Conley, Mrs. T. M. ..... 2811 Dellwood Dr.
Craig, Mrs. R. A. ..... Route 1
Craig, Mrs. Ruben ..... 350 W. 50 N.
Cuthbert, Mrs. F. S. ..... 1027 W. Walnut
Earl, Mrs. M. M. ..... 1735 W. Walnut
Ferry, Mrs. P. J. ..... 1207 W. Sycamore
Fretz, Mrs. Richard C. ..... 145 Westmorland Dr.
Golper, Mrs. M. N. ..... 411 Morningside Drive
Good, Mrs. R. P. ..... 227 N. Forest Dr.
Grothouse, Mrs. Carl B. ..... 515 Rainbow Dr.
Halfast, Mrs. Richard W. ..... 2505 Katherine Ave.
Hoyt, Mrs. John M. ..... 1017 S. Delphos
Hutto, Miss Arvilla ..... 1020 W. Walnut
Hutto, Mrs. O. D. ..... 1020 W. Walnut
Hutto, Mrs. W. H. ..... R. R. 1
Jewell, Mrs. G. M. ..... 1318 W. Sycamore
Kremers, Mrs. George A. ..... 2401 S. Wabash
Lung, Mrs. Bruce ..... 115 Conradt Ave.
Martin, Mrs. Will J. ..... 409 W. Sycamore
McClure, Mrs. Warren N. ..... 309 Lody Lane
McIndoo, Mrs. R. E. ..... 820 W. Walnut
Mendelson, Mrs. Stanley M. ..... 2325 S. Wabash
Michael, Mrs. Robert L. ..... R. R. 1
Morrison, Mrs. W. R. ..... 413 Conradt Ave.
Murray, Mrs. E. C. ..... 2200 S. Webster
Perkins, Mrs. John L. ..... 2425 S. Washington
Phares, Mrs. R. W. ..... 400 S. Western
Prather, Mrs. P. E. ..... 123 Magnolia Dr.
Rudicel, Mrs. M. W. ..... 1604 Kingston Rd.
Schwartz, Mrs. F. C. ..... West Sycamore Rd.
Shenk, Mrs. E. M. ..... 306 N. Webster
Sorenson, Mrs. Raymond ..... 1616 W. Walnut
Spangler, Mrs. J. S. ..... 2126 S. Webster
Wachob, Mrs. Tom W., Jr. ..... 806 James Dr.
Wible, Mrs. James H. ..... R. R. #2, W. Jefferson Rd.

Evans, Mrs. Robert ..... Russiaville
Ware, Mrs. John R. ..... Russiaville
Tranter, Mrs. William F. ..... Sharpsville

HUNTINGTON COUNTY

Huntington

Brubaker, Mrs. Harold S. ..... 721 Flaxmill Rd.
Casey, Mrs. Stanley M. ..... 408 E. Market St.

Cope, Mrs. Stanton E.....1022 N. Jefferson St.
Erehart, Mrs. Mark G.....Maple Grove Rd.
Eviston, Mrs. J. Boyd.....1392 Poplar St.
Gray, Mrs. Paul M.....340 E. Market St.
Grayston, Mrs. Wallace S.....303 E. Market St.
James, Mrs. Thomas, Jr.....1044 Poplar St.
Johnston, Mrs. Robert G.....339 E. Market St.
Marks, Mrs. Howard H.....1120 N. Jefferson
Meiser, Mrs. Robert D.....1738 Cherry St.
Miller, Mrs. Wayne S.....354 E. Washington St.
Mitman, Mrs. Floyd B.....1470 Poplar St.
Omstead, Mrs. Trevalyn W.....231 Vine Street
Wagner, Mrs. Richard.....1355 Guilford St.

Woods, Mrs. Halden C.....Markle
Cooper, Mrs. B. Trent.....Roanoke
Bennett, Mrs. J. B.....Warren
Ray, Mrs. Carl S.....Warren

JACKSON-JENNINGS COUNTIES

Brownstown

Gillespie, Mrs. G. R.....701 Commerec
Shields, Mrs. Jack.....721 W. Spring

Crothersville

Adair, Mrs. W. K.....208 S. Armstrong
Bard, Mrs. Frank B.....305 E. Howard
Butler, Mrs. Joe B.....215 S. Preston
Rothring, Mrs. Howard.....R. R. 2
Scharbrough, Mrs. Wm.....Medora

North Vernon

Berkshire, Mrs. Shaffer.....433 Margaret
Calli, Mrs. Louis J.....408 S. State
Green, Mrs. John.....Elm St.
Johnson, Mrs. William J.....318 Jennings St.
Matthews, Mrs. David W.....Walnut St.
Thayer, Mrs. Benet W.....214 Jennings St.

Seymour

Baxter, Mrs. Harry....710 West Dr., Sunset Pkwy.
Black, Mrs. J. M...671 Braewick Rd., Sunset Pkwy.
Bobb, Mrs. Kenneth E.....311 Lee Blvd.
Bosch, Mrs. Ralph O...930 South Dr., Sunset Pkwy.
Day, Mrs. Durbin.....515 W. Sixth St.
Gillespie, Mrs. Charles E.
840 North Dr., Sunset Pkwy.
Graessle, Mrs. H. P....640 East Dr., Sunset Pkwy.
Kamman, Miss Martha.....332 W. Oak St.
Martin, Mrs. Guy.....1408 Ewing Rd.
Osterman, Mrs. L. H.....901 Garden Ave.
Ripley, Mrs. John W.....2001 Ewing St.
Shortridge, Mrs. Wilbur H.....313 Carter Blvd.
Templeton, Mrs. Ian
723 Sweetbriar Ct., Sunset Pkwy.
Wiethoff, Mrs. C. A...615 West Dr., Sunset Pkwy.

JASPER-NEWTON COUNTIES

Schantz, Mrs. Richard.....Remington
Schoonveld, Mrs. Arthur.....Brook
Yegerlehner, Mrs. R. S.....Kentland
Parker, Mrs. John.....Goodland
Brady, Mrs. Kingdon.....Morocco

Rensselaer

Beaver, Mrs. Raymond E.....111 Thompson St.
Greene, Mrs. Robert W.....732 Elza St.
O'Brien, Mrs. Francis E.....Rensselaer
Ockermann, Mrs. Kenneth R.....202 Home St.
Williams, Mrs. Earl Kenneth.....617 Dean Place
Williams, Mrs. Paul A.....Rensselaer

Hartsough, Mrs. Ralph I.....Remington

JAY COUNTY

Girod, Mrs. Donald A.....106 Moore Ave., Dunkirk
Heller, Mrs. N. L.....Dunkirk

Portland

Badders, Mrs. Ara C.....709 W. North
Cripe, Mrs. Wm. H.....507 W. High
Cronin, Mrs. H. Joseph.....828 E. Water
Fitzpatrick, Mrs. James S.....420 N. Pleasant
Gillum, Mrs. Eugene.....W. Votaw Street
Keeling, Mrs. F. E.....609 W. Race
Morrison, Mrs. George G.....R. R. #4
Schenck, Mrs. Ralph.....W. Seventh
Spahr, Mrs. Donald E.....615 W. Race
Steffy, Mrs. Ralph M.....321 E. Race

JEFFERSON-SWITZERLAND COUNTIES

Madison

Alcorn, Mrs. Merritt O., Jr.....R. R. 2
Childs, Mrs. Wallace Edward....414 N. Broadway
Gambill, Mrs. John R.....Madison State Hospital
Haney, Mrs. William Keith.....R. R. 5
Hare, Mrs. Frank W.....705 W. 2nd Street
May, Mrs. George Arthur.....226 Maywood Lane
McAtee, Mrs. Ott B.....Madison State Hospital
Pratt, Mrs. Ralph M., Jr.....2315 Blackmore St.
Shuck, Mrs. Wm. A.....R. F. D. 1
Sloan, Mrs. Keith W.....340 Bunton Lane
Whitsitt, Mrs. Schuyler A.....718 W. Main St.
Zink, Mrs. Robert Otto.....502 Broadway

JOHNSON COUNTY

Gammell, Mrs. L. L.
707 E. Main Cross St., Edinburg

Franklin

Andrews, Mrs. Hugh K.....1138 Orchard Lane
Bullers, Mrs. Robert C.....551 Center St.
Bullington, Mrs. George.....R. F. D. #4
Chappel, Mrs. A. T.....174 Center Court
Deppe, Mrs. Charles F.....1215 Park Ave.
Ferrara, Mrs. Joseph E.....1000 E. King St.
Foster, Mrs. R. H. K.....1025 Orchard Lane
Hibbs, Mrs. William G.....R. F. D. 1
Jones, Mrs. Charles A.....1010 E. Adams Dr.
Mock, Mrs. Harry E.....201 E. Monroe St.
Murphy, Mrs. Harry E.....150 N. Main St.
Portteus, Mrs. Walter L.....R. R. 2, Box 11-B
Province, Mrs. Wm. D.....51 N. Water St.
Records, Mrs. Arthur W.....216 E. Jefferson St.
Ritteman, Mrs. George.....R. R. 3
Stogsdill, Mrs. W. W.....R. R. #4
Walters, Mrs. Jack L.....876 Glendale Drive

Greenwood

Brown, Mrs. George E.....Beech Park Dr.
Fox, Mrs. Richard.....110 Roselane
Machledt, Mrs. John H.....243 S. Madison
Onyett, Mrs. Harold .....R. R. 4, Box 125
Sheek, Mrs. Kenneth I.....407 S. Forest Dr.
Snodgrass, Mrs. Robert.....360 S. Madison
Tiley, Mrs. George.....40 N. Madison

KNOX COUNTY

Shanklin, Mrs. Jack L.....Bicknell

Vincennes

Anderson, Mrs. John.....1202 Busseron St.
Anderson, Mrs. Richard M.....Monroe City Rd.
Arbogast, Mrs. Paul B.....1420 Old Orchard Rd.
Barrett, Mrs. Thomas L.....2520 Old Orchard Rd.

Bartlett, Mrs. Donald T.....429 S. 6th St.
Beckes, Mrs. Ellsworth W.....220 N. Fifth
Black, Mrs. Boyd K.....State Road 67 - N
Chattin, Mrs. Herbert O.....729 Main
Coffel, Mrs. Melvin H.....Simpson Lake
Corsentino, Mrs. Bart.....110 State Rd. 67
Curtner, Mrs. Myron L.....216 N. Sixth
Edwards, Mrs. Edward T., Jr....Old Bruceville Rd.
Ewing, Mrs. Nathaniel D.....Monroe City Rd.
Green, Mrs. Carl L.....R.R. #1
Hendrix, Mrs. Charles.....1202 E. Sycamore
Humphreys, Mrs. Joe S.....1602 Weed Lane
Kline, Mrs. Chas. D.....516 N. 6th St.
McCormick, Mrs. Hubert D.....518 N. Fourth
McDowell, Mrs. M. M.....1322 Audubon Rd.
McMahan, Mrs. V. C.....Monroe City Rd.
Nichols, Mrs. Robert J.....1515 Burnett Lane
Pierce, Mrs. W. J.....810 Broadway
Reilly, Mrs. James F.....401 Buntin St.
Schulze, Mrs. Wm.....422½ Buntin St.
Shaffer, Mrs. Kenneth.....2600 Ridge Rd.
Smith, Mrs. S. Joseph.....504 N. Fourth Street
Spencer, Mrs. Frederic.....902 Perry Street
Stein, Mrs. Richard A.....1304 E. St. Clair
Stewart, Mrs. Frank W.....Hillcrest Rd.
Sullenger, Mrs. A. A.....803 Seminary St.
Vaughn, Mrs. Walter R.....406 N. Third
von de Leith, Mrs. William.....Monroe City Rd.
Welch, Mrs. Norbert M.....Monroe City Rd.

KOSCIUSKO COUNTY

Bahler, Mrs. Dean R.....P. O. Box 217, Leesburg
Hursey, Mrs. Virgil G.....Milford
Urschel, Mrs. Dan L.....Mentone
Wilson, Mrs. Wymond B...P. O. Box 421, Mentone
Pierson, Mrs. Pearl H.....R. R. 1, Silver Lake

Warsaw

Arford, Mrs. John E.....104 Argonne Rd.
Baum, Mrs. John R.....307 7th Winona St.
Cron, Mrs. William.....R. R. 2
Doremire, Mrs. Robert D.....105 Meri Mac
Hashemi, Mrs. Hossein.....1306 Ranch Rd.
Johnson, Mrs. John J.....R. R. 2
Murphy, Mrs. Samuel C.....216 South High St.
Richer, Mrs. Orville.....914 E. Main St.
Schlemmer, Mrs. George H.....528 N. Lake St.
Shrader, Mrs. Carl.....Spring Hill Acres
Thomas, Mrs. E. Winton.....711 E. Main St.

LAKE COUNTY

Cedar Lake

Miller, Mrs. D. C.....P. O. Box 297
Misch, Mrs. W. A.....R. R. 4, Box 756

Crown Point

Gutierrez, Mrs. P. E.....126 N. Court St.
Horst, Mrs. W. N.....R. R. 7, Box 151

East Chicago

Barron, Mrs. Elmer A.....3902 Ivy St.
Campagna, Mrs. E. A.....4320 Ivy St.
Ernst, Mrs. H. C.....4219 Baring Ave.
Fleischer, Mrs. J. C.....4135 Ivy St.
Grosso, Mrs. William G.....4132 Northcote Ave.
Gustaitis, Mrs. John W.....4318 Parrish Ave.
Niblick, Mrs. James S.....4115 Fir St.
Shapiro, Mrs. Joseph.....4214 Parrish Ave.
Shapiro, Mrs. S. W.....1517 Melbrook

East Gary

Mather, Mrs. J. Winford.....2367 Vigo St.
Penn, Mrs. R. A.....2334 Vigo St.
Valencia, Mrs. Monico.....2421 Walnut St.

Gary

Abramson, Mrs. Allen .....7001 E. 1st Ave.
Almquist, Mrs. C. O.....550 Lincoln St.
Angeles, Mrs. U. A.....815 Polk St.
Armalavage, Mrs. L. J.....6572 Birch St.
Behn, Mrs. Walter.....1514 W. 5th St.
Bergal, Mrs. M. B.....925 W. 35th Ave.
Bills, Mrs R. N.....534 Lincoln St.
Brady, Mrs. Samuel J.....451 Garfield St.
Bringas, Mrs. Irinco B.....803 Johnson St.
Brincko, Mrs. John .....3537 Harrison St.
Carberry, Mrs. G. A.....591 Johnson St.
Carbone, Mrs. Joseph A.....526 Johnson St.
Chevigny, Mrs. J. J.....654 Johnson St.
Cooper, Mrs. Leo K.....670 Hayes St.
Dierolf, Mrs. Edward J.....630 Montgomery St.
Elliott, Mrs. Ralph A.....1726 W. Sixth Ave.
English, Mrs. Hubert M.....575 Taft St.
Fadell, Mrs. Mathew J.....701 W. 55th Ave.
Glover, Mrs. W. J.....3540 Taylor Ave.
Goldberg, Mrs. Harold B.....825 W. 35th Ave.
Goldstone, Mrs. Adolph.....1430 W. Seventh St.
Goldstone, Mrs. Joseph.....600 Cleveland St.
Jahns, Mrs. A. A.....655 Roosevelt St.
Jordon, Mrs. S. Y.....430 W. 44th Ave.
Kendrick, Mrs. Frank J.....701 Polk St.
Kobrin, Mrs. Meyer W.....2300 W. Sixth Ave.
Kolletis, Mrs. J. G.....800 Hayes St.
Kopcha, Mrs. Joseph E.....650 Pierce St.
Korn, Mrs. Jerome M.....2119 W. Fifth Ave.
Lebioda, Mrs. Henry S.....230 Morningside Ave.
Lewis, Mrs. George N.....573 Roosevelt St.
Llamas, Mrs. D. F.....4831 Kentucky St.
Lorenty, Mrs. T. B.....3654 Madison St.
Manalo, Mrs. F. S.....833 Filmore St.
May, Mrs. R. Milton.....657 Van Buren St.
Milos, Mrs. Robert.....725 Filmore St.
Minczewski, Mrs. Richard C....5528 Van Buren St.
Morris, Mrs. Hyman R.....2401 W. Sixth Ave.
Moswin, Mrs. Jack A.....701 Arthur St.
Nelson, Mrs. W. A.....1050 Warren St.
Nilges, Mrs. Richard.....237 Glen Park Ave.
Ornelas, Mrs. Joseph P.....230 W. 36th Ave.
Palmer, Mrs. Russell H.....2006 W. Fourth Place
Pappas, Mrs. Edward T.....569 Pierce St.
Poracky, Mrs. Bernard.....5598 Van Buren St.
Robinson, Mrs. Walter K...500 N. Montgomery St.
Roth, Mrs. Leo.....7033 E. 1st Ave.
Rubin, Mrs. Simon S.....2131 W. Fifth Ave.
Russo, Mrs. Andrew E.....2131 W. 5th Ave.
Ryan, Mrs. H. J.....630 McKinley St.
Sala, Mrs. Joseph J.....2333 W. Fifth Ave.
Sala, Mrs. Walter.....659 McKinley St.
Schultz, Mrs. K. J.....4132 Massachusetts St.
Scully, Mrs. J. T.....715 Johnson St.
Senese, Mrs. Thomas J.....581 Johnson St.
Shevick, Mrs. Alexander.....733 Filmore St.
Slama, Mrs. George F.....3520 Polk St.
Stimson, Mrs. Harry R.....4338 Jefferson St.
Thomas, Mrs. Daniel D.....2001 W. 7th Street
Vye, Mrs. J. Preston.....3620 Madison St.
Weiscopf, Mrs. H. S.....608 Roosevelt St.
Yast, Mrs. Charles J.....740 Filmore St.
Yocum, Mrs. Paul S., Sr.....6999 Hemlock
Young, Mrs. G. M.....4580 Washington St.
Zucker, Mrs. Edward.....7009 E. 1st St.

Griffith

Lundeberg, Mrs. Ralph A.....303 N. Harvey
Purcell, Mrs. Richard.....300 N. Lafayette St.
Siekierski, Mrs. J. M.....445 N. Broad Street

Hammond

Allegretti, Mrs. Michael L.....6237 Forest Ave.
Bacevich, Mrs. A. J.....6939 Olcott Ave.

Beconovich, Mrs. Robert.....6540 Forest Ave.
Bombar, Mrs. Leslie E.....826 Rosewood
Bonaventura, Mrs. Angelo P...7112 Woodmar Ave.
Costello, Mrs. Albert J.....6737 Magoun Ave.
Cotter, Mrs. Edward R.....7225 Knickerbocker
Egnatz, Mrs. Nick.....820 Highland St.
Elledge, Mrs. Ray.....6415 Forest Ave.
Fischer, Mrs. Burnell.....49 Indi-Illi Park
Gevirtz, Mrs. Milton B.....6905 Magoun Ave.
Hack, Mrs. Edmund C.....7147 Olcott St.
Hickman, Mrs. A. Lee, Jr.....7412 Knickerbocker
Husted, Mrs. Robert G.....7248 Forest Ave.
Kenney, Mrs. Francis D.....8131 Forest Ave.
Komoroske, Mrs. John E.....35 Highland Ave.
Koransky, Mrs. David S.....7048 Forest Ave.
Kretsch, Mrs. Russell W.....7214 Hohman Ave.
Lazo, Mrs. Vincente R.....5411 Wood
Marks, Mrs. Ora L.....7111 Olcott Ave.
Mason, Mrs. R. L.....132 Rimbach Ave.
Modjeski, Mrs. Joseph R.....7327 Knickerbocker
Modjeski, Mrs. Raymond J.....223 Locust St.
Neal, Mrs. L. W.....7301 Forest Ave.
Panares, Mrs. S. V.....4 172nd Place
Peck, Mrs. Edward A.....6422 Moraine Ave.
Pilot, Mrs. Jean.....7137 Knickerbocker Pkwy.
Remich, Mrs. Antone C.....6412 Moraine Ave.
Rendel, Mrs. Donald T.....18 172nd St.
Rhind, Mrs. A. W.....7126 Forest Ave.
Row, Mrs. Perry Quentin,.....6706 Hohman Ave.
Rubright, Mrs. Robert.....7025 Monroe Ave.
Rudolph, Mrs. F. G.....6607 Forest Ave.
Santare, Mrs. Vincent J.....6508 Forest Ave.
Shulruff, Mrs. Harry I.....7244 Hohman Ave.
Shanklin, Mrs. E. M.....54 Ruth St.
Stern, Mrs. S. Lewis.....226 Oakwood
Teegarden, Mrs. Joseph A., Jr.
7204 Woodman Ave.
Thegze, Mrs. George A.....7435 Olcott Ave.
Wong, Mrs. Samuel N.....632 169th St.

Beilke, Mrs. C. A.....8723 Parkway Dr., Highland
Larrabee, Mrs. James....2214 Oakdale, Highland
Bernard, Mrs. Marvin R.....651 Waters, Hobart
Bradley, Mrs. Charles F...638 S. Pennsylvania St., Hobart
Dhein, Mrs. Donald T.
6744 Jefferson St., Merrillville

Mansueto, Mrs. Mario D.
4 Forestdale, Calumet City, Ill.
Potts, Mrs. William A.
3543 Ridge Rd., E., Lansing, Ill.
Sroka, Mrs. A. G.....17216 Wentworth Ave., Lansing, Ill.
Stasick, Mrs. Murray..228 W. Warren, Lansing, Ill.

Munster

Arbeiter, Mrs. Herbert I.....119 Beverly Place
Arrowsmith, Mrs. James L.....8131 Forest Ave.
Benchik, Mrs. Frank A.....8326 Hawthorne Dr.
Boys, Mrs. F. F.....8517 Crestwood Ave.
Chael, Mrs. Tom C.....252 Belmont Place
Eggers, Mrs. Ernest L.....8147 Meadow Lane
Kenney, Mrs. Francis.....8131 Forest Ave.
Kuhn, Mrs. Arthur J.....1535 35th St.
Lanman, Mrs. John U.....1448 MacArthur Blvd.
Lautz, Mrs. Herbert A.....7943 Forest Ave.
Long, Mrs. Keith J.....1327 Ridgeway
Marks, Mrs. Salvo P.....8320 Parkview Ave.
Mintz, Mrs. Alfred M.....1423 Kraft St.
McLean, Mrs. James S.....7836 Ridge Rd.
Rasch, Mrs. George C.....1519 35th St.
Schlesinger, Mrs. D. J.....1506 MacArthur Blvd.
Schleisinger, Mrs. Jack.....7648 Hohman Ave.
Sroka, Mrs. Stanley J.....7540 Forest Ave.
Stevens, Mrs. Edwin W.....8627 Beech
Teplinsky, Mrs. L. L.....1528 Twelve Oaks Dr.
Trachtenberg, Mrs. Lee.....7411 White Oak
Walker, Mrs. A. P.....1504 Park Dr.
Westhaysen, Mrs. Peter V.....127 Beverly Pl.

Whiting

Angel, Mrs. Virgil.....2125 Indianapolis Blvd.
Greisen, Mrs. J. C.....1709 Stanton Ave.
Weinberg, Mrs. B. A.....2022 Lake Ave.

LAWRENCE COUNTY

Bedford

Allen, Mrs. L. Howard.....1318 14th St.
Austin, Mrs. Richard P.....1315 15th St.
Campbell, Mrs. William T.....3008 16th St.
Duncan, Mrs. Raymond E.....116 Edgewood Dr.
Dusard, Mrs. Joseph C.....1107 N St.
Edmonds, Mrs. Kendrick T.....1303 15th St.
Emery, Mrs. Charles B.....Brook Knoll
Fountaine, Mrs. Thomas J.....1620 18th St.
Greer, Mrs. William E.....2514 19th St.
Hammel, Mrs. Howard T.....1822 15th St.
Hawkins, Mrs. Richard D.....1308 15th St.
Kastings, Mrs. Gerald E.....Parkview Addition
Kerr, Mrs. Donald M.....1415 20th St.
Morrow, Mrs. Robert J.....501 Southwood St.
Noe, Mrs. William R.....1224 14th
Scherschel, Mrs. John P.....1713 H St.
Waldo, Mrs. Guy Harold Jr.....2218 I St.
Wohlfeld, Mrs. J. B.....1224 15th St.
Wynne, Mrs. R. E.....1601 16th St.

Hamilton, Mrs. James.....703 Oak St., Mitchell
Oswalt, Mrs. James .....901 Curry St., Mitchell
Robinson, Mrs. William.....R. R. 1, Mitchell
Benham, Mrs. Lawrence E.....R. R. 2, Springville

MADISON COUNTY

LeRoy, Mrs. A. G.....Alexandria

Anderson

Aagesen, Mrs. W. J.....3 Wind Ridge
Armington, Mrs. Charles L.....823 W. 7th Street
Armington, Mrs. John C.....206 W. 14th St.
Austin, Mrs. Charles E.....1612 Westwood Dr.
Baughn, Mrs. W. L. .....1517 Winding Way
Beeler, Mrs. Frank K.....20 Overlook Dr.
Bixler, Mrs. Donald P.....1515 Green Way Dr.
Blassaras, Mrs. Crist A.....916 Dresser Dr.
Bowers, Mrs. Richard C.....3508 Dogwood Dr.
Bridges, Mrs. Alvin L.....R. R. 2, Box 296 a
Brown, Mrs. James M.....909 Forest Dr.
Buckles, Mrs. David L. ...44 Knoll Rd., Edgewood
Conrad, Mrs. Ernest M.....2124 Meridian St.
Doenges, Mrs. James L.....1601 Van Buskirk Rd.
Donaldson, Mrs. Frank C.....308 Winding Way
Drake, Mrs. James R.....1104 Pearl St.
Drake, Mrs. John C.....920 N. Madison Ave.
Dulin, Mrs. Basil B.....1120 Maryland Drive
Ellis, Mrs. Seth W.....1105 Green Way Dr.
Elsten, Mrs. Wayne A.
1333 Maryland Dr., Forest Manor
Erehart, Mrs. Archie D.....1221 Irving Way
Faust, Mrs. Howard Jr.....1321 W. 8th St.
Ferguson, Mrs. Donald H.....3430 Redwood Rd.
Fischer, Mrs. Warren E.....1410 Van Buskirk Rd.
Gante, Mrs. Henry W.....2005 Nichol Ave.
Hart, Mrs. Wm. D.....1026 W. Eighth St.
Hensler, Mrs. Benton M.
717 Winding Way, Edgewood
Jarrett, Mrs. Paul E.....2541 N. Shore Blvd.
Jones, Mrs. Albert T.....3316 Cherry Rd.
Jones, Mrs. David G.....126 W. 12th St.
Kelly, Mrs. Wendell C....23 Colony Rd., Edgewood
Kiely, Mrs. John T.....1011 Raible Ave.
King, Mrs. Joseph W.....260 Davis Dr., Edgewood

Kopp, Mrs. William R.....1200 Arrow Ave.
Larmore, Mrs. Joseph L.
1301 Winding Way, Edgewood
Litzenberger, Mrs. Sam W.....837 Forrest Dr.
Long, Mrs. Paul L.....828 Dresser Dr.
Metcalf, Mrs. George B.....830 W. Eighth St.
Moneyhun, Mrs. James E.....1815 Ivy Dr.
Morris, Mrs. Robert A.....410 Golf Club Rd.
Neale, Mrs. Alfred E.....725 Forest Dr.
Nesbitt, Mrs. Leonard L.....60 River Forest
Patterson, Mrs. William K.....8 South Park Dr.
Polhemus, Mrs. Warren C.....1800 W. 11th St.
Rosenbaum, Mrs. Lloyd E.....804 Dresser Dr.
Ross, Mrs. Guy E.....1124 N. Madison Ave.
Sharp, Mrs. William L.....725 North Shore Blvd.
Sheldon, Mrs. Suel A.....2812 Greenbriar Rd.
Stamper, Mrs. Joseph H.....619 State Road 67 W.
Stamper, Mrs. Robert J.....3104 Sherman St.
Stinson, Mrs. William M.....201 Longwood Ave.
Swan, Mrs. Richard C.....707 Forrest Dr.
Wagoner, Mrs. John R.....3522 Hawthorne Rd.
Weiss, Mrs. Louis L.....1225 N. Madison Ave.
Webb, Mrs. Harry D.....1308 Maryland Dr.
Wilder, Mrs. Gordon B.....338 W. Eighth St.
Williams, Mrs. Francis M.....1012 Park Rd.
Williams, Mrs. Robert H....715 North Shore Blvd.
Wilkinson, Mrs. Roger L.
1525 Winding Way, Edgewood
Wishard, Mrs. Fred B.....2805 Brown St.

Stump, Mrs. Richard L.....Daleville
Rhynearson, Mrs. Hal R...235 N. Merrill, Fortville
Ayres, Mrs. Kenneth D.....R. R. 1, Markleville
Williams, Mrs. Robert D.....Markleville
Hammer, Mrs. J. W.....Middletown
Leahy, Mrs. H. J.....R. R. 1, Box 83 C, Pendleton
McLaughlin, Mrs. Calvin P.
Fall Creek Parkway, Pendleton
Van Ness, Mrs. William..216 S. Main, Summitville

MARION COUNTY

Ramage, Mrs. Walter F...244 S. First, Beech Grove

Indianapolis

A

Albertson, Mrs. Frank P.....5031 Rockville Rd.
Aldrich, Mrs. Harry D.....5805 Sherman Dr.
Allen, Mrs. Robert K.....737 Sherwood Dr.
Alvis, Mrs. Edmond O.....474 W. 92nd St.
Appel, Mrs. Richard H...4465 Marcy Lane, No. 190
Arbuckle, Mrs. William E....5326 E. St. Joseph St.
Armer, Mrs. Robert M.....2259 Randell
Arnold, Mrs. Robert D.
6450 Around the Hills Road
Avery, Mrs. George O...5321 N. Kessler Blvd. N.D.

B

Bacastow, Mrs. Merle S.....1705 E. 81st St.
Bachmann, Mrs. Arnold J.....1615 Oles Drive
Bakemeier, Mrs. Otto H.....5535 E. St. Clair St.
Bakemeier, Mrs. Robert E.....1210 N. Butler Ave.
Balch, Mrs. James R.....4444 College Ave.
Ball, Mrs. Joseph E.....6612 E. Ninth St.
Banks, Mrs. Horace M.....3631 Forest Manor Ave.
Baptisti, Mrs. Arthur, Jr.....4401 N. Meridian St.
Bartley, Mrs. Max D.....5640 N. Pennsylvania St.
Batman, Mrs. Gordon W.....6906 N. Delaware St.
Baumeister, Mrs. Herbert E...314 W. Hampton Dr.
Beach, Mrs. Robert R.....5810 E. Pleasant Run Pkwy., N. Dr.
Beamer, Mrs. Parker R.....4620 Boulevard Place
Beasley, Mrs. Thos. J.....715 E. 70th Place
Beaver, Mrs. Howard W.....303 E. Edgewood Ave.
Beck, Mrs. Evart M.....6445 N. Olney St.
Becker, Mrs. Harry G.....5641 Haverford Ave.
Beeler, Mrs. John W.....7974 N. Illinois St.
Benedict, Mrs. Paul F.....2550 Blue Grass Dr.
Bennett, Mrs. Ivan F.....R. R. 18, Box 285
Berman, Mrs. J. K.....2810 W. 38th St.
Bibler, Mrs. Lester D.....4360 N. Pennsylvania St.
Bill, Mrs. Robert O.....8750 Washington Blvd., W. Dr.
Blake, Mrs. Albert L.....6471 Knygton Rd.
Blatt, Mrs. A. Ebner.....5330 N. Illinois St.
Boling, Mrs. Grover C., Jr.....6205 Bramshaw Rd.
Booth, Mrs. Boynton H.....107 E. 48th St.
Bowman, Mrs. George W.....5634 Carrollton Ave.
Boyer, Mrs. Floyd A.....136 S. Wittfield St.
Brady, Mrs. Thomas A., Jr.....225 Wellington Rd.
Brayton, Mrs. John R.....3128 E. Fall Creek Blvd.
Brayton, Mrs. Lee.....5540 N. Illinois St.
Brickley, Mrs. Richard A.....506 W. 46th St.
Brodie, Mrs. Donald W.....R. R. 13, Box 397
Brown, Mrs. Archie E...4145 Melbourne Rd. W. Dr.
Brown, Mrs. David E.....7230 N. Lake Side Dr.
Brown, Mrs. DeWitt W., Jr...4363 Cold Springs Rd.
Brown, Mrs. Thomas C., Jr.....8780 Driftwood Dr.
Brown, Mrs. Wendell.....3750 N. Gale St.
Browning, Mrs. James S.....6339 N. Keystone Ave.
Brueckmann, Mrs. Robert.....2356 N. Kenyon
Bunde, Mrs. Carl A.....5245 Knollton Rd.
Burdette, Mrs. Harold.....5733 Broadway
Butler, Mrs. Robert M.....4849 N. Ritter Ave.

C

Cahn, Mrs. Hugo M.....5535 N. Pennsylvania St.
Call, Mrs. Herbert F.....710 E. 57th St.
Calvert, Mrs. John H., Jr.....4450 Guilford Ave.
Campbell, Mrs. John A.....5201 Grandview Dr.
Carson, Mrs. E. Wayne.....7177 N. Meridian St.
Carter, Mrs. Oren E.....5461 Kenwood Ave.
Chattin, Mrs. William R.....4209 Roselawn Dr.
Chernish, Mrs. Stanley M.....4403 Radnor Rd.
Chivington, Mrs. Paul B., Jr.....5730 N. Parker
Chroniak, Mrs. Walter
5916 E. Pleasant Run Pkwy. N. Dr.
Clark, Mrs. Lawson J.
2725 E. Kessler Blvd. E. Dr.
Coggeshall, Mrs. Warren.....6305 Bramshaw Rd.
Cohn, Mrs. A. F.....1120 Southview Dr.
Conway, Mrs. Glenn.....2235 E. Garfield Dr.
Cortese, Mrs. James V.....6302 Minlo Dr.
Cortese, Mrs. Thomas A.....3240 Brill Rd.
Countryman, Mrs. F. W.....5633 Central Ave.
Crawford, Mrs. John A.....3848 Washington Blvd.
Cross, Mrs. David G.....2801 Redfern Dr.
Culbertson, Mrs. C. G.....6060 Park Ave.
Cure, Mrs. Charles W.....320 Willow Springs Rd.
Currie, Mrs. Robert W.....512 E. 57th St.
Curry, Mrs. R. Louis.....5260 Carrollton
Cuthbert, Mrs. Marvin P.
6935 N. Pennsylvania St.

D

Daley, Mrs. Edward H.....5118 East Dickson Road
Daly, Mrs. Joseph M.....5969 Singleton St.
Davis, Mrs. John A.....3630 Marrison Place
Davis, Mrs. Sam J.....4545 Broadway
Dearmin, Mrs. Robert M.....5147 N. Delaware St.
DeArmond, Mrs. Albert M...5401 N. Delaware St.
Deever, Mrs. John W.....6801 S. East St.
Dennison, Mrs. A. Dudley, Jr.
7910 Wincombe Blvd.
Denny, Mrs. James W...6633 Spring Brook, N. Dr.
Donato, Mrs. Albert M.....5915 Lawrence Dr.
Doran, Mrs. J. Hal.....3733 N. Denny St.
Dorman, Mrs. W. Leland.6631 Spring Brook, N. Dr.
Doughty, Mrs. Samuel R., Jr.
5817 N. Dearborn St.
Drew, Mrs. Arthur L., Jr.....333 Beverly Dr.
Dugan, Mrs. William M.....5747 Rolling Ridge Rd.
Dupes, Mrs. Lowell E.....5851 White Oak Ct.

Dryden, Mrs. Gale.....5835 N. Tacoma Ave.
Dyar, Mrs. Edwin W., Jr...5910 Washington Blvd.
Dyke, Mrs. Richard W.....6314 Hoover Road

E

Eastman, Mrs. Joseph Rilus....4965 Coburn Street
Eaton, Mrs. Edwin R.....5750 Allisonville Rd.
Eaton, Mrs. Lyman D.....R. R. 19, Box 487Y
Ebert, Mrs. J. Wayne.....1125 Southview Dr.
Egbert, Mrs. Herbert L.....419 W. 63rd St.
Eicher, Mrs. Palmer O.....4401 Washington Blvd.
Eldridge, Mrs. Gail E.....5746 Central Ave.
Elkins, Mrs. James P.....2045 Lick Creek Dr.
Ellis, Mrs. Bert E.....2595 N. Girls School Rd.
Ellis, Mrs. William N.....4908 E. 46th Street
Emhardt, Mrs. John T.....3305 Brill Rd.
Emhardt, Mrs. John W.....5425 Washington Blvd.
Ensminger, Mrs. Leonard A...1321 N. Meridian St.
Evans, Mrs. Paul V.....7415 Dean Rd.
Everly, Mrs. Ralph V.....1105 E. 58th St.

F

Farrell, Mrs. Joseph T.....543 N. Audubon Rd.
Fausset, Mrs. C. Basil.....7757 N. Meridian St.
Ferry, Mrs. Francis A.....935 Southern Ave.
Finneran, Mrs. Joseph C.....3819 N. Delaware St.
Fischer, Mrs. A. Alan .....3230 W. 41st St.
Flanagan, Mrs. Paul M.....415 E. 48th St.
Flanders, Mrs. Robert, Jr.....5930 N. Olney St.
Flanigan, Mrs. Meredith B.....3305 Rutledge Dr.
Fleischl, Mrs. Herbert.....4390 Manning Rd.
Flora, Mrs. Joseph O.....5604 Rockville Rd.
Folkening, Mrs. Norval C.....5501 Camden
Foster, Mrs. Lee N. Jr.....3824 Ashbourne Lane
Fouts, Mrs. Paul J.....8393 N. Illinois St.
Freeman, Mrs. Leslie W.....5461 Julian Ave.
Freeman, Mrs. Max E.....4802 Thornleigh Dr.
French, Mrs. Richard N., Jr.
440 N. Winona St., Apt. 324
Fry, Mrs. Robert D.....5717 Broadway

G

Gaddy, Mrs. E. T.....R. R. #2, Box 179
Gaddy, Mrs. Nelson D.....2551 Blue Grass Ct.
Garber, Mrs. J. Neill....7036 N. Pennsylvania St.
Garceau, Mrs. George J...5539 N. Pennsylvania St.
Gardiner, Mrs. Sprague H.....330 W. 62nd St.
Garner, Mrs. W. Stanley.....4021 Cranbrook Dr.
Garrett, Mrs. Robert A.....1403 W. 52nd St.
Gastineau, Mrs. Frank M.
5344 N. Pennsylvania St.
Geider, Mrs. Roy A.
5816 Pleasant Run Pkwy. N. Dr.
Gick, Mrs. Herman H.....451 Eastern Ave.
Gifford, Mrs. Fred E.....5125 N. Meridian St.
Gillespie, Mrs. Charles F.....4530 Berkshire Rd.
Gillespie, Mrs. Jacob E.....4426 Broadway
Goldman, Mrs. Samuel.....428 Woodmere Dr.
Gormley, Mrs. Joseph J.....4402 Thrush Drive
Graham, Mrs. John D.....6401 Osborn Dr.
Gratz, Mrs. Ray.....5619 Rosslyn Ave.
Green, Mrs. Oscar.....6219 Indianola
Greene, Mrs. Morgan E.....3029 E. Hanna Ave.
Greist, Mrs. John H.....4343 Washington Blvd.
Griffith, Mrs. Richard S.....2002 Cunningham Road
Grisell, Mrs. Ted L.....5411 Broadway
Gruber, Mrs. Charles M., Jr.
3102 Kessler Blvd. E. Dr.
Gustafson, Mrs. Gerald W.
5768 N. Pennsylvania St.

H

Habegger, Mrs. E. Dale.....3120 W. 51st St.
Hadley, Mrs. David.....5601 N. Pennsylvania St.
Haggard, Mrs. Edmund B...5914 N. Emerson Ave.
Hall, Mrs. Frank M.....8633 N. Pennsylvania St.
Hall, Mrs. Jack H.....1906 N. Capitol Ave.
Hampshire, Mrs. Donald....7979 Morningside Dr.
Hanna, Mrs. Thomas A.....5009 W. 15th St.
Hansell, Mrs. Robert M.....3532 N. Gladstone Ave.
Harcourt, Mrs. Allan K.....5418 Allisonville Rd.
Harding, Mrs. M. Richard.....4220 DeVon Court
Harding, Mrs. Myron S.....5410 Radnor Rd.
Harger, Mrs. Robert W.....46 West 52nd Street
Harold, Mrs. Norris E.....3545 N. Denny St.
Hasewinkel, Mrs. Carrol W.....R. R. 2, Box 354
Haslinger, Mrs. Clarence J.....5236 Boulevard Pl.
Hatfield, Mrs. Nicholas W.
4118 N. Pennsylvania St.
Haymond, Mrs. Joseph L...2745 Crescent Hill Lane
Haynes, Mrs. John Thomas, 4545 Marcy Lane, #273
Hays, Mrs. Everett L.....2607 Manker Ave.
Healey, Mrs. Robert J.....741 E. 53rd St.
Hedrick, Mrs. Philip W.....4808 Central Ave.
Heimburger, Mrs. R. F.....4462 Central Ave.
Hendricks, Mrs. John W.....124 W. 64th St.
Henry, Russell S.....4367 Lincoln Rd.
Hepburn, Mrs. Charles K.....7570 Morningside Dr.
Hetherington, Mrs. A. M.....445 E. 71st St.
Heubi, Mrs. John E.....6904 N. Park Ave.
Hickam, Mrs. John B.....7050 N. Pennsylvania St.
Hickman, Mrs. Walter F.....3535 Del Mar Rd.
Hicks, Mrs. Murwyn L.....4125 E. 61st St.
Hilldrup, Mrs. Don G.....5672 N. Illinois St.
Himebaugh, Mrs. J. R. S.....3954 N. Adams St.
Holman, Mrs. Jerome E., Jr.....5930 Central Ave.
Holman, Mrs. Jerome E., Sr.
4503 Kessler Blvd., E. Dr.
Hood, Mrs. Ainslee A.....1810 Rosedale Drive
Howell, Mrs. Joseph D.....4514 E. 79th St.
Howell, Mrs. Robert D.....6941 Washington Blvd.
Huddle, Mrs. John E.....4738 N. Pennsylvania St.
Hudson, Mrs. Foster J.....525 W. Hampton Dr.
Hughes, Mrs. William F., Sr...4025 N. Meridian St.
Hull, Mrs. Ronald.....6465 Dover Rd.
Hurteau, Mrs. William W.....201 West 75th St.
Huse, Mrs. Wm. Murray..5131 N. Pennsylvania St.

I-J

Irwin, Mrs. Glenn W., Jr.....8025 N. Illinois St.
Iske, Mrs. Paul G.....5355 N. Delaware St.
Jaeger, Mrs. Alfred S.....3057 Washington Blvd.
Jaquith, Mrs. Orville S.....261 Blue Ridge Rd.
Jay, Mrs. Arthur N.....815 West 64th St.
Jennings, Mrs. Frank.....2601 Cold Springs Rd.
Jewett, Mrs. Joe H.....5803 Sherman Ave.
Jinks, Mrs. Clifford H.....1831 E. 61st St.
Johnson, Mrs. Thomas W...5735 Washington Blvd.
Jones, Mrs. David E.....5433 Hawthorne Dr.
Joseph, Mrs. Rex M.....620 Hickory Lane
Jowitt, Mrs. Richard.....6021 E. 42nd St.

K

Kammen, Mrs. Leo.....7030 Central Ave.
Katterjohn, Mrs. James C.....5867 Central Ave.
Keenan, Mrs. George.....2015 E. Thompson Rd.
Keenan, Mrs. Reid L.....3702 N. Delaware St.
Keever, Mrs. Charles H., Sr.
9016 Keever Dr., R. R. 18, Box 289B
Keiser, Mrs. V. D.....5709 Broadway
Kelly, Mrs. Walter F.
6845 E. Pleasant Run Pkwy. S. Dr.
Kennedy, Mrs. Hunter F.....757 N. Bolton Ave.
Kennedy, Mrs. Joseph T.....4046 Sheridan Ave.
Kenney, Mrs. David B.....5401 Eastridge Dr.
Kenzler, Mrs. Jack I.....4140 Flamingo, E. Dr.
Kerr, Mrs. Harry R.....5774 Washington Blvd.
Kilgore, Mrs. Byron W.....2002 E. 62nd St.
King, Mrs. Harold K.....4606 Washington Blvd.
Kingsbury, Mrs. John K.....5776 E. Michigan St.
Kirtley, Mrs. William R.....7447 N. Park Ave.
Kiser, Mrs. Edgar F.....5610 Central Ave.
Kitterman, Mrs. Harry E.....5108 Graceland
Klain, Mrs. Benjamin V...8419 N. Pennsylvania St.
Klatte, Mrs. Eugene C.....3520 Lawry Rd.

Kneidel, Mrs. John H.....918 E. 57th St.
Knowles, Mrs. Robert P.....R. R. 18, Box 271
Kohlstaedt, Mrs. Kenneth G.....645 E. 80th St.
Kooiker, Mrs. J. E.....3540 Watson Road
Koons, Mrs. Karl M.....5767 N. Pennsylvania St.
Kornafel, Mrs. L. H.....6201 College Ave.
Kuntz, Mrs. Herman W.....2065 Lick Creek Drive
Kurlander, Mrs. Gerald J.....3720 N. Meridian St.
Kwitney, Mrs. I. J.....5774 Broadway Terrace

L

LaDine, Mrs. Clarence B.....4221 E. 35th St.
Lamb, Mrs. Emmett B.....1180 Golden Hill Dr.
Lamb, Mrs. Russell W.....4636 N. Capitol Ave.
Lamber, Mrs. Chet K.....3103 N. Meridian St.
Laramore, Mrs. Ward.....5835 N. Keystone Ave.
Lasich, Mrs. Anthony R.....965 N. Burbank Rd.
Lawler, Mrs. George F.....5601 E. St. Clair St.
Leasure, Mrs. J. Kent.....3115 N. Meridian
Leff, Mrs. Abe H.....160 Pennridge Dr.
Leffel, Mrs. James M., Jr.....1140 West 56th St.
Leffler, Mrs. W. T.....250 E. 70th St.
LeMaster, Mrs. Theodore R.....2621 McLeay Dr.
Levi, Mrs. Leon.....6886 N. Pennsylvania St.
Lewis, Mrs. Earl.....380 S. Kenmore
Lewis, Mrs. Robert J.....5800 Lawrence Dr.
Lichtenberg, Mrs. Melvin....5677 N. Meridian St.
Lidikay, Mrs. Edward C.....6235 Tuxedo
Lindenborg, Mrs. Paul G.....5649 Rosslyn Ave.
Lingeman, Mrs. R. E.....3845 N. Meridian St.
Link, Mrs. Goethe.....R. 6, Box 152
Lochry, Mrs. Ralph L.....63 Isle of Venice #11
Ft. Lauderdale, Fla.
Lord, Mrs. Glenn C.....4455 Washington Blvd.
Louden, Mrs. Robert W.....1510 Marion Dr.
Loughlin, Mrs. Leo.....5410 N. Pennsylvania St.
Love, Mrs. George N.....5331 Washington Blvd.
Love, Mrs. Jesshill.....R. 17, Box 596
Lozow, Mrs. David.....7510 E. 52nd St.
Ludwig, Mrs. Oscar D.....2251 S. Ransdell, Apt. 9
Lukemeyer, Mrs. George T...3845 N. Campbell Ave.
Lurie, Mrs. Paul R.....5 W. 79th St.
Luros, Mrs. J. Theodore.....156 Fairway Dr.
Lybrook, Mrs. William B.
4585 Kessler Blvd., E. Dr.

M

MacDougall, Mrs. John D.....4306 Norwaldo Ave.
McBride, Mrs. James S.....720 E. 80th St.
McCartney, Mrs. Donald H.....410 East 56th St.
McClain, Mrs. Edwin S.....550 W. 77th St., N. Dr.
McCormick, Mrs. Charles O., Jr.
4240 Glencairn Lane
McGrath, Mrs. Michael F...6183 Washington Blvd.
McGuff, Mrs. Paul E.....3668 Central Ave.
McLaren, Mrs. David E.....4030 Meadows Dr.
McQuiston, Mrs. Ralph J.....6120 Lawrence Dr.
McTurnan, Mrs. Robert W.....6967 Central Ave.
Mackey, Mrs. John E.....940 W. 58th St.
Madden, Mrs. Robert J.....1543 N. Euclid Ave.
Manalan, Mrs. M. M.....7807 Meadowbrook Dr.
Manders, Mrs. Karl L.....215 E. 71st Street
Manion, Mrs. Marlow W...5132 N. New Jersey St.
Manning, Mrs. Randolph....5302 N. Delaware St.
Manzie, Mrs. Michael.....2687 W. 44th St.
Marks, Mrs. Maurice I.....152 Fairway Dr.
Marsh, Mrs. Carl M.....4112 Marrison Place
Marshall, Mrs. Albert L., Jr...7802 Allisonville Rd.
Marshall, Mrs. Cavins R.....4162 N. Meridian St.
Martin, Mrs. Loren H.....5338 Washington Blvd.
Martz, Mrs. Carl D.....7926 Hawthorn Ct.
Masters, Mrs. John M.....34 E. 46th St.
Matthew, Mrs. W. Burleigh..800 W. Kessler Blvd.
Matthews, Mrs. B. J.....966 N. Graham
Matthews, Mrs. William M...1122 N. Bolton Ave.
Maxam, Mrs. Beverly T.....1703 Beeler St.
Megenhardt, Mrs. Dennis S.
3038 E. Fall Creek Blvd.
Meiks, Mrs. Lyman T.....4203 N. Pennsylvania St.
Mericle, Mrs. Earl W.....4480 N. Meridian St.
Merrell, Mrs. Paul.....5367 Kenwood
Mertz, Mrs. John H. O.....6950 Central Ave.
Michael, Mrs. Isaac E.....3366 N. Kessler Blvd.
Miller, Mrs. Jerry.....6050 Ewing St.
Miller, Mrs. John D.....Sunnyside Sanatorium
Miller, Mrs. Roscoe E.....R. R. #17, Box 503
Mitchell, Mrs. Earl N.....2263 E. Riverside Dr.
Mitchell, Mrs. Edward O.....4807 Millersville Rd.
Moenning, Mrs. John E.....2114 Winfield Ave.
Molt, Mrs. William F.....2315 N. Talbot Ave.
Montgomery, Mrs. W. Foster.....4546 Park Ave.
Moore, Mrs. Ben B.....5005 N. Illinois St.
Moore, Mrs. Donald F.....1315 West 10th Street
Moore, Mrs. Harold T.....5802 Allisonville Rd.
Morchan, Mrs. Samuel.....7007 Broadway
Morrison, Mrs. Lewis E., II.....4450 Park Ave.
Morton, Mrs. Joseph L.....3222 W. 42nd St.
Morton, Mrs. Walter P.
3434 E. Fall Creek Blvd., N. Dr.
Moss, Mrs. H. C.....410 E. 47th St.
Mouser, Mrs. Robert W.....6047 N. Meridian St.
Muller, Mrs. L. P.....5608 College Ave.
Muller, Mrs. Paul F.....4050 Washington Blvd.
Myers, Mrs. Roy V.....4450 E. Kessler Blvd.

N

Nafe, Mrs. Cleon A.....5060 N. Meridian St.
Nagan, Mrs. Robert F.....3902 Devon Dr.
Nay, Mrs. Richard M.....5525 N. Meridian
Need, Mrs. Louis T.....3627 Bluff Rd.
Nester, Miss Lena Laura..5324 N. Pennsylvania St.
Nie, Mrs. Louis W.....4305 Central Ave.
Nohl, Mrs. John M.....5410 Eastridge Dr.
Nolin, Mrs. Richard T.....6329 N. Michigan Rd.
Nolting, Mrs. Henry F.....155 W. Hampton Dr.
Norman, Mrs. William H.....6416 Dean Road
Norris, Mrs. Max S.....540 E. 36th
Nourse, Mrs. Myron H.....8064 Morningside Dr.
Nugent, Mrs. Edwin J.....6840 N. Delaware St.
Nurnberger, Mrs. John I....5215 Washington Blvd.

O

O'Brian, Mrs. Earl J.....3425 West 57th Street
Ochsner, Mrs. Harold C.....4565 Cold Spring Rd.
Offutt, Mrs. Andrew C.....750 N. Campbell Ave.
Otten, Mrs. Claude F.....5222 Washington Blvd.
Owen, Mrs. John E.....4429 N. Illinois St.
Owens, Mrs. Tracy C.....2823 N. Meridian St.

P

Palmer, Mrs. Harley P.....2023 East Stop 8 Rd.
Pandolfo, Mrs. Harry.....529 Markwod Ave.
Parr, Mrs. Robert L.....6229 Evanston Ave.
Patton, Mrs. Martin T...3060 N. Meridian, Apt. 504
Paulissen, Mrs. George T.....741 Markwood
Paynter, Mrs. Morris B.....115 Roberts Rd.
Pearson, Mrs. Lyman R.....5215 N. Illinois St.
Peck, Mrs. Franklin B., Jr....8760 Carrollton Ave.
Peirce, Mrs. James D.....3159 N. Pennsylvania St.
Pennington, Mrs. Walter E.....5727 Broadway Tr.
Permer, Mrs. Erwin.....5590 Grandview Dr.
Peters, Mrs. Robert J. D.....3203 E. Michigan St.
Petranoff, Mrs. Theodore V. 2814 Questend, S. Dr.
Pfaff, Mrs. O. G.....4605 N. Meridian St.
Phillips, Mrs. David L.
8799 Washington Blvd., E. Dr.
Pickett, Mrs. Robert D.....4713 Millersville Rd.
Pilcher, Mrs. Jack E.....4601 Graceland Ave.
Pontius, Mrs. Edwin G.....10254 Carrollton Ave.
Popplewell, Mrs. A. G.....141 E. Southport Rd.
Price, Mrs. Francis W.....550 East Edgewood Ave.
Price, Mrs. James O...448 Wayside Dr., R.R. #14
Pryor, Mrs. Richard A.....6134 Carrollton Ave.

R

Raber, Mrs. Robert M.....265 Williams Ct.
Rader, Mrs. George S.....3778 E. 62nd St.
Rafalski, Mrs. Thomas A.....3011 Sharon Ave.
Ragan, Mrs. William D.....4633 Hinesley Ave.
Ramage, Mrs. Walter F.....244 S. 1st St.
Ramsey, Mrs. Frank B.....1401 W. 52nd St.
Reed, Mrs. Phillip B.....4131 N. Meridian St.
Rees, Mrs. Russell C.
926 Ellenberger Pkwy., W. Dr.
Reid, Mrs. Charles A.....6506 Madison Ave.
Reid, Mrs. Robert H.....1657 E. 81st St.
Rhamy, Mrs. Robert K.....2706 E. 65th St.
Rice, Mrs. Frederick A., Jr.....5802 E. 46th St.
Rice, Mrs. Raymond M.....7799 E. Holliday Drive
Richardson, Mrs. Thad T.....6126 E. St. Joseph St.
Ridalfo, Mrs. Anthony S.....1708 Ellen Dr.
Robb, Mrs. John A.....5151 N. Pennsylvania St.
Rogers, Mrs. Donald L.....2618 Bluffwood Dr. W.
Roll, Mrs. John W.....4407 Eastbourne Drive
Roller, Mrs. Charles W.....2301 Garfield Dr.
Romberger, Mrs. Floyd T., Jr.....10 W. 64th St.
Rosenak, Mrs. Bernard D.....5254 N. Delaware St.
Ross, Mrs. Alexander T.....6050 Knyghton Rd.
Row, Mrs. D. Hamilton.....5214 Grandview Drive
Ruddell, Mrs. Karl R.....2626 N. Meridian St.
Ruddell, Mrs. Keith R.....1201 Golden Hill Drive
Rust, Mrs. Byron K.....8120 Sycamore Rd.
Rust, Mrs. Roland B., Jr.....4458 Priscilla Ave.
Ryan, Mrs. Glenn V.
3168 E. Fall Creek Pkwy., N. Dr.

S

Sage, Mrs. Russell A.....8706 College Avenue
Salb, Mrs. Max C.....6741 Allisonville Rd.
Schaffer, Mrs. Edward V.....3785 E. 62nd St.
Schecter, Mrs. John S.....2560 E. 91st St.
Schlegel, Mrs. Donald M.....6230 Dean Rd.
Schmidt, Mrs. Loren F.....5880 Carrollton Ave.
Schmoyer, Mrs. M. Ray.....7338 N. Audubon Rd.
Schneider, Mrs. Carl J.....340 N. Kenyon
Schuchman, Mrs. Gabriel.....5944 Central Ave.
Schuster, Mrs. Dwight.....4503 Washington Blvd.
Scott, Mrs. George E.....3636 Layman
Scott, Mrs. Jasper P.....5840 Winthrop Ave.
Scott, Mrs. John R.....7966 N. Illinois St.
Scott, Mrs. Robert P.....6183 River View Dr.
Seaman, Mrs. Charles F.....6017 Hillside, E. Dr.
Sedam, Mrs. Herbert L.....6931 Central Ave.
Segar, Mrs. William E.....4855 Victoria Rd.
Sellmer, Mrs. George W.....8765 Rosewood Lane
Sexson, Mrs. Hiram T.....5455 N. Meridian St.
Shafer, Mrs. Marion R.....6290 Allisonville Rd.
Sheehan, Mrs. Francis G.....R. R. 10, Box 257A
Shullenberger, Mrs. Wendell A. 4535 Central Ave.
Shumaker, Mrs. H. B., Jr.....4330 Central Ave.
Sicks, Mrs. O. W.....5609 N. Pennsylvania St.
Siderys, Mrs. Harry.....3450 N. Lynhurst Dr.
Siebe, Mrs. Jack C.....5011 E. 40th St.
Siersdorfer, Mrs. T. N.....5559 W. Morris St.
Sims, Mrs. J. Lawrence.....3723 N. Gale St.
Sluss, Mrs. David.....3657 Washington Blvd.
Smith, Mrs. Edward B.....3322 Guilford Ave.
Smith, Mrs. E. Rogers.....160 W. 47th St.
Smith, Mrs. Roy Lee.....R. R. 6, Box 232
Snider, Mrs. Byron.....2717 S. East St.
Solomon, Mrs. R. A.....5330 N. Pennsylvania
Soper, Mrs. Hunter A.....5321 Boulevard Place
Sovine, Mrs. J. W.....8182 N. Illinois St.
Spahr, Mrs. John F., Jr.
3014 Green Hills Lane, N. Dr.
Spalding, Mrs. Joseph J.....112 W. 44th St.
Sparks, Mrs. Alan L.....5466 N. Pennsylvania St.
Spears, Mrs. John M.....5507 S. East St.
Speckman, Mrs. Glenn H.....5342 Park Ave.
Spivey, Mrs. Russell J.....R. R. 1, Box 542
Sputh, Mrs. C. B., Jr.....5671 Rolling Ridge Rd.
Sputh, Mrs. Carl B., Sr.....7860 Barlum Dr.
Stansbury, Mrs. Wm. E.....5610 E. 16th St.
Stayton, Mrs. Chester A., Sr..6925 N. Delaware St.
Stayton, Mrs. Chester A., Jr.....7065 Central Ave.
Stephens, Mrs. Kuhrman H.....5210 Boy Scout Rd.
Stoelting, Mrs. V. K.....4706 Laurel Circle
Stone, Mrs. Alvin T.....5727 Broadway
Stone, Mrs. David F.....5603 Indianola Ave.
Storey, Mrs. D. Edmund..808 Forest Blvd., N. Dr.
Streeter, Mrs. Ralph.....5265 N. Meridian St.
Strickland, Mrs. Neil R.....5117 E. 70th St.
Stroup, Mrs. Tyler J.....5758 College Ave.
Stucky, Mrs. Elsworth K.....4528 N. Meridian St.
Stump, Mrs. Loyd K.....4250 Kessler Lane
Summerlin, Mrs. Jack D.....4635 N. Capitol Ave.
Sutton, Mrs. William E.....5670 Guilford Ave.
Swan, Mrs. John R.....320 Arden Dr.
Symmes, Mrs. Alfred T.....6445 N. Illinois St.

T

Talbott, Mrs. Dan E.....6470 N. Michigan Rd.
Tanner, Mrs. Henry S.....4461 N. Pennsylvania St.
Taylor, Mrs. Clifford C.....5938 Crittenden Ave.
Taylor, Mrs. Cyril.....2936 W. 33rd St.
Taylor, Mrs. Frederick W.....40 E. 43rd St.
Teague, Mrs. Frank W.....R. R. #14, Box 726
Tether, Mrs. Joseph E. Jr..5735 N. Pennsylvania St.
Tharpe, Mrs. Ray E.....6161 Sunset Lane
Thatcher, Mrs. Hugh K., Jr.....408 E. 45th St.
Thomas, Mrs. Charles R.....246 S. Gale St.
Thomas, Mrs. Fred A.....3914 N. New Jersey St.
Thomas, Mrs. Lowell I.....28 W. Hampton Dr.
Thomas, Mrs. Morris E.....5207 N. New Jersey
Thompson, Mrs. John V.....7899 Ridge Rd.
Thompson, Mrs. Paul D..5939 Hillside Ave., E. Dr.
Thompson, Mrs. Wayne H.....6365 Knyghton Rd.
Thornburg, Mrs. K. E.....4702 Washington Blvd.
Throop, Mrs. Frank B.....4030 N. Pensylvania St.
Thurston, Mrs. A. L.....421 E. 41st St.
Tinsley, Mrs. Walter B.....3314 Carrollton Ave.
Tinsley, Mrs. Walter B. Jr.....4505 Melbourne Rd.
Tischer, Mrs. E. Paul.....6801 Dean Rd.
Tondra, Mrs. John M.....4511 Broadway
Torrella, Mrs. Jose A.....5721 W. 18th St.
Trusler, Mrs. Harold M.....6150 N. Meridian St.
Tuchman, Mrs. Joseph H.....8515 Spring View Dr.
Tucker, Mrs. Warren S...5338 N. Pennsylvania St.

V

Vandivier, Mrs. Robert M.....5407 N. Capitol Ave.
Van Meter, Mrs. C. Powell....4102 Marrison Place
Van Nuys, Mrs. John D.....2120 E. Kessler Blvd.
VanOsdol, Mrs. Harry A.....43 W. Hampton Dr.
Van Tassel, Mrs. C. J., Jr...5832 Washington Blvd.
Vollrath, Mrs. Victor J.....5202 N. Illinois St.
VonDerHaar, Mrs. Gerard...7301 East 13th Street
Vore, Mrs. Robert B.....3710 Cheviot Place

W

Waldo, Mrs. J. Thayer.....420 W. 64th St.
Walther, Mrs. Joseph E...4266 N. Pennsylvania St.
Walton, Mrs. William M.....5242 Boulevard Place
Warriner, Mrs. James B.....990 N. Bolton Ave.
Warvel, Mrs. John H....4360 Kessler Blvd., N. Dr.
Weinland, Mrs. George C.....4341 Central Avenue
Weiss, Mrs. Jason.....4201 Lincoln Rd.
West, Mrs. Joseph L.....2110 W. 38th St.
Westfall, Mrs. B. Kemper, Jr..4001 N. Meridian St.
Westfall, Mrs. John B.....5425 N. New Jersey St.
Wheeler, Mrs. David E.....4520 Bertrand Road
White, Mrs. Donald J.....5430 N. Delaware St.
White, Mrs. Douglas H. Jr.....6920 Munsee Lane
White, Mrs. John B.....6425 Lawrence Dr.
White, Mrs. Philip T.....5780 White Oak Ct.
Wilkens, Mrs. Irvin W.
4820 E. Pleasant Run Pkwy., N. D.

Williams, Mrs. Clifford L.....Central St. Hospital
Wilmore, Mrs. Ralph C.....6477 N. Tuxedo St.
Wilson, Mrs. Oliver R.....3519 Washington Blvd.
Wise, Mrs. William.....4934 N. Pennsylvania St.
Wise, Mrs. Wm. R.....4895 Knollton Rd.
Wishard, Mrs. William N., Jr.
5720 N. Pennsylvania St.
Witham, Mrs. Robert L.....4904 Staughton Drive
Wolfram, Mrs. Don J.....5716 N. Pennsylvania St.
Wood, Mrs. Donald E.....6463 N. Illinois St.
Woolling, Mrs. Kenneth R.....5303 Boulevard Pl.
Wrege, Mrs. Malcolm.....6505 Riverview Dr.
Wright, Mrs. J. Wm., Jr.....4220 Knollton Rd.
Wyttenbach, Mrs. John E.....5509 Kenwood Ave.

Y-Z

Yacko, Mrs. Michael L.....9740 E. 11th St.
Young, Mrs. John M.....4535 Marcy Lane, No. 261
Zell, Mrs. Evertson H.....4747 Millersville Rd.
Zerfas, Mrs. Charles P. A.....R. 1, Box 220

New Augusta

Asher, Mrs. Ernest O.....Box 6
Asher, Mrs. James W.....8381 Moore Rd.

Forbes, Mrs. Robert S.....R. 1, Box 502, Camby
Kendrick, Mrs. William M.....R. R. #1, Mooresville
Jones, Mrs. George L.....Wanamaker
Abreu, Mrs. Benedict E.....R. R. 2, Zionsville

MARSHALL COUNTY

Hampton, Mrs. James.....Argos
Graham, Mrs. C. R.....Bourbon
Bowen, Mrs. Otis R.....304 N. Center St., Bremen
Burkett, Mrs. Cecil.....Grant St., Bremen
Stine, Mrs. Marshall.....Shumaler Dr., Bremen
Norris, Mrs. Ernest B...2805 E. Shore Dr., Culver
Reed, Mrs. Donald.....Lakefront & Mill, Culver

Plymouth

Coursey, Mrs. James.....R. R.
Klingler, Mrs. M. O.....805 Pennsylvania Ave.
Kubley, Mrs. James P.....624 E. LaPorte St.
Peterson, Mrs. Ronald.....R. R. #2
Reed, Mrs. Robert G.....235 Hogarth
Rimel, Mrs. James F.....909 Bayless
Robertson, Mrs. James S.....1010 Ferndale Ave.
Vore, Mrs. Loring W.....Myers Lake, R. R. 4

MIAMI COUNTY

Shrock, Mrs. E. E.....Amboy
Line, Mrs. Homer.....Chili
Hill, Mrs. Loyd.....Denver
Herd, Mrs. C. R.....Fairview
Rendel, Mrs. H. E.....Mexico

Peru

Barnett, Helen.....109 W. Seventh
Boone, Mrs. Max L.....301 Adams
Johnson, Mrs. Owen.....106 W. 6th St.
Malouf, Mrs. S. D.....359 W. Third St.
Snyder, Mrs. Parker S.....159 W. 6th St.
Wildman, Mrs. R. E.....R. R. 2
Yarling, Miss Francis.....117 E. Fifth St.

MONTGOMERY COUNTY

Crawfordsville

Burks, Mrs. Jess E.....512 W. Wabash Ave.
Cornell, Mrs. Robert.....1000 S. Washington
Daugherty, Mrs. Fred N.....415 W. Main St.
Eggers, Mrs. Richard R.....203 West St.
Fisher, Mrs. Frank L.....1801 Eastwood Dr.
Haller, Mrs. Thomas C.....508 W. Main St.
Humphreys, Mrs. John W.....1309 Durham Dr.
Kinnaman, Mrs. Howard A.....R. R. 5
Kirtley, Mrs. James N.....615 Thornwood Road
Lingeman, Mrs. Byron J.....203 Wallace Ave.
Mount, Mrs. William M.....1417 W. Main St.
Peacock, Mrs. Norman F.....111 Wallace Ave.
Pierson, Mrs. Robert H.....305 E. Main
Shannon, Mrs. Wesley E.....411 S. Walnut St.
Sharp, Mrs. John L.....1403 E. Main St.
Wallace, Mrs. Hawthorne C.....107 W. Jefferson

Otten, Mrs. Ralph R.....Darlington
Blix, Mrs. Fred.....Ladoga
Denny, Mrs. Frank T.....Ladoga
Davis, Mrs. William H.....New Market
Kindell, Mrs. Herschel D.....New Richmond
Byrne, Mrs. Louis.....Roachdale
Richards, Mrs. Edgar E.....Russellville
Rusk, Mrs. Hubert M.....Wallace

MORGAN COUNTY

Martinsville

Brubeck, Mrs. Robert D.....Martinsville
Eisenberg, Mrs. David.....340 E. Cunningham
Gray, Mrs. Leon.....260 N. Ohio
Miller, Mrs. Ray.....290 E. Washington
Pitkin, Mrs. Edward.....309 Washington
Pitkin, Mrs. McKendree C.....440 E. Washington
Sweet, Mrs. Austin.....Martinsville
Taylor, Mrs. L. F.....399 N. St. Clair
Van Wienan, Mrs. John.....439 N. Jefferson
Willan, Mrs. Horace R.....109 S. Jefferson
Winter, Mrs. William.....269 E. Green

Mooresville

Bivin, Mrs. J. H.....N. Indiana Rd.
Comer, Mrs. C. W.....R. R. 2
Comer, Mrs. Kenneth.....R. R. 2
Kendrick, Mrs. William.....R. R. #1
Van Bokkelen, Mrs. Robert W...124 S. Indiana St.

Murphy, Mrs. M. G.....Morgantown

OWEN-MONROE COUNTIES

Bloomington

Austin, Mrs. D. C.....114 S. Grant
Borland, Mrs. Ray.....Moores Pike
Buckingham, Mrs. Richard E.....705 S. Fess
Creek, Mrs. Jean A.....2303 Fritz Dr.
DeMott, Mrs. Russell.....904 S. Rose St.
Estes, Mrs. Ambrose.....701 Highland St.
Fowler, Mrs. Ross.....Pleasant Ridge Rd.
Hardtke, Mrs. Eldred F.....1400 Pickwick Place
Hepner, Mrs. H. S.....302 E. 7th St.
Holland, Mrs. D. J.....1100 Atwater
Holland, Mrs. Philip T.....1001 S. Jordon Ave.
Hrisomalos, Mrs. Frank.....505 E. Kirkwood St.
Lundblad, Mrs. W. M.....400 East Side Dr.
Lyons, Mrs. Robert.....S. Walnut Rd.
Marchant, Mrs. Clarence.....350 S. College
McIntire, Mrs. C. R.....North Dunn Rd.
Miller, Mrs. John.....1210 E. Wylie St.
Poolitsan, Mrs. George.....1217 E. First St.
Quarles, Mrs. Bryan.....811 Woodlawn St.
Ramsey, Mrs. Hugh S.....619 E. 1st St.
Reed, Mrs. William C.....1215 Atwater Ave.
Rieger, Mrs. I. Taylor.....1319 E. First St.
Rogers, Mrs. Floyd.....804 E. 8th St.
Rollins, Mrs. Thomas.....815 S. Rose St.
Schell, Mrs. H. D.....1410 Maxwell Lane

Sibbett, Mrs. Joseph.....818 Sheridan Dr.
Stangle, Mrs. William.....603 N. Fess
Thomas, Mrs. Harry.....129 S. Swain St.
Topolgus, Mrs. James.....1015 Atwater Ave.
Wilson, Mrs. T. L.....Bender Road
Winters, Mrs. Matthew.....407 N. Park St.

Stouder, Mrs. C. E.....Ellettsville

PARKE-VERMILLION COUNTIES

Clinton

Evans, Mrs. F. J.....1315 S. Main St.
Gerrish, Mrs. W. D.....125 S. 5th St.
Herzberg, Mrs. Milton.....545 S. Fourth St.
Kercheval, Mrs. J. M.....Box 192

Goodrum, Mrs. Wm. R.....Cayuga
Britton, Mrs. W. D.....Montezuma
DeRenne, Mrs. W. L.....190 Market St., Newport
Saunders, Mrs. J. L.....Newport
Johnson, Mrs. W. A.....Perrysville

Rockville

Bloomer, Mrs. J. R.....115 N. Market St.
Bloomer, Mrs. R. S.....502 W. York St.
Harstad, Mrs. C.....515 W. High St.
Kempf, Mrs. Gerald F.....Ind. State Sanitarium
Merrell, Mrs. Basil M.....516 S. Market St.

PERRY-SPENCER COUNTIES

Bush, Mrs. Hargis R.....Sixth St., Cannelton
Glackman, Mrs. John C...207 Center St., Rockport

Tell City

Coultas, Mrs. P. J.....509 Main St.
Dome, Mrs. Hardin S.....147 11th St.
Dukes, Mrs. David A.....521 Main St.
Glenn, Mrs. F. C.....436 Main St.
James, Mrs. John Mark.....24 11th St.
James, Mrs. N. A.....740 Ninth St.
Lashley, Mrs. D. L.....606 Ninth St.
Lohoff, Mrs. Lewis C.....425 10th St.
Neifert, Mrs. Noel L.....1118 Blum St.
Smith, Mrs. Fred, Jr.....1407 12th Street

Snyder, Mrs. E. R.....Troy

PORTER COUNTY

Chesterton

Ashmore, Mrs. Herbert C.....317 Bowser
Hall, Mrs. Thomas.....Dune Acres
Harless, Mrs. C. M.....123 W. Indiana Ave.
Reed, Mrs. John E.....Wilson St.
Robertson, Mrs. W. C.....600 E. Morgan

Valparaiso

Brown, Mrs. J. C.....458 Park Ave.
Davis, Mrs. Carl.....202 Indiana
DeGrazia, Mrs. E. J.....410 Washington
Douglas, Mrs. George R.....404 Washington
Eades, Mrs. Ralph.....203 Jefferson
Frank, Mrs. John R.....303 Indiana
Griffin, Mrs. Charles H.....362 McIntyre Ct.
Koenig, Mrs. Robert.....1804 Beulah Vista Dr.
LaRocca, Mrs. Joseph.....402 Erie
Makovsky, Mrs. Theodore...1807 Beulah Vista Dr.
O'Neill, Mrs. Martin J.....301 Washington
Sacks, Mrs. Leonard Z.....563 Ravine Dr.
Seipel, Mrs. Herman O.....302 Lafayette
Vietzke, Mrs. Paul.....102 Lafayette

PUTNAM COUNTY

Veach, Mrs. Richard L.....Bainbridge
Gray, Mrs. Clyde C.....Cloverdale
Ellet, Mrs. John D.....Coatsville

Greencastle

Dettloff, Mrs. Frederick R.....300 Highfall Ave.
Fuson, Mrs. W. J.....108 Northwood Blvd.
Johnson, Mrs. James B.....314 Highfall Ave.
Reigle, Mrs. Fredrick C.....509 Meadow Dr.
Schauwecker, Mrs. Cleon M.....613 Ridge Ave.
Smith, Mrs. Wm.....R. F. D. 2
Steele, Mrs. Dick J.....207 Northwood Blvd.
Tennis, Mrs. George T.....605 S. Jackson
Tipton, Mrs. William R.....103 Northwood Blvd.
Wiseman, Mrs. V. Earle.....6 Durham

RANDOLPH COUNTY

Farmland

Nixon, Mrs. Byron.....312 N. Main
White, Mrs. Harvey E.....200 S. Main

Harmon, Mrs. Wayne.....113 Church St., Lynn
Shallenberger, Mrs. H. R.....Modoc
Potter, Mrs. Richard M..120 W. Walnut, Ridgeville

Union City

Chambers, Mrs. Carol R.....1000 N. Columbia
Chambers, Mrs. Leroy B.....800 N. Columbia
McClure, Mrs. Morris E.....225 N. High St.
Phipps, Mrs. Leland K.....516 N. Howard
Reid, Mrs. Robert W.....706 W. Division
Wagoner, Mrs. B. D.....701 W. Division

Winchester

Dininger, Mrs. W. S.....303 S. Main
Engle, Mrs. Russell B.....R. R. 2
Painter, Mrs. Lowell W.....507 S. Main
Slick, Mrs. C. R.....512 S. Oak Street
Sparks, Mrs. Paul W.....601 W. Will
Spitler, Mrs. C. A.....R. R. #4

RIPLEY COUNTY

Freeland, Mrs. Bill..714 Edgewood Rd., Batesville
Hisrich, Mrs. L. W.....222 Maplewood, Batesville
Lippoldt, Mrs. Chas. L. Edgewood Rd., Batesville
Warn, Mrs. William.....Milan
Row, Mrs. George.....R. R. 3, Osgood
Smith, Mrs. Lee R.....Osgood
McConnell, Mrs. William C.....Sunman
Moran, Mrs. N. D.....Versailles

RUSH COUNTY

McNabb, Mrs. George B.....Carthage
McNabb, Mrs. Richard.....Carthage
Worth, Mrs. C. Willard.....Milroy

Rushville

Atkins, Mrs. C. C.....410 N. Perkins
Corpe, Mrs. Kenneth F.....R. R. 4
Deerhake, Mrs. William A.....501 N. Harrison
Denny, Mrs. Melvin.....R. R. #1
Ellis, Mrs. Davis W.....721 N. Perkins
Green, Mrs. Frank H.....516 N. Morgan
Hoover, Mrs. Eugene.....501 N. Harrison
Johnson, Mrs. Robert I.....841 N. Harrison
McKee, Mrs. Harry S.....R. R. 6
Norris, Mrs. Marvin.....1107 N. Main St.
Shanks, Mrs. Roy E.....1110 N. Morgan

SHELBY COUNTY

Nigh, Mrs. R. M.....Fairland
Davis, Mrs. John A.....Flat Rock

Shelbyville

Arata, Mrs. Lucian A.....327 W. Broadway
Barnum, Mrs. Emerson.....310 Howard St.
Dalton, Mrs. Wilson L.....1712 Culbertson
Gehres, Mrs. Robert W.....610 Shelby
Grove, Mrs. E. G.....242 W. Broadway
Inlow, Mrs. Herbert H.....212 N. Harrison
Inlow, Mrs. W. D.....Spring Hill Rd.
McFadden, Marian.....28 W. Mechanic St.
McFadden, Mrs. Walter C.....28 W. Mechanic
Miller, Mrs. R. C.....17 W. Mechanic
Phares, Miss Frances.....408 S. Harrison
Richard, Mrs. Norman F.....541 Lockerbie Rd.
Scott, Mrs. V. B.....R. R. 2, N. Riley Hwy.
Silbert, Mrs. David B.....1100 Fairfield Drive
Spindler, Mrs. Robert D.....165 W. Mechanic
Tindall, Mrs. Paul R.....164 W. Franklin
Tindall, Mrs. W. R.....616 S. Harrison
Tower, Mrs. James H., Jr.....1018 S. West Street
Whitcomb, Mrs. Roger F.....218 W. Broadway

ST. JOSEPH COUNTY

Mishawaka

Fujawa, Mrs. M. J.....721 Lincoln Way E.
Martin, Mrs. Chas. F., Jr.....2125 Linden Ave.
Barone, Mrs. C. V.....59053 Bremen Highway
Ganser, Mrs. Ralph.....1035 Lincolnway E.
Ganser, Mrs. Richard A.....1020 Wilson Blvd.
Goethals, Mrs. C. J.....602 Lincolnway W.
McDonald, Mrs. R. M.....12252 E. Jefferson Road
Orr, Mrs. Robert.....1335 Prospect Dr.
Reed, Mrs. Robert.....903 Homewood
Sirlin, Mrs. Edward M.....14736 Jefferson Rd.
Spalding, Mrs. Wendell L.....60100 So. Fir Road
Templeton, Mrs. Ames R.....522 Calhoun St.
Walerko, Mrs. Frank M.....515 N. Clay St.
Walters, Mrs. Charles E.....16166 Ireland Rd.
Whitlock, Mrs. Francis.....304 Lincoln Way E.
Whitlock, Mrs. Merle E.....16146 Chandler Blvd.
Wurster, Mrs. H. C.....221 E. Third St.
Wyland, Mrs. B. J.....510 Calhoun St.
Zimmer, Mrs. H. J.....333 Edgewater Dr.

Houser, Mrs. D. S.
24751 N. Riley Rd., North Liberty

South Bend

A

Acker, Mrs. Robert B.....103 S. Ironwood Dr.
Arisman, Mrs. R. K.....1615 E. Colfax Ave.

B

Backs, Mrs. Alton J.....1953 Inglewood Place
Balla, Mrs. Morris.....1516 E. Wayne St.
Baran, Mrs. Charles.....1808 E. Jefferson Blvd.
Bartsch, Mrs. Harvey L.....1330 E. Victoria
Bechtold, Mrs. S. E.....313 Pendle St.
Bell, Mrs. H. D.....1357 Champeau St.
Bennett, Mrs. Jene R.....1826 E. Jefferson Blvd.
Berke, Mrs. Robert D.....2510 Erskine Blvd.
Biasini, Mrs. B. A.....19585 Glendale Road
Bickel, Mrs. David A.....1335 E. Wayne St. N.
Birmingham, Mrs. P. J.....1126 E. Irvington
Bishop, Mrs. C. Allen.....1301 Garland Rd.
Bixler, Mrs. Louis C.....1817 Portage Ave.
Blackburn, Mrs. Erwin.....1340 E. Madison Ave.
Bodnar, Mrs. Leslie M.....1843 Portage Ave.
Borough, Mrs. Lester D.....816 E. Woodside
Brechtl, Mrs. H. J.....2305 E. Washington
Buchanan, Mrs. Wallace D.....1326 E. Wayne St., N.
Buechner, Mrs. Fred W.....603 W. Marion St.
Buslee, Mrs. Roger M.....1331 E. South St.
Bussard, Mrs. C. F.....719 W. North Shore Drive
Bussard, Mrs. Frank.....1311 Sunnymede Ave.
Butts, Mrs. Milton.....118 N. Walnut St.

C

Carter, Mrs. F. R. N.....2000 E. Jefferson Blvd.
Cassady, Mrs. John R.....1805 Marquette Blvd.
Cassady, Mrs. J. V.....2216 E. Madison Ave.
Chamblee, Mrs. R. W.....1435 Corby Blvd.
Clark, Mrs. W. H.....1227 Garland Rd.
Colip, Mrs. George D.....260 David St.
Condit, Mrs. D. H.....1521 E. Wayne St.
Cook, Mrs. Gordon C.....1620 Southwood Ave.
Crowley, Mrs. J. B.....17821 Ponader Dr.
Custer, Mrs. Edward W.....52383 Laurel Road

D

Denham, Mrs. Robert H. Jr.....1429 E. Wayne St.
DeVoe, Mrs. K. R.....621 Woodcliff Dr.
Dingley, Mrs. Albert F.....1976 Briar Way
Dodd, Mrs. Robert D.....1510 Tudor Lane
Dolezal, Mrs. Bernard J.....815 Park Ave.
Duggan, Mrs. James A.....110 Peashway
Dunlap, Mrs. D. Logan.....123 North Shore Dr.

E

Eades, Mrs. R. Charles.....232 Marquette Ave.
Ebin, Mrs. J. L.....1223 N. Lawrence
Edwards, Mrs. Bernard E.....1340 Garland Rd.
Egan, Mrs. Sherman L.....944 Riverside Dr.
English, Mrs. J. Paul.....3116 Robinhood Lane
Ericksen, Mrs. L. G.....1212 E. Woodside
Erickson, Mrs. G. Walter.....3012 Robinhood Lane

F

Feferman, Mrs. Martin E.....125 S. Esther St.
Feldman, Mrs. Max.....702 N. Lafayette Blvd.
Filipek, Mrs. Walter.....2513 Lincoln Way West
Firestein, Mrs. Ben Z.....125 W. Marion Street
Firestein, Mrs. Ray.....502 N. Ironwood Drive
Fish, Mrs. Edson C.....19054 Summers Drive
Frank, Mrs. Herbert.....2616 S. Twyckenham Dr.
Frank, Mrs. L. L.....534 N. Lafayette Blvd.
Frank, Mrs. L. L., Jr.....1750 N. Wilbur
Frash, Mrs. D. W.....1912 Miami Street
Frey, Mrs. William B.....1714 E. Bader
Friedman, Mrs. Morris S.....1617 E. Jefferson Blvd.

G

Gaffney, Mrs. R. A.....534 Peashway
Gates, Mrs. George E.....411 W. North Shore Dr.
Gilman, Mrs. Marcus.....1925 E. Jefferson Blvd.
Godersky, Mrs. George.....2744 Sampson St.
Goraczewski, Mrs. T. C.....1016 W. Washington
Graf, Mrs. John P.....424 Peashway
Green, Mrs. George F.....1515 E. Wayne St.
Green, Mrs. Norvel E.....1726 E. LaSalle Ave.
Grove, Mrs. James H.....60268 Mayflower Rd.

H

Hamilton, Mrs. Charles O.
1418 E. Washington Ave.
Haugseth, Mrs. E. K.....820 N. Ironwood
Hawkins, Mrs. Glen E.....17280 Parker Ave.
Helmer, Mrs. John.....1825 Wilbur St.
Hildebrand, Mrs. J. O.....1637 Southbrook Dr.
Hill, Mrs. Theodore.....107 N. Eddy St.
Hill, Mrs. Wallace C.....1221 Sunnymede Ave.
Hillman, Mrs. Marion W.....1516 Marquette Blvd.
Holdeman, Mrs. Lillian S.....615 W. Colfax Avenue

Holtzman, Mrs. Norman.....3322 Whitcomb
Hord, Mrs. Luther J. Jr.....23763 State Rd. #2
Hyde, Mrs. C. C.....1521 E. Colfax Ave.

J

Johns, Mrs. N. C.....1329 N. St. Joseph St.

K

Kamm, Mrs. Bernard A.....125 W. Marion St.
Karn, Mrs. John W.....1535 Wall St.
Krueger, Mrs. John E.....620 Peashway
Kuhn, Mrs. Frederick L.....1215 S. Michigan St.

L

Lamb, Mrs. Leonard J...1321 E. Wayne St., South
Lane, Mrs. William H.....845 Park Ave.
Lang, Mrs. Joseph E.....505 Dixie Hwy., No.
Lester, Mrs. Vern L.....2819 Woodmont
Levatin, Mrs. B.....1814 E. Churchill Dr.
Levkoff, Mrs. Abner.....3239 Essex Dr.
Lionberger, Mrs. John R...1419 E. Jefferson Blvd.
Liss, Mrs. Emanuel....Apt. B.52112-20 72nd Dr., Forest Hills 75, New York
Lockhart, Mrs. Philip B.....1611 E. Wayne

M

MacLeod, Mrs. John K.....930 Simmon Ct.
Mahank, Mrs. Camiel C.....1804 E. Jefferson
Marquis, Mrs. Gordon.....329 Wakewa
Mason, Mrs. Bernard A.....2719 Marine St.
McCraley, Mrs. W. J.....1737 Belmont Ave.
McMeel, Mrs. James.....1138 Whitehall Dr.
Metcalfe, Mrs. G. E.....1209 E. Wayne, No.
Miller, Mrs. Milo K.....1018 E. Oakside
Mott, Mrs. C. A.....2733 Lincolnway West
Mueller, Mrs. H. M.....3525 Windingwood Dr.
Murphy, Mrs. Eugene C.....1411 Sunnymede Ave.

N-O

Nelson, Mrs. Raymond E.....1909 E. Madison St.
Olson, Mrs. Donald T.....127 S. Ellsworth Pl.
Olson, Mrs. Kenneth L.....1228 E. Woodside Ave.
Oren, Mrs. William.....1149 E. Belmont

P

Parsons, Mrs. Robert.....1464 Ridgedale Rd.
Pauszek, Mrs. Thomas B.....916 Riverside Dr.
Petrass, Mrs. Andrew.....22027 Liberty Highway
Plain, Mrs. George.....17836 Ponader Drive
Pyle, Mrs. H. Dale.....115 N. Sunnyside Ave.

R

Rigley, Mrs. Edward L.....1704 Ridgedale Rd.
Rosenheimer, Mrs. George M.....1425 E. Woodside
Rubens, Mrs. Eli.....1240 E. Irvington
Rudolph, Mrs. Carl.....2016 E. Madison Street

S

Sanderson, Mrs. Robert B...1331 Sunnymede Ave.
Sandock, Mrs. I.....1203 N. Notre Dame Ave.
Sandock, Mrs. Louis E.....235 S. Esther St.
Sandoz, Mrs. H. H.....239 S. Hawthorne Dr.
Sandoz, Mrs. Louis A.....304 S. Twyckenham Dr.
Schaphorst, Mrs. Richard A....1124 Whitehall Dr.
Schiller, Mrs. Herbert A.....1813 E. Cedar St.
Scott, Mrs. Frank M.....1220 E. Woodside
Selby, Mrs. K. E.....1327 E. Wayne, No.
Sellers, Mrs. Francis.....3209 Mishawaka Ave.
Sensenich, Mrs. R. L.....128 S. Scott St.
Sharp, Mrs. Merle C.....17772 Woodthrush Lane
Shriner, Mrs. Richard L.....53362 Juniper Road
Sisson, Mrs. Norval D.....1614 Oak Park Dr.
Skillern, Mrs. Scott.....1553 Southbrook Dr.
Slominski, Mrs. Harry H.....1862 College St.
Spenner, Mrs. R. W.....R. R. #3, Diamond Lake
Stiver, Mrs. Dan D.....1127 E. Wayne St. N.
Stogdill, Mrs. William.....520 N. Coquillard
Stratigos, Mrs. Joseph S.....2048 Pratt Ct.

T

Thompson, Mrs. John M.....1618 E. Cedar St.
Thornton, Mrs. M. J.....R. R. #2, Miami Rd.
Tirman, Mrs. Wallace S...1224 E. Wayne St., No.

V-W-Z

Vagner, Mrs. S. Bernard...53190 Willow Run Road
Vurpillat, Mrs. F. J.....2102 E. Cedar St.
Walker, Mrs. Edwin M., Jr.....501 N. Ironwood
Ward, Mrs. James.....19248 Summers Dr.
Weiss, Mrs. Eugene.....1605 E. Washington Ave.
Wilson, Mrs. James M.....1416 E. Monroe St.
Zeiger, Mrs. Irwin L.....1205 E. Irvington

STARKE COUNTY

DeNaut, Mrs. J. F.....4 N. Heaton, Knox
Howard, Mrs. Henry.....308 W. New York, Knox
Ingwell, Mrs. Guy B.....402 E. Lake, Knox
Leinbach, Mrs. Earl R.....206 Davis, Hamlet
Matthew, Mrs. J. R..605 Keller Ave., North Judson
McClure, Mrs. Clark.....R. R. 1, Knox

TIPPECANOE-WHITE COUNTIES

Lafayette

Babb, Mrs. Forrest J.....2106 South 9th St.
Buhrmester, Mrs. Harry C.....Freiberger Lane
Canganelli, Mrs. Vincent G.....Rd. 43 South
Carpenter, Mrs. John B.....1720 Scott St.
Dubois, Mrs. Ramon B.....519 Calvert Lane
Fields, Mrs. Donald C.....1010 Highland Ave.
Flack, Mrs. R. A.....3600 Cypress Lane
Frey, Mrs. Harley H.....927 Highland Ave.
Graham, Mrs. Thomas G.....1213 Wea Ave.
Gripe, Mrs. Richard P.....1623 S. Fifth St.
Harter, Mrs. Eli B.....918 King St.
Holladay, Mrs. L. J.....1403 S. 14th St.
Johnson, Mrs. Herbert S.....712 Cherokee
Jones, Mrs. David.....2055 S. Ninth St.
Karberg, Mrs. Richard J.....1212 El Prado
Klepinger, Mrs. Harry E.....909 N. 21st St.
Kohne, Mrs. Robert W.....1001 Pontiac
Landis, Mrs. C. Byron.....70 Collins Dr.
Marvel, Mrs. Howard R.....1106 Hedgewood Dr.
Mather, Mrs. Robert L.....119 N. 6th St.
McAdams, Mrs. Hugh B.....2110 Birch Lane
McClelland, Mrs. D. C.....1021 Highland Ave.
McKinley, Mrs. Joseph.....610 Lingle Terrace
Neumann, Mrs. Kenneth O.....1410 S. 18th St.
Onorato, Mrs. Joseph.....2606 South St.
Ratcliff, Mrs. Frank W.....1000 Wea Ave
Rothrock, Mrs. Philip W.....605 Lingle Ave.
Shively, Mrs. John L.....1615 S. 5th St.
Sholty, Mrs. William M.....Shadeland Farm Rd.
Trout, Mrs. Carl J.....800 State St.
Underwood, Mrs. George M.....2800 Longlois Dr.
VanReed, Mrs. Earl.....806 S. 9th St.
Vermilya, Mrs. R. W.....Cedar Bluff Rd.
Williams, Mrs. Robert E.....403 Asher

West Lafayette

Bayley, Mrs. William.....622 Rose St.
Bolin, Mrs. Robert C.....908 Windsor Dr.
Burkle, Mrs. J. C.....121 University St.
Burns, Mrs. John T.....2201 N. Salisbury St.
Calvert, Mrs. R. R.....308 Park Lane
Combs, Mrs. Loyal W.....514 Rose St.
Davis, Mrs. Howard B.....833 Hillcrest Rd.
Engeler, Mrs. James E.....1316 N. Grant St.

Harden, Mrs. Murray E.....610 Carrolton Rd.
Hogle, Mrs. Frank D.....334 Laurel Dr.
Hughes, Mrs. Richard R.....908 Carrolton Blvd.
Hull, Mrs. James E.....605 Carrolton Blvd.
Johnson, Mrs. Lowell R.....1601 Woodland Dr.
Klatch, Mrs. Ben Z.....1415 Woodland Dr.
Loop, Mrs. Frederick A.....119 Leslie Dr.
Marsh, Mrs. George W.....2121 Happy Hollow Rd.
McAdams, Mrs. Robert.....625 Ridgewood
Mather, Mrs. Charles R.....1815 Ravinia Rd.
Miller, Mrs. Roland E.....600 Ridgewood Dr.
Peyton, Mrs. Frank W.....612 Ridgewood Dr.
Stahl, Mrs. E. T.....324 Park Lane
Vanbuskirk, Mrs. Edwin L.....1301 Ravinia
VanDen Bosch, Mrs. W. R.....715 Princess Dr.

Henderson, Mrs. Robert N.....Box 397, Brookston
Lind, Mrs. Jaap J.....Mulberry
Weller, Mrs. Robert.....Rossville

VANDERBURGH COUNTY

(Southwestern)

Stover, Mrs. Wendell C.
20 Lake Shore Dr., Boonville

Evansville

A

Acre, Mrs. Robert R.....2311 Lincoln Ave.
Adler, Mrs. Ray N.....1660 Lincoln Ave.
Adye, Mrs. Wallace M.....320 Inwood Dr.
Antes, Mrs. Earl H.....1201 Bonnieview Dr.
Arendell, Mrs. Robert E.....710 S. Weinbach Ave.
Austin, Mrs. Eugene W.....2163 Bayard Park Dr.

B

Baker, Mrs. Mason R.....900 Bellemeade Ave.
Barnhart, Mrs. Willard T.....507 S. Boeke Rd.
Beck, Mrs. Robert E.....301 Inwood Drive
Begley, Mrs. Joseph W.....700 Blue Ridge Rd.
Bender, Mrs. Martin J.....2716 Capitol Blvd.
Bennett, Mrs. Abner P.....961 Blue Ridge Rd.
Bissonette, Mrs. Roger P.....911 Colony Rd.
Boone, Mrs. Robert D.....7501 E. Chandler Ave.
Brakel, Mrs. Frank, Jr.....1849 McConnell Ave.
Britt, Mrs. Robert L.....6416 Arcadian Hwy.
Brown, Mrs. George W.....2051 E. Florida St.
Bryan, Mrs. Stanton L.....3211 E. Mulberry St.
Buehner, Mrs. Donald F.....1200 Bonnieview Dr.
Burger, Mrs. Thomas C.....2331 Washington Ave.
Burnikel, Mrs. Ray H.....960 S. Rotherwood Ave.
Burress, Mrs. Clyde.....10100 Old St. Rd.

C

Cacia, Mrs. John J.....420 S. Boeke Rd.
Caldwell, Mrs. William C.....643 College Hwy.
Carlson, Mrs. Ralph F.....1350 Bayard Park Dr.
Clark, Mrs. Thomas W.....810 Plasa Dr.
Clouse, Mrs. Paul A.....2066 Bayard Park Dr.
Cockrum, Mrs. William M.....1414 Parkside Dr.
Cole, Mrs. W. L.....18 Johnson Place
Coleman, Mrs. Joseph E.....2831 Wayside Dr.
Corcoran, Mrs. P. J. V.....2412 E. Chandler Ave.
Crawford, Mrs. James.....631 Blue Ridge Dr. North
Crevello, Mrs. Albert J.....1664 Lincoln Ave.
Crimm, Mrs. Paul D.....Boehne Hospital
Crudden, Mrs. Charles H.....2511 E. Powell Ave.
Cullnane, Mrs. Chris W.....3020 Mt. Vernon Ave.
Cymbala, Mrs. Bohden.....1141 Bayard Pk. Dr.

D

Daves, Mrs. W. Lawrence.....708 College Hwy.
Davidson, Mrs. Harold H.....800 Blue Ridge Rd.
Deems, Mrs. Myers.....6830 Arcadian Highway
Denzer, Mrs. Edward K.....540 Scenic Dr.
Denzer, Mrs. William O.....923 Bellemeade
Dieckman, Mrs. Herbert S.....Johnson Place
Dodd, Mrs. R. K.....1705 S. New Green River Rd.
Drake, Mrs. Dale W.....Little Schaefer Rd.
Dunham, Mrs. Howard.....3215 Ridge Top Place
Dycus, Mrs. Walter A.....3400 Koring Rd.
Dyer, Mrs. Wallace K.....812 St. James Blvd.

E

Ehrich, Mrs. William S.....1500 S. Kentucky Ave.
Engel, Mrs. Edgar L.....1411 E. Park Dr.

F

Faith, Mrs. Ira L., Jr.....950 Blue Ridge Road
Faul, Mrs. Henry.....725 S. Willow Rd.
Faw, Mrs. Melvin L.....3105 E. Oak Street
Fenneman, Mrs. Robert J.....1468 Bonnieview Ct.
Fisher, Mrs. William C.....1319 S. Kentucky
FitzGerald, Mrs. Maurice D.....924 Bayard Park Dr.
Fitzsimmons, Mrs. Elvin L.....500 S. Boeke Rd.

G

Garland, Mrs. Edger A.....719 Plaza Dr.
Gaul, Mrs. L. Edward.....508 S. Boeke Rd.
Getty, Mrs. William H.....1810 Mt. Auburn Road
Giorgio, Mrs. Douglas J.....916 S. Burkhart Road
Gow, Mrs. Robert C.....435 Kelsey Ave.
Griep, Mrs. Arthur H.....5414 Madison Ave.
Guckien, Mrs. Joseph L.....1612 S. E. Blvd.

H

Hammond, Mrs. R. Case.....6820 Arcadian Hwy.
Hare, Mrs. Daniel M.....2112 Lincoln
Harlan, Mrs. Wiliam.....4 Woodmere Dr.
Harned, Mrs. Ben King, Jr.....8232 Maple Lane
Hart, Mrs. Paul L.....1436 Lincoln Ave.
Hawk, Mrs. Edgar A,.R. R. 3, Outer Lincoln Ave.
Hartley, Mrs. Clarence A., Jr.....300 Hesmer Rd.
Healy, Mrs. William F.....3911 Bellemeade Ave.
Heinrich, Mrs. Weston A.....1408 Lincoln Ave.
Hendershot, Mrs. Eugene L.....7006 Newburgh Road
Hermayer, Mrs. Stephen.....1316 Bonnieview Dr.
Herrmann, Mrs. Gordon T.....218 S. Spring St.
Herzer, Mrs. Clarence C.....211 E. Mill Rd.
Himebaugh, Mrs. Gilbert J.....408 S. Alvord Blvd.
Hoover, Mrs. Guy J.....864 Lodge Ave.
Hovda, Mrs. Richard B.....800 St. James Blvd.
Huggins, Mrs. Victor S.....520 S. Alvord Blvd.
Hyatt, Mrs. Gilbert T.....1616 Mt. Auburn Rd.

J-K

Johnson, Mrs. Stephen L.....2215 Lincoln Ave.
Johnson, Mrs. Victor.....1303 Masker Pk. Dr.
Kelly, Mrs. John B.....9130 Petersburg Rd.
Kiechle, Mrs. Fred L.....726 S. E. First St.
Kincaid, Mrs. Robert S.....1000 N. Spring St.

L

Laubscher, Mrs. Clarence A.....6621 Kratzville Rd.
Lawrence, Mrs. Joseph C.....1362 E. Chandler Ave.
Leibundguth, Mrs. Henry.....5206 Lincoln Ave.
Leslie, Mrs. Ermil T.....3214 E. Mulberry St.
Logan, Mrs. Jesse R.....503 First Ave.
Lyman, Mrs. Frank L.....419 N. Barker Ave.

M

MacKenzie, Mrs. Pierce.....2300 E. Gum St.
Mathews, Mrs. James R.....901 Meadow Rd.
Maxson, Mrs. Roy V.....763 S. Weinbach Ave.
Mayberry, Mrs. Alton R.....6125 Washington Ave.
McCool, Mrs. Joe H.....6314 Old State Rd.
McDonald, Mrs. J. D.....4300 Lincoln Ave.
Mehl, Mrs. Rudolph A.....631 Blue Ridge Dr.
Meyer, Mrs. Keith T.....399 S. Alvord Blvd.

Miller, Mrs. LaVerne B.....501 Scenic Drive
Miller, Mrs. Milton J.....8201 Newburgh Rd.
Miller, Mrs. Minor W.....701 S. Weinbach Ave.
Miller, Mrs. Robert J.....701 Plaza Dr.
Mills, Mrs. Fred E.....555 S. Kelsey Ave.
Mino, Mrs. Robert A.....2777 Wayside Dr.
Moehlenkamp, Mrs. Charles E.
5401 Stringtown Rd.
Murphy, Mrs. Edward U.....7 W. Buena Vista Rd.
Myre, Mrs. Theodore T.....7215 E. Blackford Ave.

N

Nicholson, Mrs. Raymond W.....2009 Mahrendale
Niedermayer, Mrs. Alfred J.....815 College Hwy.
Nonte, Mrs. Lee R.....714 S. Willow Rd.

O

Oswald, Mrs. Robert H..... 762 St. James Blvd.

P

Pastor, Mrs. J. W.....5901 Washington Ave.
Pemberton, Mrs. Jack James..Falstead Rd., R. R. 1
Pollard, Mrs. Walter S.....1230 S. E. Second St.
Porre, Mrs. Francis W.....909 Villa Dr.
Present, Mrs. Julian D.....201 Parker Dr.

R

Ratcliffe, Mrs. Albert W.....510 S. E. First St.
Ravdin, Mrs. Bernard D.....706 Sunset Ave.
Ravdin, Mrs. Marcus .....2025 Lincoln Ave.
Reich, Mrs. Clarence E.....1209 N. Fulton Ave.
Richey, Mrs. Clifford O.....407 Congress Ave.
Rietman, Mrs. H. Jerome.....2325 Lincoln Ave.
Rininger, Mrs. Harold C.....2154 E. Gum St.
Ritchie, Mrs. William D.....5201 Stringtown Rd.
Rosenblatt, Mrs. Bernard B....626 St. James Blvd.
Royster, Mrs. Robert Allen.....34 Johnson Place
Rusche, Mrs. Henry J.....315 W. Iowa St.
Russell, Mrs. Richard H.....1015 Harrelton Ct.

S

Schimmelpfennig, Mrs. Robert W.
3014 Washington Ave.
Schirmer, Mrs. Robert H.....2710 Hartmetz Ave.
Schneider, Mrs. Charles P...2024 W. Maryland St.
Schriefer, Mrs. Victor V.....390 S. Alvord Blvd.
Sinn, Mrs. Charles M.....1509 Redwing Dr.
Slaughter, Mrs. Howard C.....651 St. Mary's Dr.
Slaughter, Mrs. John C.....622 College Hwy.
Slaughter, Mrs. Owen L....506 St. James Blvd. So.
Smith, Mrs. Roy M.....3213 Kensington
Sprecher, Mrs. Herman C.....6601 Newburgh Road
Springstun, Mrs. W. Russel.....854 Lodge Ave.
Steele, Mrs. Paul W.....1906 Bellemeade Ave.
Sterne, Mrs. John H.....2309 E. Gum St.
Stork, Mrs. Urban F. D.....414 S. Kelsey Ave.
Strueh, Mrs. Paul E.....1207 Harrelton Ct.

T

Tager, Mrs. Stephen H.....700 S. Meadow Rd.
Tisserand, Mrs. John B. Jr...2313 Washington Ave.
Tuholski, Mrs. James M.....520 S. Roosevelt Dr.
Tweedall, Mrs. Daniel G...R. R. #8, Browning Road

V-W

Visher, Mrs. John W.....510 E. Mt. Pleasant Rd.
Vonder Haar, Mrs. Thomas E.....1152 S. Villa Dr.
Walker, Mrs. William F.....1220 Cullen Ave.
Walter, Mrs. Robert F.....1514 S. Kentucky Ave.
Warner, Mrs. Charles L.....4120 Bellemeade Ave.
Waters, Mrs. George E.....2 Woodmere Dr.
Weber, Mrs. Edgar H.....3008 E. Powell Ave.
Weiss, Mrs. H. G.....1014 E. Powell Ave.
Welborn, Mrs. Mell B.....1832 Mt. Auburn Rd.
Wilhelmus, Mrs. C. Kenneth..6929 Newburgh Rd.
Wilhelmus, Mrs. Gilbert M.....5901 Newburgh Rd.
Willison, Mrs. George W.....605 St. Mary's Dr.
Wilson, Mrs. John D.....921 Colony Rd.
Wilson, Mrs. David.....1709 S. E. Blvd.
Wilson, Mrs. Ralph.....1522 Audubon Dr.
Wynn, Mrs. Justice F.....651 S. Weinbach Ave.

Y-Z

Young, Mrs. C. Curtis, Jr.....2327 Lincoln Ave.
Zeier, Mrs. Francis G.....7910 Lauderdale Dr.
Zimmerman, Mrs. Harold.....513 S. Boeke Rd.

Challman, Mrs. William..502 Walnut, Mt. Vernon
Crist, Mrs. John R.....320 Emmick, Mt. Vernon
Hirsch, Mrs. H. L....801 Williams Dr., Mt. Vernon
Oliphant, Mrs. Frank W.
701 Mulberry St., Mt. Vernon
Vogel, Mrs. John L..530 E. Fifth St., Mt. Vernon
Colvin, Mrs. Robert C.....Peachtree St., Newburg
Durkee, Mrs. Melvin S.
Ideal Pleasure Club, Newburgh
Zwickel, Mrs. R. E.....Darby Hills, Newburgh
Ropp, Mrs. Harold E. .....New Harmony

VIGO COUNTY

Speas, Mrs. Robert C.....Box 22, Seelyville

Terre Haute

A

Allen, Mrs. Orris T.....320 Robinwood Drive
Anderson, Mrs. W. C.....380 S. 22nd St.
Ault, Mrs. Roy J.....926 Barton Avenue

B

Baldridge, Mrs. William O.....2500 N. Ninth St.
Bannon, Mrs. William G.....2126 Ohio Blvd.
Blum, Mrs. Leon L.....3200 Ohio Blvd.
Bopp, Mrs. Henry W., Sr.....132 Barton Ave.
Bopp, Mrs. Henry W., Jr.....2237 Poplar St.
Bopp, Mrs. James.....236 S. 21st St.
Boyd, Mrs. H. Clark.....651 Oak Dr.
Brown, Mrs. Robert R.....2544 N. Ninth

C-D

CaJacob, Mrs. Melville E.....1000 S. Sixth St.
Caldwell, Mrs. M. V.....R. R. 7, Box 449
Combs, Mrs. Charles N.....2516 N. Ninth St.
Combs, Mrs. Stuart R.....2620 N. 10th St.
Conklin, Mrs. James O.....127 Adams St.
Conway, Mrs. Thomas J.....1014 So. 22nd Street
Crockett, Mrs. Wayne A.....152 Monterey Ave.
Davis, Mrs. M. J.....1444 S. 6th St.
Denny, Mrs. E. Rankin.....2718 Wilson Dr.
Drummy, Mrs. W. W. Jr.....231 Fruitridge
Dyer, Mrs. G. Wallace.....2710 Wilson Dr.

E-F

Eversman, Mrs. George.....1955 Winslow
Freed, Mrs. John E., Sr.....2408 N. 10th St.
Freed, Mrs. John E., Jr.....2425 North 8th St.
Fuqua, Mrs. H. B.....2303 N. Ninth St.

G

Gerrish, Mrs. Don A.....R. R. No. 7
Gilbert, Mrs. Ivan.....2641 Crawford St.
Goodman, Mrs. Hubert T.....220 Gardendale Rd.
Gossom, Mrs. Donn R.....1904 Ohio Blvd.

H

Haslem, Mrs. Ezra R.....30 Circle Drive
Haslem, Mrs. John R.....2920 Ohio Blvd.
Hogan, Mrs. Thomas W.....332 So. 31st Street
Humphrey, Mrs. Paul E.....2631 N. Ninth St.

J-K

Johnson, Mrs. Paul D. Jr.....3101 Poplar St.
Kabel, Mrs. Robert N.....2201 Ohio Blvd.
Krieble, Mrs. W. W.....10 Bogart Dr.
Kunkler, Mrs. Arnold W.....147 Monterey Ave.

L

LaBier, Mrs. Russell..... R. R. 5
Lancet, Mrs. Robert O.....20 Nitchie Dr.
Lee, Mrs. James C.....12 Thirty-second St.
Loewenstein, Mrs. Werner L.....1909 Ohio Blvd.
Luckett, Mrs. C. L.....R. R. 2
Lyons, Mrs. L. Mason.....123 S. 21st St.

M

McAleese, Mrs. George.....1438 S. 6th St.
McBride, Mrs. Noel S.....67 Allendale Place
McCrea, Mrs. Fred R. .....2719 N. Eighth St.
McEwen, Mrs. James W.....107 Wren Dr.
McIntosh, Mrs. Wilbert.....R. R. No. 4
McLaughlin, Mrs. Gordon.....R. R. 3, Box 128
Mahoney, Mrs. Charles L.....R. R. 3
Mankin, Mrs. William.....130 S. 20th St.
Mason, Mrs. Lester M.....66 Allendale Place
Mattox, Mrs. Don A.....240 Hamilton Dr.
Mattox, Mrs. Ernest.....240 Hamilton Dr.
Miklozek, Mrs. J. E.....2204 Ohio Blvd.
Miller, Mrs. D. B.....920 So. 6th St.
Mitchell, Mrs. Albert M.....333 S. 22nd St.
Musselman, Mrs. Glenn.....7222 Wabash Avenue

N-O-P

Nay, Mrs. Ernest O.....29 S. 20th St.
Neudorff, Mrs. L. G.....213 Barton Avenue
Oliphant, Mrs. Robert W.....8 31st St. Ct.
Pearce, Mrs. Roy V.....269 S. 26th Street Dr.

R

Reynolds, Mrs. R. J.....72 Allendale Place
Richart, Mrs. James V.....336 Hamilton Dr.
Riggs, Mrs. Floyd.....137 S. 24th St.
Rogers, Mrs. Shirrell R.....1101 S. 6th St.
Rubin, Mrs. M. M.....2401 Ohio Blvd.

S

Scherb, Mrs. Burton E.....211 Gardendale Rd.
Schott, Mrs. Edward J.....653 Oak St.
Schumaker, Mrs. Robert A.....R. R. 4
Shaffer, Mrs. James S.....2200 Third Ave.
Showalter, Mrs. John R., Jr..2511 N. Eighth St.
Siebenmorgen, Mrs. Louis .....1200 S. Eighth St.
Siebenmorgen, Mrs. Paul ....2515 N. Seventh St.
Silverman, Mrs. Norman M.....1142 S. Center St.
Stoelting, Mrs. J. L.....1919 N. Seventh St.
Strecker, Mrs. William L.....100 S. 20th St.
Sullivan, Mrs. John M.....2242 College Ave.

T-V

Taylor, Mrs. Donald J.....9 Chickadee Dr.
Topping, Mrs. Malachi C.....3505 Ohio Blvd.
Van Arsdall, Mrs. C. R.....2229 Crawford
Veach, Mrs. Wm. L.....10 Monroe Blvd.
Voges, Mrs. Ed. C.....327 Hamilton Dr.

W-Z

Weber, Mrs. Joseph.....2121 N. 11th St.
Weinbaum, Mrs. Jack G.....2705 Oak St.
White, Mrs. James V.....1227 S. Sixth St.
Wiedemann, Mrs. Frank E.....1530 S. Sixth St.
Wilson, Mrs. F. L.....1124 S. Center
Zwerner, Mrs. Paul F.....2510 N. Eighth St.

Meyn, Mrs. Werner P.
R. R. #1, West Terre Haute

WABASH COUNTY

Walker, Mrs. James L.....P. O. Box 8, LaFontaine

Wabash

Dannacher, Mrs. William.....518 North Wabash
Elward, Mrs. Carl.....550 Hamlin St.
Goldstone, Mrs. Harvey.....East Hill
Hanneken, Mrs. Vincent.....86 Comstock St.
LaSalle, Mrs. Richard.....126 Parkway
LaSalle, Mrs. R. M.....442 N. Wabash St.
LaSalle, Mrs. Robert M. Jr..... R. F. D. #4
Mills, Mrs. John F.....24 East Main
Pearson, Mrs. William E., R. F. D., Pleasant Valley
Rauh, Mrs. Robert.....620 Bond Street
Whisler, Mrs. Frederick M.....111 East Hill

WASHINGTON-ORANGE COUNTIES

Salem

Apple, Mrs. Eddie R.....503 W. Market
Coleman, Mrs. Henry G.....R. R. 4
Fultz, Mrs. Roy L.....703 W. Market
Huckleberry, Mrs. Irvin E.....502 W. Mulberry
Mitchell, Mrs. John I.....204 S. High
Paynter, Mrs. Lawrence W.....202 E. Walnut

Paoli

Hammond, Mrs. Keith.....Paoli
Manship, Mrs. Stanley.....Paoli
McCalla, Mrs. Charles X.....Paoli
Spears, Mrs. John K.....Paoli

Tower, Mrs. Kermit T.....Campbellsburg
Keseric, Mrs. Nicholas .....French Lick
Sugarman, Mrs. Benjamin E.....French Lick

WAYNE-UNION COUNTIES

Kenyon, Mrs. Emil..303 Mulberry, Cambridge City
Barton, Mrs. William M..North Morton, Centerville
Stepleton, Mrs. John D.....R. R. 2, Centerville
Shepard, Mrs. Fred F.....College Corner
Hutchison, Mrs. Don R.....Fountain City
Clarkson, Mrs. C. G.....Liberty
Lewis, Mrs. J. Frank.....Liberty
McWilliams, Mrs. William B.....Liberty

Richmond

Adney, Mrs. Frank.....214 S. E. Parkway
Ake, Mrs. Loren.....220 S. 18th St.
Allen, Mrs. Robert T.....212 S. 21st St.
Ballenger, Mrs. Wm. E.....3224 Berwyn Lane
Brown, Mrs. Richard J.....231 S. 15th St.
Buche, Mrs. Frederick P.....2408 S. "E" St.
Coble, Mrs. Frank H.....Liberty Pike
Cook, Mrs. Norman R.....30 S. 21st St.
Cox, Mrs. Leon T.....10 Clifton Rd.
Daggy, Mrs. B. T.....2500 S. "A" St.
Daggy, Mrs. James R.....2422 S. "D" St.
Dingle, Mrs. Paul E.....206 S. 32nd St.
Dreyer, Mrs. Ralph W.....410 S. W. "F" St.
Ebbinghouse, Mrs. Tom....Spring Grove Heights
Griffis, Mrs. V. C.....201 S. 23rd St.
Guthrie, Mrs. James R.....636 S. 19th St.

Hagie, Mrs. Franklin.....Backmeyer Rd.
Harmon, Mrs. Carl J.....Keystone Apt. 6
Herring, Mrs. George N...Richmond State Hospital
Hill, Mrs. Harold D.....123 S. 23rd St.
Hoffman, Mrs. Curtis.....204 S. 21st St.
Johnson, Mrs. George M.....115 S. 23rd St.
Johnson, Mrs. Paul S.....200 S. 18th St.
Kime, Mrs. Charles E.....501 S. 19th St.
Klepfer, Mrs. Jefferson F...Richmond State Hosp.
Laird, Mrs. Leslie.....Richmond State Hospital
Lee, Mrs. Glenn Ward.....404 S. 15th St.
Ling, Mrs. John F.....6 Parkway Lane
Logan, Mrs. James Z.....15 Parkway Lane
Loomis, Mrs. Charles H.....Garwood Rd.
Mader, Mrs. John H.....1528 Chester Blvd.
Malcolm, Mrs. Russell L...2630 Pleasant View Rd.
Meredith, Mrs. Elwood J.....200 S. 20th St.
Millis, Mrs. Arthur B.....4 Sunset Dr.
Park, Mrs. Byron J.....412 S. 16th St.
Passino, Mrs. James.....115 S. 16th St.
Ramsdell, Mrs. Glenn A.....Henley Rd. So.
Ross, Mrs. Harry P.....220 S. 19th St.
Ross, Mrs. James S.....321 S. 14th St.
Runge, Mrs. Paul W.....115 S. 17th St.
Sage, Mrs. Charles V.....416 S. 18th St.
Sherer, Mrs. Kenneth E.....232 S. 15th St.
Shields, Mrs. Tom S.....2203 S. "E" St.
Snyder, Mrs. Morris C.....125 S. 20th St.
Stilwell, Mrs. William R.....2607 S. C. Place
Sweet, Mrs. Howard E.....20 S. 22nd St.
Taylor, Mrs. William R.....27 S. 14th St.
Vance, Mrs. William C.....200 S. 21st St.
Wanninger, Mrs. Horace.....315 S. 15th St.
Warrick, Mrs. Francis B.....2106 South "B" St.
Weitemier, Mrs. R. A.....25 S. 25th St.
Wertenberger, Mrs. Morris....206 Henley Rd. So.
Whallon, Mrs. Arthur J.....29 S. 10th St.
Wiland, Mrs. Olin K.....2603 S. C. Place
Wisener, Mrs. Guthrie H.....401 S. 18th St.

WELLS COUNTY

Bluffton

Bishop, Mrs. Robert E.....1200 Sycamore Lane
Boonstra, Mrs. Charles E.
1110 Highland Pk. Circle
Bradley, Mrs. Louis.....504 W. South St.
Caylor, Mrs. Charles H.....1220 Sycamore Lane
Caylor, Mrs. Harold D. .....411 W. Market St.
Caylor, Mrs. Truman E. .....920 River Rd.
Cook, Mrs. Robert G.....1225 Summitt Ave.
Dorrance, Mrs. Thomas O.....302 Northwood Dr.
Eisaman, Mrs. Jack L.....1011 Riverview Dr.
Jackson, Mrs. Charles E.....1012 Riverview Dr.
Kephart, Mrs. Bruce .....910 Riverview Dr.
Meier, Mrs. Donald W.....1205 Summitt Dr.
Milroy, Mrs. Robert .....504 W. Cherry St.
Pietz, Mrs. David .....120 West South St.
Rudy, Mrs. Donald .....627 McCoy Rd.
Smith, Mrs. H. Brooks.....333 S. Wayne
Symon, Mrs. William E.....632 S. Main St.
Talbert, Mrs. Pierre C.....508 W. Cherry
Yoder, Mrs. Richard P.....931 South Wayne

WHITE COUNTY

Derhammer, Mrs. George L.....Brookston
Netherton, Mrs. C. R.....Chalmers
Sullivan, Mrs. James .....Francisville
Houser, Mrs. Wayne.....Monon
McClure, Mrs. Stanley E.....Monon

Monticello

Beck, Mrs. David C.....R. #3
Carney, Mrs. John.....R. R. #2
Dickerson, Mrs. W. Martin.....608 N. Illinois St.
Fullerton, Mrs. Robert L.....Beach Drive
Hibner, Mrs. Nolan A.....214 S. Illinois
Morris, Mrs. Warren V.....R. R. #3

Mayfield, Mrs. C. H.....Reynolds
Baynes, Mrs. Frank.....Wolcott

WHITLEY COUNTY

Hershey, Mrs. Ernest A., Jr.....Churubusco
Minick, Mrs. L. J.....Churubusco

Columbia City

Hamilton, Mrs. Thomas G.....416 W. Market St.
Heritier, Mrs. C. Jules.....410 E. Van Buren St.
Langohr, Mrs. John L.....321 N. Main St.
Lehmberg, Mrs. Otto F.....West Park Dr.
Luckey, Mrs. James.....R. R. #4
Niccum, Mrs. Warren L.....Brennan Addn.
Nolt, Mrs. E. V.....Westwood Park
Reid, Mrs. Donald B.....118½ E. Van Buren St.
Roth, Mrs. James R.....Route 4
Vogel, Mrs. John L.....Jefferson St. Ext.
Waite, Mrs. Jerome H.....Columbia City, R. R. #5
Wilson, Mrs. John S.....313 S. Chauncey St.

Mishler, Mrs. Joseph B.....Pierceton
Stalter, Mrs. Gaylord.....North Webster
Huffman, Mrs. Park..701 State St., South Whitley

MEMBERS-AT-LARGE

1. Alford, Mrs. James A.....Hamilton, Steuben
2. Amy, Mrs. William E.
120 S. Capitol, Corydon, Harrison
3. Beardsley, Mrs. Frank A.
751 E. South St., Frankfort, Clinton
4. Benedict, Mrs. Charles D.
LaGrange, LaGrange
5. Benz, Mrs. Jesse C.
Box #115, Marengo, Crawford
6. Bethea, Mrs. Robert O., Jr.
Main St., Farmersburg, Sullivan
7. Blessinger, Mrs. Louis H.
738 N. Capitol Ave., Corydon, Harrison
8. Bogardus, Mrs. Carl R.
Kyana Farm, Austin, Scott
9. Burkhardt, Mrs. Boyd
328 N. West St., Tipton, Tipton
10. Cameron, Mrs. Don F.....Angola, Steuben
11. Carlyle, Mrs. Ivan E...Michigantown, Clinton
12. Carneal, Mrs. T. E.
305 S. Market, Winamac, Pulaski
13. Carrel, Mrs. Francis E.
557 E. Washington St., Frankfort, Clinton
14. Carter, Mrs. Jean V.
215 Green St., Tipton, Tipton
15. Compton, Mrs. George
221 N. Independence, Tipton, Tipton
16. Covell, Mrs. Harry M.
909 Midway Dr., Auburn, DeKalb
17. Dukes, Mrs. David J.
439 E. Chestnut, Corydon, Harrison
18. Dukes, Mrs. F. M.....Dugger, Sullivan
19. Erickson, Mrs. Harold L.
Box 1356, Windfall, Tipton
20. Geisinger, Mrs. L. N.
805 S. Indiana Ave., Auburn, DeKalb
21. Glosson, Mrs. J. R.....R. R. 2, Clay City, Clay
22. Gobbel, Mrs. N. E.....English, Harrison
23. Hathaway, Mrs. Clayton B.
410 N. Broadway, Butler, DeKalb
24. Hoffman, Mrs. Max N.
709 Park Ave., Covington, Fountain
25. Hollenburg, Mrs. Edward L.
813 N. Hathaway, Winamac, Pulaski

26. Holmes, Mrs. C. D.
555 E. Walnut St., Frankfort, Clinton
27. Humphrey, Mrs. E. M.
1005 Orchard Dr., Covington, Fountain
28. Jennings, Mrs. Loren
807 S. Lee, Garrett, DeKalb
29. Kantzer, Mrs. Floyd B.
6080 E. Keyser St., Garrett, DeKalb
30. Kincaid, Mrs. Raymond
204 Columbia, Tipton, Tipton
31. Kurtz, Mrs. W. A.....R. R. 1, Tipton, Tipton
32. Lett, Mrs. E. Briscoe
502 W. 1st St., Loogootee, Daviess-Martin
33. Luckey, Mrs. Robert C.....Wolf Lake, Noble
34. Lynch, Mrs. Otis R.....Marengo, Crawford
35. Maris, Mrs. Lee J....Attica, Fountain-Warren
36. Mason, Mrs. Donald G.
401 E. Maumee, Angola, Steuben
37. Maurer, Mrs. Frank
6 E. Park St., Brazil, Clay
38. Maurer, Mrs. Robert
1115 N. Meridian, Brazil, Clay
39. McClain, Mrs. Marvin L.
1115 E. McClain, Scottsburg, Scott
40. McKittrick, Mrs. Jack
No. 1 Green Acres, Washington, Daviess
41. McNaughton, Mrs. L. M.
6 Brentwood Dr., Washington, Daviess
42. Nash, Mrs. Justin R.....Albion, Noble
43. Petrick, Mrs. P. P.
409 E. Washington, Attica, Fountain-Warren
44. Pulskamp, Mrs. B. H.....Wolcottville, Noble
45. Rang, Mrs. Arthur A.
211 N. E. 9th St., Washington, Daviess
46. Raymundo, Mrs. Viviano
114 David Dr., Attica, Fountain
47. Reynolds, Mrs. R. Perry
209 S. Britton St., Garrett, DeKalb
48. Rohrer, Mrs. James R.....Elnora, Daviess
49. Rotman, Mrs. Sam
603 S. Washington, Jasonville, Greene
50. Scott, Mrs. I. H.
30 W. Washington, Sullivan, Sullivan
51. Sneary, Mrs. Kenneth D.....Avilla, Noble
52. Stephens, Mrs. Lowell R.
600 E. Liberty St., Covington, Fountain
53. Stouder, Mrs. Albert E.....Kempton, Tipton
54. Stultz, Mrs. Quentin F.
3 Hawthorn Dr., Ligonier, Noble
55. Tranter, Mrs. W. F.
4 E. Walnut, Sharpsville, Tipton
56. Turner, Mrs. Jack J.
227 E. Main St., Bloomfield, Greene
57. Wait, Mrs. Chester.....Colfax, Clinton
58. Weaver, Mrs. T. M.....R. R. 2, Brazil, Clay
59. Webster, Mrs. Robert K.
25 N. Beech St., Brazil, Clay
60. Werich, Mrs. Charles I.
Box 126, R. R. 1, Butler, DeKalb
61. Williams, Mrs. John H.
221 Vanburen St., Shipshewana, LaGrange
62. Williams, Mrs. H. O.
735 Mitchell St., Kendallville, Noble
63. Woner, Mrs. John.....R. R. 3, Linton, Greene
64. Work, Mrs. B. A.
451 Howard Terrace, Frankfort, Clinton
65. Yunkers, Mrs. Philip
Box 188, Howe, LaGrange

Space Reserved for Your Change-of-address Notes

1960 Yearbook

The Journal of the Indiana State Medical Association

State Elected Officials 964

State Health Organizations 965

Professional Medical and Allied Organizations 976

Voluntary Organizations 986

I.U. School of Medicine, Heads of Departments 689

Indiana Accredited Schools of Nursing 990

Indiana Accredited Practical Nursing Schools 992

Approved Hospitals in Indiana 994

Approved Mental Hospitals 1004

Licensed Nursing Homes in Indiana 1006

Deaths of Indiana Physicians in 1959 1020

Presidents of ISMA Since Its Organization 1023

Constitution and Bylaws of the ISMA 1024

Poison Control Centers in Indiana 1038

Disease Prevention by Immunization and Chemoprophylaxis 1040

INDIANA DELEGATION IN CONGRESS*

UNITED STATES SENATORS*

Senior Senator—Hon. Homer E. Capehart.
(R) Washington, Indiana.

Junior Senator—Hon. Vance Hartke.
(D) Evansville, Indiana.

*** Address them at Senate Office Building, Washington, D. C.**

UNITED STATES REPRESENTATIVES†

First District—Hon. Ray J. Madden.
(D) 578 Broadway, Gary.

Second District—Hon. Charles A. Halleck.
(R) Rensselaer.

Third District—Hon. John Brademas.
(D) 750 Leland Ave., South Bend.

Fourth District—Hon. E. Ross Adair.
(R) 925 Lincoln Tower, Fort Wayne.

Fifth District—Hon. J. Edward Roush.
(D) 2340 College, Huntington.

Sixth District—Hon. Fred Wampler.
(D) 579 S. Brown, Terre Haute.

Seventh District—Hon. William Bray.
(R) Martinsville.

Eighth District—Hon. Winfield K. Denton.
(D) Evansville.

Ninth District—Hon. Earl Hogan.
(D) 204 Washington, Columbus.

Tenth District—Hon. Randall Harmon.
(D) 1509 Burlington Drive, Muncie.

Eleventh District—Hon. Joseph Barr.
(D) 2150 W. 44th St., Indianapolis.

† Address them at House Office Building, Washington, D. C.

STATE OFFICERS

Office	Incumbent	Politics	Room Number
Governor	Harold W. Handley	R	206
Lieutenant Governor	Crawford F. Parker	R	332
Secretary of State	John R. Walsh	D	201
Treasurer of State	Jack A. Haymaker	D	242
Auditor of State	Albert Steinwedel	D	238
Attorney General	Edwin K. Steers	R	219
Supt. of Public Instruction	Wm. E. Wilson	D	227
Clerk of Supreme Court	Mrs. Alice C. Whitecotton	D	314
Reporter of Supreme Court and Appellate Court	Virginia Caylor	R	416

*** Incumbent.**

TELEX, Creators of the Finest Precision Hearing Aids

OUR Policy embraces the belief that the Diagnosis and Treatment of Deafness lies within the special province of the Physician and, particularly, of the Otologist. We believe that our services complement those of the medical profession, therefore TELEX will always conduct its business so as to merit the Doctor's confidence.

- Monaural and binaural fittings with new style ear-level aids.

TELEX HEARING CENTER

41 E. Washington St., Suite 406 • Tel. ME 2-0316 • Indianapolis 4, Ind.

V. C. HELM

State Health Organizations

DEPARTMENT OF HEALTH
1330 West Michigan St., Indianapolis

Bertram Groesbeck, Jr., M.D., Director, Indianapolis
William D. Murchie, Administrative Assistant, Indianapolis

Medical Advisory Committee
Norman F. Richard, M.D., Shelbyville.
W. H. Howard, M.D., Hammond
Earl W. Mericle, M.D., Indianapolis
Glenn Irwin, M.D., Indianapolis

DIVISION OF MEDICAL INSTITUTIONS

Bertram Groesbeck, Jr., M.D., Acting Commissioner, Indianapolis

School for the Blind—Indianapolis
D. A. Hutchinson, Superintendent
Paul V. Grabill, Business Administrator

School for the Deaf—Indianapolis
William J. McClure, Superintendent
James E. Thomas, Business Administrator

Indiana Agency for the Blind—Indianapolis
Howard Carroll, Director, Indianapolis
Mrs. Bee Williamson, Administrative Clerk

State Sanitorium—Rockville
J. V. Pace, M.D., Superintendent
Robert L. McMullen, Business Administrator

Southern Indiana Tuberculosis Hospital—New Albany
Joseph H. Geyer, M.D., Superintendent
Hudson Hise, Business Administrator

Soldiers' Home—Lafayette
Col. Herman H. Schmitz, Commandant
Major Clyde Whitson, Business Administrator

Soldiers' and Sailors' Children's Home—Knightstown
L. A. Cortner, Superintendent
S. M. Chase, Business Administrator

Northern Indiana Children's Hospital—South Bend
D. M. Hippensteel, Superintendent

DIVISION OF MENTAL HEALTH

Stewart T. Ginsberg, M.D., Commissioner, Indianapolis
John W. Southworth, M.D., Deputy Commissioner, Indianapolis
Robert W. King, Business Administrator

Mental Health Advisory Council
Grant E. Metcalfe, M.D., Chairman, South Bend
Alexander T. Ross, M.D., Indianapolis
James Huckelberry, D.D.S., Indianapolis
Ben J. Weaver, Indianapolis
Frank H. Green, M.D., Rushville
Mr. Otto Fifield, Crown Point
Mrs. Arthur Robinson, Indianapolis
Walter Kennedy, M.D., New Castle
Carter Dunstone, M.D., Fort Wayne
William C. Vance, M.D., Richmond
Rabbi Albert M. Shulman, South Bend
Robert S. Smith, Indianapolis
Mrs. Peter McGrath, Evansville
Robert P. Acher, M.D., Greensburg

MENTAL INSTITUTIONS

Central State Hospital—Indianapolis
C. L. Williams, M.D., Superintendent
Sidney Smock, Business Administrator

Evansville State Hospital—Evansville
Milton Anderson, M.D., Superintendent
George Jones, Business Administrator

Logansport State Hospital—Logansport
Ernest J. Fogel, M.D., Superintendent
A. L. Maines, Business Administrator

Madison State Hospital—Madison
Ott B. McAtee, M.D., Superintendent
Ralph W. Jordan, Business Administrator

Norman M. Beatty Memorial Hospital—Westville
David P. Morton, M.D., Superintendent
Thomas R. Stoller, Business Administrator

Larue D. Carter Memorial Hospital—Indianapolis
Donald F. Moore, M.D., Medical Director
Victor Gootee, Business Administrator

Richmond State Hospital—Richmond
Jefferson Klepfer, M.D., Superintendent
William Brenizer, Business Administrator

Fort Wayne State School—Fort Wayne
Bernard Dolnick, Superintendent
H. T. Dean, Jr., Business Administrator

Muscatatuck State School—Butlerville
Donald H. Jolly, M.D., Superintendent
Marvin A. Thompson, Business Administrator

New Castle State Hospital, New Castle
William E. Murray, M.D., Superintenent
George Rauch, Business Administrator

Continued

State Health

Continued

INDIANA STATE BOARD OF HEALTH

A. C. Offutt, M.D., Secretary and State Health Commissioner

Louis B. Herdrich, Director, Division of Personnel and Training

Health, State Board of

Maynard K. Hine, D.D.S., Chairman, Indianapolis

Lowell W. Hinchman, D.V.M., Vice-Chairman, Glenwood

Glenn L. Jenkins, Ph.D., Lafayette

Don E. Bloodgood, B.S.C.E., C.E., Lafayette

Richard M. Craig, M.D., Fort Wayne

Joseph E. Dudding, M.D., Hope

Mrs. Helen R. Johnson, R.N., Indianapolis

Joseph L. Quinn, Jr., Terre Haute

Richard H. Woolery, M.D., Bedford

Bureau of Central Services

W. J. Strange, Director

George E. Arnold, Director, Division of Budget and Accounts

J. Howard Kurner, Director, Division of Stores and Mail

Bureau of Environmental Sanitation

B. A. Poole, Director

Robert W. Heider, Director, Division of Sanitary Engineering

Rollin E. Meek, Director, Division of Weights and Measures

T. E. Sullivan, Director, Division of Foods and Drugs

John Taylor, Director, Division of Dairy Products

John F. Keppler, Director, Division of Industrial Hygiene

Bureau of Health Education, Records and Statistics

Robert Yoho, H.S.D., Director

Robert A. Calhoun, P.E.D., Director, Division of Public Health Statistics

Margaret A. Dunham, Director, Division of Nutritional Services

Joseph E. Holwager, Director, Division of Vital Records

Malcolm A. Mason, Director, Division of Health and Physical Education

Bureau of Laboratories

Josephine Van Fleet, M.D., Director

Kathryn Albright, Director, Virology Laboratory Laboratory

Tinsel L. Eddleman, Director, Dairy Laboratory

Charles F. Hill, Director, Serology Laboratory

Stephen R. Kin, Director, Water Laboratory

Walter A. Miller, Director, Microbiology Laboratory

Glen C. Weber, Director, Food and Drug Laboratory

Bureau of Preventive Medicine

Louis W. Spolyar, M.D., Director

W. C. Anderson, M.D., Director, Division of Chronic Diseases & Tuberculosis Control

Charles L. Howell, D.D.S., Director, Division of Dental Health

A. L. Marshall, Jr., M.D., Director, Division of Communicable Disease Control

Louis W. Spolyar, M.D., Acting Director, Division of Rehabilitation

Bureau of Special Health Services

Verne K. Harvey, Jr., M.D., Director

Ethel R. Jacobs, R.N., Director, Division of Public Health Nursing

Martha O'Malley, M.D., Director, Division of Hospital & Institutional Services

Verne K. Harvey, Jr., M.D., Director, Division of Maternal and Child Health

Max L. Barrett, Acting Director, Northeastern Branch Office, Fort Wayne

Harold S. Griswold, Acting Director, Southwestern Branch Office, Washington

Edward A. Riley, Acting Director, Northwestern Branch Office, LaPorte

William F. Uhl, Acting Director, Southeastern Branch Office, Columbus

James H. McCoy, Acting Director, Central Area, Indianapolis

Bedding Advisory Board, Indiana

A. O. Steves, Chairman, Anderson

R. Thomas McGill, Vice-Chairman, Indianapolis

Mr. Frank Horr, Marion

Mr. James Kirkwood, Wakarusa

Mr. P. D. Powers, Indianapolis

Mr. Hugh J. Thompson, Michigan City

Mr. John Klump, Indianapolis

Commission on Forensic Sciences

Lt. Charles A. Davis, Director

Indiana State Police Laboratory, Stout Field, Indianapolis 21, Ind.

A. C. Offutt, M.D., Secretary

Lee M. LeMay

Edward B. Smith, M.D.

Roy B. Storms, M.D.

Commission for Physically Handicapped

Dr. Neal E. Baxter, Chairman, 306 E. Fifth St., Bloomington

Theodore Dombrowski, Secretary, Gary

Kenneth N. Orr, Executive Secretary (effective July 1, 1960), Sullivan

Continued



she calls it "nervous indigestion"

diagnosis: a wrought-up patient with a functional gastro-intestinal disorder compounded by inadequate digestion. **treatment:** reassurance first, then medication to relieve the gastric symptoms, calm the emotions, and enhance the digestive process. **prescription:** new Donnazyme—providing the multiple actions of widely accepted Donnatal® and Entozyme®—two tablets t.i.d., or as necessary.

Each Donnazyme tablet contains
—In the gastric-soluble outer layer: Hyoscyamine sulfate, 0.0518 mg.; Atropine sulfate, 0.0097 mg.; Hyoscine hydrobromide, 0.0033 mg.; Phenobarbital (1/8 gr.), 8.1 mg.; and Pepsin, N. F., 150 mg. **In the enteric-coated core:** Pancreatin, N. F., 300 mg., and Bile salts, 150 mg.

ANTISPASMODIC - SEDATIVE - DIGESTANT

DONNAZYME®

A. H. ROBINS COMPANY, INCORPORATED • RICHMOND 20, VIRGINIA

State Health

Continued

Howard Lytle, Indianapolis
Ralph Biery, Dayton
Ralph N. Phelps, Indianapolis
Mrs. Carolyn C. Tucker, Indianapolis
Ort L. Walter, Indianapolis
Dr. S. T. Ginsberg, Indianapolis
Dr. Ralph McDonald, Indianapolis
Dr. Alexander T. Ross, Indianapolis
Dr. Frank M. Hall, Indianapolis
Joseph W. Elbert, D.O., Petersburg

Health, Hospital Regulating and Licensing Council
Guy A. Owsley, M.D., Chairman, Hartford City

Richard H. Woolery, M.D., Bedford, Ex Officio
Albert Kelly, Indianapolis, Ex Officio
Mrs. Helen Boyer, R.N., Bedford
Albert G. Hahn, L.H.D., Evansville
Mr. E. C. Moeller, Fort Wayne
Miss Olive M. Murphy, R.N., Columbus
Sister Scholastica, Indianapolis

Mobile Home Advisory Board
Mrs. Katherine S. Cox, Indianapolis

Kenneth A. Harrison, Indianapolis
William D. Shillinger, Indianapolis, Ex Officio
D. G. Bernoske, M.D., Crown Point
Myron C. Poole, Elwood
Mr. Howard Simmons, Danville

Nursing Home Council
Franklin Finkenbinder, Chairman, South Bend

Mary Gill, Chairman Pro tempore, Indianapolis
Mrs. Janet Cooper, R.N., Bluffton
Walter Buuck, Fort Wayne
Paul G. Iske, M.D., Indianapolis
Edmund J. Shea, Indianapolis
Robert O. Brown, Indianapolis, Ex-Officio
J. L. Foster, Indianapolis, Ex-Officio
A. C. Offutt, M.D., Indianapolis, Ex-Officio

Radiation Control Advisory Commission
A. C. Offutt, M.D., Chairman, Indianapolis

Henry C. Briggs, Secretary, Indianapolis
J. E. Christian, Ph.D., West Lafayette
James C. Katterjohn, M.D., Indianapolis
John E. Magnuson, D.D.S., LaPorte
Wallace B. Mathews, Whiting
William D. Province, M.D., Franklin
Charles Rice, Ph.D., Indianapolis
Robert S. Webb, Indianapolis
L. Derrell Weaver, Indianapolis

Tuberculosis Council, Indiana
Joe K. White, Chairman, Noblesville

Edward Boyer, M.D., Indianapolis
M. Arthur Grant, M.D., Fairmount
Chester D. Kelly, Indianapolis
Thomas R. Owens, M.D., Muncie
Joe C. Rice, Elkhart
A. C. Offutt, M.D., Indianapolis, Ex Officio

Stream Pollution Control Board
Anson S. Thomas, Chairman, Indianapolis

Lewis S. Finch, Vice-Chairman, Indianapolis
Robert W. Kellum, Indianapolis
E. Kenneth Marlin, Farmland, Ex-Officio
A. C. Offutt, M.D., Indianapolis, Ex-Officio
Lt. Gov. Crawford F. Parker, Mooreland, Ex-Officio
B. A. Poole, Technical Secretary, Indianapolis

STATE ANATOMICAL BOARD

Andrew C. Offutt, M.D., Chairman, Indianapolis, Ex-Officio
Edwin N. Kime, M.D., Secretary-Treasurer, Indianapolis
Warren Andrew, M.D., Indianapolis
William Bierman, D.C., Indianapolis
Maynard K. Hine, D.D.S., Indianapolis
John D. Van Nuys, M.D., Indianapolis
Richard L. Webb, M.D., Bloomington

DEPARTMENT OF PUBLIC WELFARE

141 South Meridian Street, Indianapolis

Albert Kelly, Administrator, Kokomo
Miss Evelyn G. Bell, Assistant Administrator, Indianapolis
Oscar C. Crawford, Administrative Assistant, Indianapolis
Robert O. Brown, Director, Division of Public Assistance, Martinsville
Miss Lucille De Voe, Director, Children's Division, Indianapolis
Dr. Frank M. Hall, Medical Director and Acting Director, Division of Services for Crippled Children, Indianapolis
Mr. William R. Sterrett, Director, Division of Administrative Services, Indianapolis

STATE BOARD OF PUBLIC WELFARE

Stanley A. B. Cooper, President, Brazil
Evans Woollen, III, Vice-President, Indianapolis
Robert M. Curless, Wabash
Mrs. J. Clifton Hirschman, Indianapolis
Very Rev. Msgr. W. Edward Sweigart, Gary

LIVESTOCK SANITARY BOARD

Room 422, 611 N. Park Ave., Indianapolis
Joe K. White, Chairman, Noblesville
Clarence W. Lawson, Vice-Chairman, Boswell
Joe W. Green, D.V.M., Secretary and State Veterinarian, Pittsboro

Continued

Tofrānil®

brand of imipramine HCl

in depression

lights the road to recovery in 80 per cent of cases

In the treatment of depression Tofrānil has established the remarkable record of producing remission or improvement in approximately 80 per cent of cases.[1-7]

Tofrānil is well tolerated in usage—is adaptable to either office or hospital practice—is administrable by either oral or intramuscular routes.

Tofrānil
a potent thymoleptic . . .
not a MAO inhibitor.

Does act effectively in *all* types of depression regardless of severity or chronicity.

Does not inhibit monoamine oxidase in brain or liver; produce CNS stimulation; or potentiate other drugs such as barbiturates and alcohol.

Detailed Literature Available on Request.



Tofrānil® brand of imipramine HCl: tablets of 25 mg., bottles of 100. Ampuls for intramuscular administration only, each containing 25 mg. in 2 cc. of solution, cartons of 10 and 50.

References: 1. Ayd, F. J., Jr.: Bull. School Med., Univ. Maryland *44*:29, 1959. 2. Azima, H., and Vispo, R. H.: A.M.A. Arch. Neurol. & Psychiat. *81*:658, 1959. 3. Lehmann, H. E.; Cahn, C. H., and de Verteuil, R. L.: Canad. Psychiat. A. J. *3*:155, 1958. 4. Mann, A. M. and MacPherson, A. S.: Canad. Psychiat. A. J. *4*:38, 1959. 5. Sloane, R. B.; Habib, A., and Batt, U. E.: Canad. M.A.J. *80*:540, 1959. 6. Straker, M.: Canad. M.A.J. *80*:546, 1959. 7. Strauss, H.: New York J. Med. *59*:2906, 1959.

Geigy, Ardsley, New York

Geigy

TO4-60

State Health

Continued

M. D. Neuhauser, D.V.M., West Lafayette
Edward O. Haelterman, D.V.M. (Acting), Lafayette
Phares L. White, Oxford
A. I. Martin, Ramsey
Thomas W. Freas, D.V.M., Veedersburg

INDUSTRIAL BOARD
141 South Meridian Street, Indianapolis

Joseph P. Miller, Chairman, South Bend
Ramon J. Hitch, Evansville
Leon J. Mills, Indianapolis
Rob R. McNagny, Columbia City
Warren W. Martin, Sr., Boonville
Joseph O. Pearson, Secretary, Shelbyville

STATE BOARD OF BARBER EXAMINERS
No. 416, 141 South Meridian St., Indianapolis

E. R. Newlon, President, Indianapolis
C. O. Maze, Vice-President, Greenwood
Edgar C. Correll, Executive Secretary, Bloomington

STATE BOARD OF BEAUTY CULTURIST EXAMINERS
145 W. Washington St.

Hubert N. Grimes, M.D., President, Indianapolis
Anna Cline, Vice-President, Corydon
Mrs. Irene Prosch, Secretary, Indianapolis

STATE BOARD OF DENTAL EXAMINERS

George A. Fisher, D.D.S., President, Evansville
Carl A. Frech, D.D.S., Secretary, Gary National Bank Building, Gary
James W. Huckelberry, D.D.S., Indianapolis
William A. Shoemaker, D.D.S., Mishawaka
Paul T. Worster, D.D.S., Anderson

STATE BOARD OF MEDICAL REGISTRATION AND EXAMINATION
538 Knights of Pythias Bldg., Indianapolis 4.

Lall G. Montgomery, M.D., President, Muncie
Hugh W. Eikenberry, M.D., Vice President, Indianapolis
Paul T. Lamey, M.D., Secretary, Anderson
Angelo P. Bonaventura, M.D., Hammond
Wendell C. Stover, M.D., Boonville
H. Dearing Wolf, D.O., Treasurer, Indianapolis
Clarence F. Aumann, D.C., Indianapolis

STATE BOARD OF NURSES REGISTRATION AND NURSING EDUCATION
307 Ober Building, Indianapolis

Miss Mary Ruth Maginsky, R.N., President, Hammond
Miss Marie Kolter, R.N., Secretary, Fort Wayne
Miss Orpah B. Mosemann, R.N., Goshen
Sister Catherine, R.N., Evansville
Miss Helen J. Weber, R.N., Bloomington
Miss Caroline Hauenstein, R.N., Executive Secretary, Indianapolis

BOARD OF REGISTRATION AND EXAMINATION IN OPTOMETRY
116 Buffalo St., Warsaw

Dr. Ed Cain, O.D., Secretary, South Bend
Kenneth D. Dutton, O.D., Kokomo
H. F. Garton, O.D., LaPorte
Donald W. Conner, O.D., Terre Haute

STATE BOARD OF PODIATRY EXAMINERS
538 Knights of Pythias Building, Indianapolis

Howard M. Dill, D.S.C., President, Fort Wayne
Paul T. Lamey, M.D., Secretary, Anderson
Ronald E. Tanner, D.S.C., Indianapolis
Hugh W. Eikenberry, M.D., Indianapolis
H. Dearing Wolf, D.O., Indianapolis

VETERINARY EXAMINATION BOARD
Room 422, 611 N. Park Ave., Indianapolis

M. D. Neuhauser, D.V.M., Chairman, West Lafayette
William Magrane, D.V.M., Vice-Chairman, Mishawaka
Lester Wroe, D.V.M., Treasurer, Rockport
John F. Medlock, D.V.M., Bedford
B. V. Allen, D.V.M., Ft. Wayne
Joe W. Green, D.V.M., Secretary and State Veterinarian, Pittsboro

COMMISSION ON AGING AND AGED
3516 Central Ave., Indianapolis

Dr. Warren Andrew, Indianapolis
Dr. Frank O. Beck, Bloomington
Frank Beckwith, Indianapolis
Jack Brenn, Huntington
Dr. Richard Burkhardt, Muncie
Dr. George E. Davis, West Lafayette
Sen. Jesse L. Dickinson, South Bend
Mrs. Clarence Getz, Fort Wayne
Dr. Herbert C. Hunsaker, West Lafayette
Dr. Morton Leeds, Indianapolis
Ewing Miller, Terre Haute
Dr. Nathan Salon, Fort Wayne
Bruce Savage, Indianapolis
Lynn Stewart, Columbus
Mrs. T. Dale Swem, South Bend
Robert Weirich, East Chicago
Max F. Wright, Indianapolis
Edgar L. Yeager, Indianapolis
Mrs. Truman Yuncker, Greencastle

HEARING COMMISSION

Dr. M. D. Steer, Lafayette
Vince Knopf, Indianapolis
J. William Wright, Jr., M.D., Indianapolis
David E. Brown, M.D., Indianapolis
Wilbur Young, Indianapolis

COMMISSION ON VETERANS' AFFAIRS
431 N. Meridian St., Indianapolis

Melvin Hensley, Chairman, Tipton
Richard L. Roudebush, Indianapolis
Robert Dale Work, Evansville

(This is one of a series of public information advertisements)

HOSPITAL DOCTOR SPONSORED

Indiana Blue Cross was founded in 1944 by the Indiana Hospital Association to provide prepayment of hospital services. Indiana Blue Shield was created in 1946 by the Indiana State Medical Association to help pay your doctor's bills.

Since their founding, Blue Cross and Blue Shield have paid out more than $300,000,000 in benefits. Today, one Hoosier in three is a member. Working directly with hospitals and doctors, Blue Cross-Blue Shield keeps up with changing health care conditions, meets community needs by giving the greatest benefits at the lowest possible cost.

Ask your employer about group membership. Requests for information about individual memberships may be obtained at your doctor's office or the hospital. Or, inquire at the Blue Cross-Blue Shield office listed in the Yellow Pages of your telephone book.

above all...

BLUE CROSS **BLUE SHIELD**

Mutual Hospital Insurance, Inc. Mutual Medical Insurance, Inc.

TO HAVE, TO HOLD, TO DEPEND UPON

110 N. Illinois Street • Indianapolis 9, Indiana

OVER 80 YEARS' SPECIALIZED EXPERIENCE IN THE RESTORATIVE TREATMENT OF

"THE PROBLEM DRINKER"

At The Keeley Institute your patients are assured of receiving:

- the most modern, coordinated, comprehensive, rehabilitative regimen
- in addition to medical, nutritional and physiotherapeutic treatment, we also offer psychiatric diagnosis and psychotherapy
- full cooperation throughout with the referring physician
- in addition to the care of the alcoholic we also treat narcotic and drug addiction
- surprisingly low cost—to cover all medical care, medicines, laboratory work, room and excellent cuisine

You can obtain more detailed information by writing us direct.

WE WELCOME YOUR REFERRALS...

THE KEELEY INSTITUTE
DWIGHT, ILLINOIS

Member American Hospital Association, Member Illinois Hospital Association. Licensed by the Department of Public Health, State of Illinois.

State Health

Continued

Joseph F. Quill, Indianapolis
James M. Trimble, State Service Officer
Jack E. Colglazier, Asst. State Service Officer

SELECTIVE SERVICE SYSTEM
INDIANA STATE HEADQUARTERS
36 South Pennsylvania St., Indianapolis

Lt. Col. Wayne E. Rhodes, State Director, Indianapolis

Lt. Col. Walter L. Miller, Deputy State Director, Indianapolis

Lt. Col. Vernon E. Clark, Procurement Officer, Indianapolis

Major Clarence R. Harris, Chief Administrative Division, Indianapolis

Capt. George H. Warner, Chief Field Division, Indianapolis ◄



In Indianapolis, Indiana—choose...

CLAYPOOL HOTEL

Completely Air-Conditioned . . . Radio and Television in Guest Rooms . . . Newly Furnished Throughout

An AFFILIATED NATIONAL HOTEL

CONSIDER THESE 6 IMPORTANT THERAPEUTIC ATTRIBUTES OF

SYNCILLIN™



potassium phenethicillin (POTASSIUM PENICILLIN-152)

ANTIBIOTIC ACTIVITY DIRECTLY PROPORTIONAL TO ORAL DOSE

REDUCED RATE OF INACTIVATION BY STAPH PENICILLINASE

SOME STAPH STRAINS MORE SENSITIVE TO SYNCILLIN IN VITRO

BRISTOL LABORATORIES, SYRACUSE, NEW YORK

BRISTOL





Professional Medical and Allied Organizations

Due to the additional content of the Yearbook, cut-off date for changes in the following groups was in March. Some have changed in the interim. However, it is felt that where officers have changed, a query to those listed here will put interested persons in contact with such groups.

OFFICERS OF THE AMERICAN MEDICAL ASSOCIATION

535 North Dearborn Street, Chicago 10, Illinois

President—Louis M. Orr, M.D., Orlando, Fla.
President-Elect—E. Vincent Askey, M.D., Los Angeles.
Vice-President—J. Stanley Kenney, M.D., New York, N. Y.
Secretary-Treasurer—Raymond M. McKeown, M.D., Coos Bay, Oregon.
Speaker, House of Delegates—Norman A. Welch, M.D., Boston, Mass.
Vice Speaker, House of Delegates — Milford O. Rouse, M.D., Dallas, Texas.
Chairman, Board of Trustees—Leonard W. Larson, M.D., Bismarck, N. D.
Executive Vice-President—F. J. L. Blasingame, M.D., Chicago.
Assistant Executive Vice-President — Ernest B. Howard, M.D., Chicago.
Division of Scientific Activities—Acting Director, Ernest B. Howard, M.D., Chicago.
Division of Environmental Medicine — Director, F. D. Yoder, M.D., Chicago.
Division of Scientific Publications—Director, J. H. Talbott, M.D., Chicago.
Legal and Socio-Economic Activities Division—Director, Mr. C. Joseph Stetler, Chicago.
Communications Division—Director, Leo E. Brown, Chicago.
Field Service Division—Director, A. D. Gates, Chicago.
Business Division—Director, R. H. Clark, Chicago.
Judicial Council—Secretary, E. J. Holman, Chicago.
Council on Medical Education and Hospitals—Secretary, W. S. Wiggins, M.D., Chicago.
Council on Medical Service — Secretary, G. W. Cooley, Chicago.
Council on Constitution and Bylaws — Secretary, G. E. Hall, Chicago.
Council on Drugs—Secretary, H. D. Kautz, M.D., Chicago.
Council on Scientific Assembly—Secretary, C. H. Bramlitt, M.D., Chicago.
Council on Medical Physics—Secretary, R. E. DeForest, M.D., Chicago.
Council on Foods and Nutrition—Secretary, P. L. White, Sc.D., Chicago.
Council on Occupational Health—Secretary, B. D. Holland, M.D., Chicago.
Council on National Security—Secretary, F. W. Barton, Chicago.
Council on Rural Health—Mrs. A. Hibbard, Chicago.
Council on Mental Health—Secretary, R. J. Plunkett, M.D., Chicago.
Council on Legislative Activities—Secretary, C. J. Stetler, Chicago.

INDIANA STATE SOCIETY OF ANESTHESIOLOGISTS

President—J. H. Stamper, M.D., 619 State Road 67 West, Anderson.
President-Elect—Paul A. Littlefield, M.D., Indianapolis.
Secretary-Treasurer—Murwyn L. Hicks, M.D., 1502 N. Emerson, Indianapolis.

BONE AND JOINT CLUB

President—K. R. Manning, M.D., 723 Hume Mansur Bldg., Indianapolis 4.
Secretary-Treasurer—David Hadley, M.D., 809 Hume Mansur Bldg., Indianapolis 4.

INDIANA ACADEMY OF GENERAL PRACTICE

President—Harry Pandolfo, M.D., 234 E. Southern Ave., Indianapolis 25.
President-Elect—Francis L. Land, M.D.
Vice-President—Charles R. Alvey, M.D.
Treasurer—Frances T. Brown, M.D., 2126 N. Talbot Ave., Indianapolis 2.
Executive Secretary—Charles G. Dosch, 1403 N. Delaware St., Indianapolis 2.

INDIANA SOCIETY OF INTERNAL MEDICINE

President—Richard N. Kent, 731 Medical Center Bldg., Fort Wayne.
President-Elect—Arthur B. Richter, Indianapolis.
Vice-President—George W. Willison, Evansville.
Secretary-Treasurer—E. P. Tischer, 208 Hume Mansur Bldg., Indianapolis 4.

INDIANA STATE ASSOCIATION OF MEDICAL ASSISTANTS

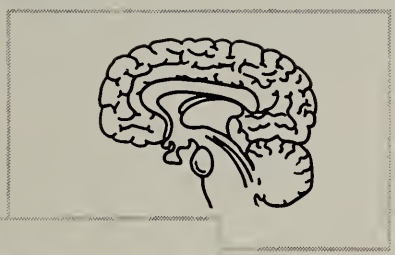
President—Miss Evelyn Sommers, 420 Sixteenth Street, Logansport, Indiana.
President-Elect—Mrs. Jean Blance, 6726 Edgebrook Drive, Fort Wayne, Indiana.
Recording Secretary—Mrs. Trudy Cleckner, 210 Edgeknoll Lane, Fort Wayne, Indiana.

Continued



basic in the care of the aging

℞ Metalex®



when body tone, mental and sensory faculties begin to fade—*she's irritable, confused, forgetful, apathetic*



when vision begins to dim—*in loss of visual acuity, in loss of peripheral vision*



when voices begin to fade—*in loss of auditory acuity, in tinnitus*

Metalex® *cerebral stimulant/vasodilator*

The stimulant—pentylenetetrazol—facilitates cerebral and reflex nerve activity.

The vasodilator—nicotinic acid—augments blood and oxygen supply to vital areas—

Thus, METALEX increases body tone and aids mental and sensory faculties.

Composition: Each teaspoonful (5 ml.) of the Elixir and each Tablet contains: Pentylenetetrazol 100 mg., Nicotinic Acid 50 mg.

Dosage: One or two teaspoonfuls of the Elixir or one or two Tablets four times a day—one-half hour before meals and before bedtime.

Available: Elixir: Pint and Gallon bottles. Tablets: Bottles of 100 and 1000.

References: 1. Goodman, L. S. and Gilman, A.: The Pharmacological Basis of Therapeutics, 2nd Ed., New York, Macmillan Company, 1955. 2. O'Reilly, P. O., Demay, M. and Kotlowski, K.: Cholesteremia and Nicotinic Acid. A.M.A. Arch. Int. Med. 100:797-801 (Nov.) 1957.

STORCK Pharmaceuticals, Inc.,
2326 Hampton Blvd., St. Louis 10, Mo.

Professional

Continued

Treasurer—Mrs. Evelyn Montgomery, 729 So. Harrison Street, Shelbyville, Indiana.
Corresponding Secretary—Miss Betty Hyres, 1112 East Market Street, Logansport, Ind.

INDIANA NEUROPSYCHIATRIC ASSOCIATION
President—Alexander T. Ross, M.D., I. U. Medical Center, Indianapolis.
President-Elect—Eldred Hardtke, M.D., Bloomington.
Vice-President—George Rader, M.D., Indianapolis.
Secretary-Treasurer—Ronald H. Hull, M.D., 723 Hume Mansur Bldg., Indianapolis.

INDIANA OBSTETRICAL AND GYNECOLOGICAL SOCIETY
President—David A. Bickel, M.D., 104 S. Main St., South Bend.
Vice-President—John F. Spahr, Jr., M.D., Indianapolis.
Secretary-Treasurer — Floyd T. Romberger, Jr., M.D., 3440 N. Meridian St., Indianapolis 8.

INDIANA ORTHOPAEDIC SOCIETY
President—Wayne Glock, M.D., 2609 Fairfield, Fort Wayne.
Vice-President—Henry S. Tanner, M.D., Indianapolis.
Secretary-Treasurer—K. R. Manning, M.D., 723 Hume Mansur Bldg., Indianapolis 4.

INDIANA ASSOCIATION OF PATHOLOGISTS
President—Leon L. Blum, M.D., 210 Rose Dispensary Bldg., Terre Haute.
President-Elect—John D. Stepleton, Richmond.
Secretary-Treasurer—Lester H. Hoyt, M.D., Methodist Hospital, Indianapolis.

INDIANA CHAPTER OF THE AMERICAN ACADEMY OF PEDIATRICS
President—William M. Browning, M.D., 3740 Central Ave., Indianapolis.
Vice-State Chairman—Ramon A. Henderson, M.D., Muncie.
Secretary—Wendell Brown, M.D., 3426 N. Meridian, Indianapolis.
Treasurer—David Jones, M.D., Lafayette.

INDIANA ROENTGEN SOCIETY
President—John R. Lionberger, M.D., 615 Sherland Bldg., South Bend.
President-Elect—Chester A. Stayton, Jr., M.D., 313 Hume Mansur Bldg., Indianapolis 4.
Secretary-Treasurer—David E. Wheeler, M.D., Community Hospital, Indianapolis 19.

AMERICAN COLLEGE OF SURGEONS, INDIANA CHAPTER
President—H. M. Trusler, M.D., 408 Hume Mansur Bldg., Indianapolis 4.
Vice-President—James M. Wilson, M.D., South Bend.

Continued

- SURGICAL INSTRUMENTS
- DIAGNOSTIC EQUIPMENT
- TREATMENT ROOM FURNITURE

Complete Repair Department

Prescription Drugs
Biologicals • Blood Typing Serums
Chemicals • Injectable Solutions
Laboratory Reagents

• OUR MOTTO:
DEPENDABILITY

PRIVATE
fittings for corrective supports and braces—Orthopedic Appliances expertly fitted by courteous men or women.

ABDOMINAL BELTS
BACK SUPPORTS
SURGICAL CORSETS
ELASTIC HOSIERY
TRUSSES

CRUTCHES • CANES
WHEEL CHAIRS • HOSPITAL BEDS

ME 4-1506

Akron
Surgical House, Inc.
IN INDIANA SINCE 1924

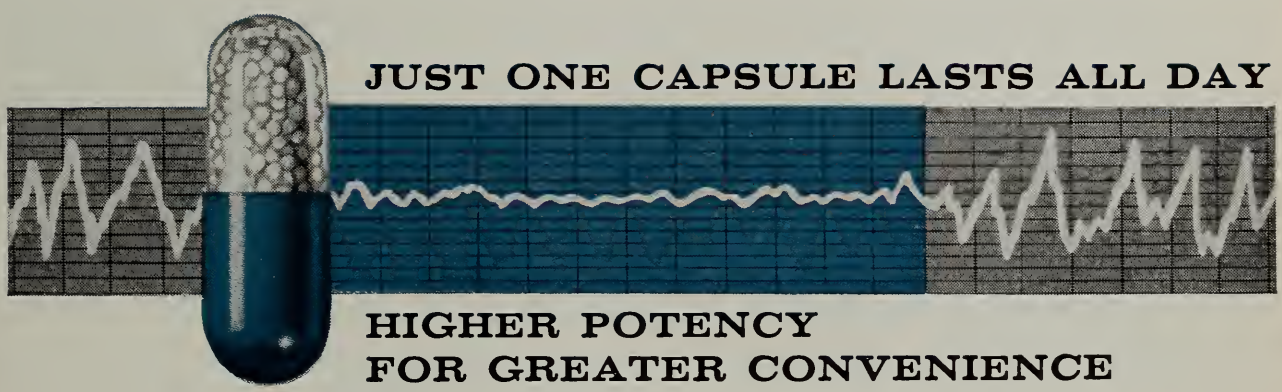
221 North Pennsylvania Street

NEW AND EXCLUSIVE

FOR SUSTAINED TRANQUILIZATION

MILTOWN® (*meprobamate*) now available
in 400 mg. continuous release capsules as

Meprospan®-400



JUST ONE CAPSULE LASTS ALL DAY

**HIGHER POTENCY
FOR GREATER CONVENIENCE**

- relieves *both* mental and muscular tension without causing depression
- does not impair mental efficiency, motor control, or normal behavior

Usual dosage: One capsule at breakfast, one capsule with evening meal

Available: *Meprospan-400*, each blue capsule contains 400 mg. Miltown (meprobamate)
Meprospan-200, each yellow capsule contains 200 mg. Miltown (meprobamate)

Both potencies in bottles of 30.

®WALLACE LABORATORIES, *New Brunswick, N. J.*

CME-8426

Professional

Continued

Secretary-Treasurer—J. Stanley Battersby, M.D., 1100 West Michigan St., Indianapolis.

INTERNATIONAL COLLEGE OF SURGEONS, INDIANA SECTION

President—Harry S. Rabb, M.D., 3139 E. 10th St., Indianapolis.
President-Elect—James L. Wyatt, Sr., M.D., Fort Wayne.
First Vice-President—Harry E. Kitterman, M.D., Indianapolis.
Second Vice-President—James L. Wyatt III, M.D., Fort Wayne.
Third Vice-President—Russell W. Lamb, M.D., Indianapolis.
Secretary—Robert D. Fry, M.D., 517 Hume Mansur Bldg., Indianapolis 4.
Treasurer—Simon Reisler, M.D., 318 Bankers Trust Bldg., Indianapolis.
Regent—Walter P. Moenning, M.D., Indianapolis.

INDIANA STATE DENTAL ASSOCIATION

1012 Hume Mansur Building, Indianapolis 4.
President—James M. Jones, D.D.S., Columbus.
President-Elect—William R. Shoemaker, D.D.S., Anderson.
Vice-President—Paul A. Risk, D.D.S., Lafayette.
Secretary-Treasurer—Charles L. Howell, D.D.S., Indianapolis.
Executive Secretary and Managing Editor—Broderick H. Johnson, M.A., 1012 Hume Mansur Building, Indianapolis 4.

INDIANA HOSPITAL ASSOCIATION

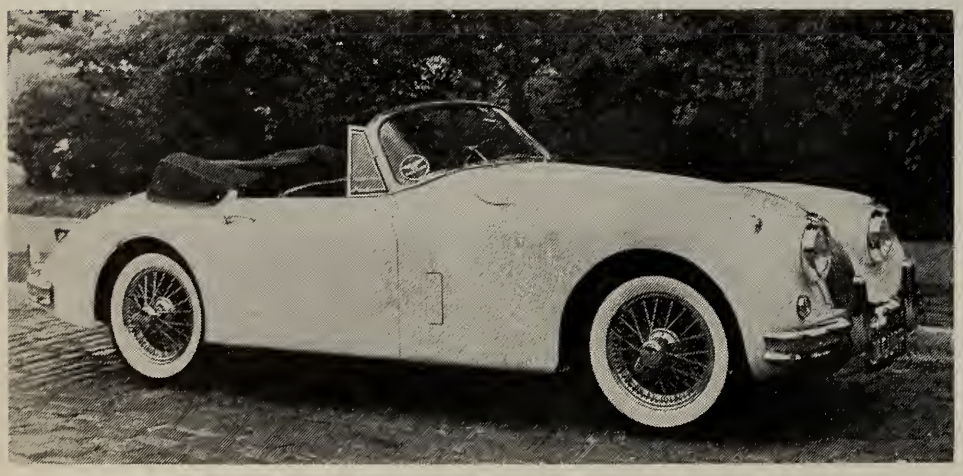
President—Everett A. Johnson, Administrator, The Methodist Hospital, Gary.
President-Elect—Wilbur C. McLin, Indianapolis.
Vice-President—Richard W. Trenkner, South Bend.
Treasurer—Edmund J. Shea, Administrator, Indiana University Medical Center, Indianapolis.
Executive Secretary—Elton Tekolste, Room 324, Illinois Bldg., 17 W. Market St., Indianapolis.

INDIANA STATE NURSES' ASSOCIATION

401 Blue Cross-Blue Shield Bldg., Indianapolis 4.
President—Florence G. Young, South Bend.
First Vice-President—Irma Bolte, Evansville.
Second Vice-President—Mrs. Dorothy Damewood, Gary.
Secretary—Ruth Longere, Indianapolis.
Treasurer—Mrs. Elizabeth Bridwell, Indianapolis.
Executive Secretary—Mrs. Helen C. Randall, R.N., 401 Blue Cross-Blue Shield Bldg., Indianapolis 4.
Professional Counseling and Placement Service, Inc.—Florence R. Brown, 401 Blue Cross-Blue Shield Bldg., Indianapolis 4.

INDIANA LEAGUE FOR NURSING, INC.

1126 N. Meridian St., Indianapolis.
President—Miss Mildred C. Boeke, Evansville College School of Nursing, Evansville. Continued



Springtime

Is Jaguar

XK 150 Time!

Drive the Jaguar XK 150 Sports Convertible

For the greatest driving adventure of your life, take the wheel of a Jaguar XK 150, the world's most famous sports car! Amazing acceleration, dazzling speed . . . with the famous Jaguar XK engine that has earned its reputation for endurance in countless international competitions. Clean, classic styling. Unmatched riding luxury. Unequalled safety with road-race-proved disc brakes. Convertible, hardtop coupe, roadster models. See also the new Jaguar 3.8 litre family sports sedan and the luxurious Mark IX. Convenient terms available.

JAGUAR

2330 NORTH MERIDIAN STREET

MIDWEST DISTRIBUTORS, Inc.

• INDIANAPOLIS

IN CONTRACEPTION...



PHOTOGRAPH: HUMAN SPERMATOZOA 400X. HEMOCYTOMETER DIFFUSION TEST.

WHY IS DIFFUSION IMPORTANT?

Because the active ingredients of a spermicidal preparation must diffuse rapidly into the seminal clot and throughout the vaginal canal to be clinically effective. Lanesta Gel offers this *dual* protection. Its four spermicidal agents quickly invade the clot to stop the main body of sperm. It spreads evenly and quickly throughout the vaginal canal—seeks out every wrinkle and fold that may offer concealment to sperm. With this rapid diffusion, your patient receives full benefit of the swift spermicidal action of Lanesta Gel — in minutes — a decisive measure in conception control.

In Lanesta Gel 7-*chloro-4-indanol,* a new, effective, nonirritating, nonallergenic spermicide, produces immediate immobilization of spermatozoa in dilution of up to 1:4,000. The addition of 10 per cent NaCl in ionic form greatly accelerates spermicidal action. Ricinoleic acid facilitates rapid inactivation and immobilization of spermatozoa and sodium lauryl sulfate acts as a dispersing agent and spermicidal detergent.

Lanesta Gel with a diaphragm provides one of the most effective means of conception control. However, whether used with or without a diaphragm, the patient and you, doctor, can be certain that Lanesta Gel provides faster spermicidal action — plus essential diffusion and retention of the spermicidal agents in a position where they can act upon the spermatozoa.

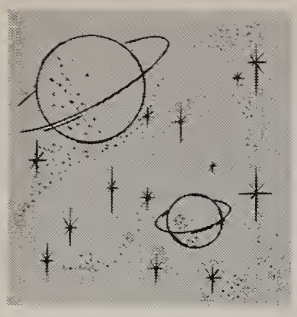


new Lanesta® Gel

Supplied: Lanesta Exquiset® . . . with diaphragm of prescribed size and type; universal introducer; Lanesta Gel, 3 oz. tube, with easy clean applicator, in an attractive purse. Lanesta Gel, 3 oz. tube with applicator; 3 oz. refill tube — available at all pharmacies.

A product of Lanteen® research.

Manufactured by Esta Medical Laboratories, Inc., Alliance, Ohio. Distributed by GEORGE A. BREON & Co., New York 18, N. Y.



VISION STIMULATES KNOWLEDGE

Truly, the age we live in is the age of vision — of far-sighted plans for a future totally different from the past. Such vision must, however, be based on past performance . . . the foundation from which to build. Just as the more than a half-century of White-Haines experience in fine ophthalmic craftsmanship is your guarantee of professional performance in the years to come.

THE White-Haines OPTICAL COMPANY
34 Modern Laboratories
OHIO • PENNSYLVANIA • MARYLAND
KENTUCKY • W. VIRGINIA • INDIANA
MICHIGAN • ILLINOIS

Professional

Continued

Secretary—Lee D. Fuller, Division of Nursing Education, Indiana University, Bloomington.
Treasurer—Dr. Isaac K. Beckes, Vincennes University, Vincennes.

INDIANA PRACTICAL NURSES' ASSOCIATION

President—Anna Paris, 5013 Caroline, Indianapolis.
First Vice-President—Mable Beavers, R. R. 5, New Castle.
Second Vice-President—Margaret Koehnke, 520 W. 2nd, Peru.
Treasurer—Gladys Davis, 404 E. 24th St., Indianapolis.
Secretary—Lucille Bryan, 230 Lincoln Way E., LaPorte.

INDIANA ASSOCIATION OF LICENSED NURSING HOMES

President—Clyde W. Turner, 515 Perry St., Vincennes.
First Vice-President—John R. Cooper, Bluffton.
Second Vice-President—Margaret L. Nickols, Muncie.
Recording Secretary—Hazel Wilson, R.N., Muncie.
Secretary-Treasurer—Emory H. Vollmer, 2630 N. College Ave., Indianapolis.

Continued

ST. PAUL FIRE and MARINE • ST. PAUL MERCURY • WESTERN LIFE •
The St. Paul Western Insurance Companies
FOUNDED 1853

CHOICE OF INDIANA STATE MEDICAL ASSOCIATION FOR PROFESSIONAL LIABILITY INSURANCE

Indiana Head Office
400 Inland Building
Indianapolis 4, Indiana
MElrose 7-1516

for your complete insurance needs . . .

☆ PROFESSIONAL
☆ PERSONAL
☆ PROPERTY

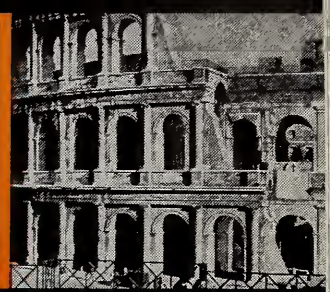
THERE IS A SAINT PAUL AGENT IN YOUR COMMUNITY AS CLOSE AS YOUR PHONE

HOME OFFICE: 385 WASHINGTON ST., ST. PAUL, MINN.

SPEED



DURATION



IN *ORAL* CONTROL OF PAIN

ACTS FASTER—usually within 5-15 minutes. **LASTS LONGER**—usually 6 hours or more. **MORE THOROUGH RELIEF**—permits uninterrupted sleep through the night. **RARELY CONSTIPATES**—excellent for chronic or bedridden patients.

AVERAGE ADULT DOSE: 1 tablet every 6 hours. May be habit-forming. Federal law permits oral prescription.

Each PERCODAN* Tablet contains 4.50 mg. dihydrohydroxycodeinone hydrochloride, 0.38 mg. dihydrohydroxycodeinone terephthalate, 0.38 mg. homatropine terephthalate, 224 mg. acetylsalicylic acid, 160 mg. phenacetin, and 32 mg. caffeine.

Also available — for greater flexibility in dosage — PERCODAN®-DEMI: The PERCODAN formula with one-half the amount of salts of dihydrohydroxycodeinone and homatropine.

Endo®

Literature? Write
ENDO LABORATORIES
Richmond Hill 18, New York

Percodan® *Tablets*

Salts of Dihydrohydroxycodeinone and Homatropine, plus APC

FOR PAIN

*U.S. Pat. 2,628,185

Indianapolis Artificial Limb Corporation

PROSTHETIC
APPLIANCES FOR LOWER AND
UPPER EXTREMITIES

MODERN FACILITY WITH
AMERICAN BOARD CERTIFICATION
CERTIFIED PROSTHETISTS



Suction Socket Limbs
Rowley Limbs
Otto Bock Locking Knee

Hosmer Plastic Arms
Miracle Arms

Crutches, Canes, Walkers, & Elastic Hosiery

Full lines of supplies for prosthesis wearers

Satisfaction Guaranteed

Doctor, when your patient is ready for a prosthetic appliance, prescribe the prosthesis desired and it will be supplied to your specifications. We have certified prosthetists with years of experience to carry out your instructions.

APPROVED CONTRACTS BY VETERANS ADMINISTRATION

Business Hours
Monday-Friday, 7 am-5 pm
Saturday, 7 am-12 noon

959 North Pennsylvania
Indianapolis 4

For information, ask for Mr. Hedges

MELROSE 4-8609

Free Parking Facilities North Side of Building

Professional

Continued

INDIANA STATE MEDICAL, DENTAL AND PHARMACEUTICAL ASSOCIATION

President—Kenneth Washington, M.D., Gary.
President-Elect—Robert Wilson, R.Ph., Indianapolis.
Vice-President—Richard H. Furgeson, Richmond.
General-Secretary—Dennis A. Bethea, M.D., Hammond.

INDIANA OCCUPATIONAL THERAPY ASSOCIATION

President—Margaret Smith, OTR, Crossroads Rehabilitation Center, Indianapolis.
Vice-President—Mariellen DeLong, Indianapolis.
Treasurer—Barbara Hamilton, Central State Hospital, Indianapolis.
Secretary—Barbara Babcock, LaRue Carter Memorial Hospital, Indianapolis.

INDIANA PHARMACEUTICAL ASSOCIATION

54 Monument Circle, Indianapolis 4.
President—O. E. Hinshaw, Elwood.
Vice-Presidents—Charles Schreiber, Tell City; Roy Haney, Muncie; Morton Wolman, Indianapolis.
Treasurer—Joseph B. Wade, Indianapolis.
Executive Secretary—L. C. Heustis, 54 Monument Circle, Indianapolis 4.

INDIANA CHAPTER, CENTRAL DISTRICT, AMERICAN PHYSICAL THERAPY ASSOCIATION

President — Otto Patton, Elkhart Rehabilitation Center, Elkhart.
Vice-President—John Lewis, South Bend.
Secretary—Robert Kennedy, St. Joseph's Hospital, Fort Wayne.
Treasurer—Louella McLaughlin, Hammond.

CENTRAL DISTRICT, INDIANA CHAPTER, AMERICAN PHYSICAL THERAPY ASSOCIATION

Chairman—Miss Carmen Julien, Supervisor of Physical Therapy, at Crossroads, Indianapolis.
Secretary—Miss Shirley Adams, Instructor in School of Physical Therapy, Indiana University Medical Center, Indianapolis.
Treasurer—Mr. Russell Lowry, Kokomo.

INDIANA PUBLIC HEALTH ASSOCIATION

President—C. T. Mayfield, D.D.S., 2012 W. Seymour, Kokomo.
President-Elect—Hester Beth Bland, H.S.D., Indianapolis.
Vice-President—Louis E. How, M.D., South Bend.
Secretary—Malcolm J. McLelland, M.S., Indiana State Board of Health, Indianapolis.
Treasurer—Samuel H. Hopper, Ph.D., School of Public Health, Indiana University Medical Center, Indianapolis. ◄

FOR ACNE

NEW pHisoAc* CREAM

Therapeutic topical application suppresses and masks lesions. Dries, peels, degerms the skin. Used with **pHisoHex®** (antiseptic detergent) washings to unplug follicles, help prevent comedones, pustules and scarring.



Teen-agers like new pHisoAc Cream. It is smooth, odorless, flesh-toned, and greaseless. It spreads and dries quickly. Ask the Winthrop representative for the special booklet, **"Teen-aged? Have acne? Feel lonely?,"** containing basic home treatment routine and psychological aid for the patient.

New pHisoAc Cream contains colloidal sulfur 6 per cent, resorcinol 1.5 per cent, hexachlorophene 0.3 per cent, orthophenylphenol 0.3 per cent, and alcohol 10 per cent (w/w). Available in 1½ oz. tubes.

*pHisoAc, trademark.

Winthrop LABORATORIES
New York 18, N. Y.

Voluntary Organizations

AMERICAN CANCER SOCIETY,
INDIANA DIVISION, INC.
215 E. New York St., Indianapolis 4.

President—William M. Krider, 401 Walnut St., Lawrenceburg.
Secretary—Mrs. Frank Wright, Sycamore Hills, Monticello.
Treasurer—Sam B. Moxley, Jr., Indianapolis.
First Vice-President and Chairman of Voluntary Services Committee—Mrs. H. P. Vonderschmitt, Bloomington.
Vice-President and Chmn., Research Committee—Marvin N. Golper, M.D., St. Joseph Memorial Hospital, Kokomo.
Vice-President and Chmn., Professional Education Committee—James M. McFadden, M.D., 35 North 25th St., Lafayette.
Vice-President and Chmn., Service Committee—Robert P. Acher, M.D., 216 E. Washington St., Greensburg.
Chairman, Crusade Committee — Wilbur Roberts, 107 Sylvia St., West Lafayette.
Chairman, Finance & Budget Committee—Albert J. Sweet, 1204 First Avenue, Evansville.
Chairman, Public Education Committee—Prof. C. W. Messersmith, 350 Sylvia St., West Lafayette.

INDIANA SOCIETY FOR CRIPPLED
CHILDREN AND ADULTS, INC.
6055 College Avenue, Indianapolis.

President—Judge Addison M. Beavers, 121 Hargrave, Boonville.
President-Elect—Fred Beckman, Fort Wayne.
Vice-President—Mrs. Floyd B. Lux, Lafayette.
Vice-President — Mrs. Frances Kubik, Michigan City.
Vice-President—Norman A. Graves, Tell City.
Secretary—Mrs. E. A. Chatham, 106 W. 4th St., Greenfield.
Treasurer—Hon. Henry F. Schricker, Indianapolis.
Executive Director—M. O. Jeglum, 6055 College Ave., Indianapolis 20.

INDIANAPOLIS DIABETES
ASSOCIATION, INC.
821 Hume Mansur Bldg., Indianapolis 4.

President—Robert L. Rudesill, M.D., 405 Hume Mansur Bldg., Indianapolis.
First Vice-President—Dale D. Dickson, M.D., Greensburg.
Second Vice-President—Walter Chroniak, M.D., Indianapolis.
Secretary—A. T. Symmes, M.D., 625 E. 38th St., Indianapolis.
Treasurer—Wm. M. Dugan, M.D., 410 Hume Mansur Bldg., Indianapolis.
Executive Secretary—Leanah McNeely, 821 Hume Mansur Bldg., Indianapolis.

INDIANA HEART ASSOCIATION
Room 112, English Foundation Bldg., 615 N. Alabama Street, Indianapolis 4.

President—Robert Yoho, Hs.D., Indianapolis.
Vice-President—Richard M. Nay, M.D., Indianapolis.
Secretary—Mrs. Georgine Hardwick, Jasper.
Treasurer—William P. Flynn, Indianapolis.
Executive Director—Robert H. Patty, Indianapolis.

INDIANA ASSOCIATION
FOR MENTAL HEALTH
Room 334 English Foundation Bldg., Indianapolis 4.

President—Lowell E. Engelking, Bartholomew.
First Vice-President—Mrs. Wilbur F. Pell, Shelby.
Second Vice-President — Mrs. John Kirkpatrick, Carroll.
Third Vice-President—Grant E. Metcalfe, M.D., St. Joseph.
Secretary—Miss Katherine Hamilton, Vigo.
Treasurer—Paul L. Boardman, Marion.

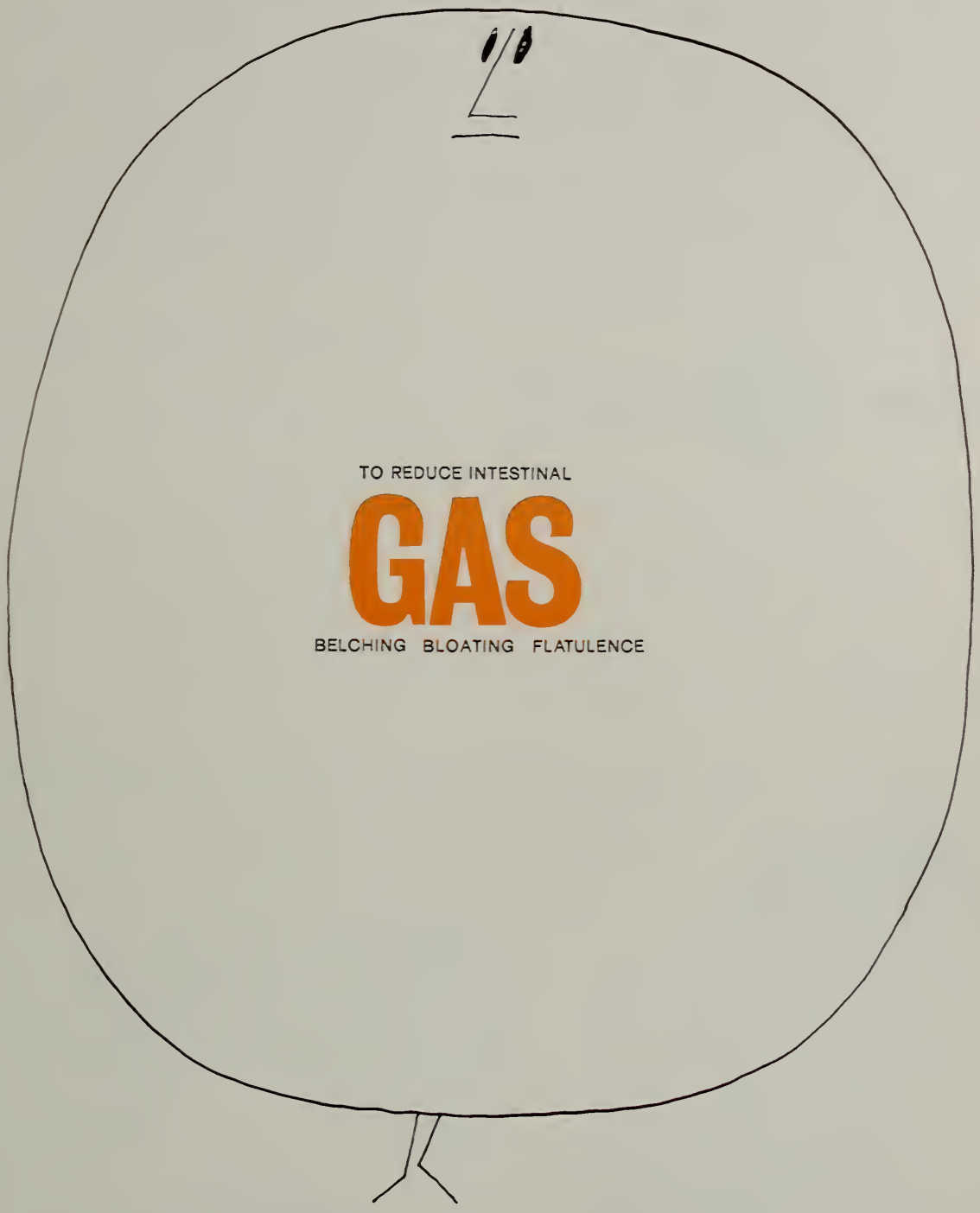
INDIANA CHAPTER, NATIONAL
MULTIPLE SCLEROSIS SOCIETY
Room 222, English Foundation Bldg., 615 N. Alabama St., Indianapolis 4.

Chairman—Clay Conner, Aetna Casualty & Surety Co., Glendale Shopping Center, Indianapolis.
Vice-Chairman—Mrs. Ronald M. Hazen, Indianapolis.
Vice-Chairman — Walter A. Letzler, Jr., Greencastle.
Vice-Chairman—Donald Ramsey, Muncie.
Vice-Chairman—V. L. Tatlock, Terre Haute.
Secretary—Frank Rexroth, 201 Massachusetts Ave., Indianapolis.
Treasurer—Mrs. G. G. Storms, R. R. 1, Zionsville.
Treasurer—Richard Whittington, American Fletcher National Bank, 45 N. Pennsylvania St., Indianapolis.
Chairman Medical Advisory Board—Alexander Ross, M.D., Indiana University Medical Center, 1100 W. Michigan St., Indianapolis.
Executive Director—Mrs. Robert J. Shultz, 615 N. Alabama St., Room 222, Indianapolis.

THE NATIONAL FOUNDATION
(Originally The National Foundation for Infantile Paralysis)
966 N. Meridian St., Indianapolis.

State Representative, Western District—Larry Eberlein.
State Representative, Eastern District—Lonnie W. Boyers.
State Representative, Southern District—Stuart Schlageter, 148 East Spring St., New Albany.

Continued



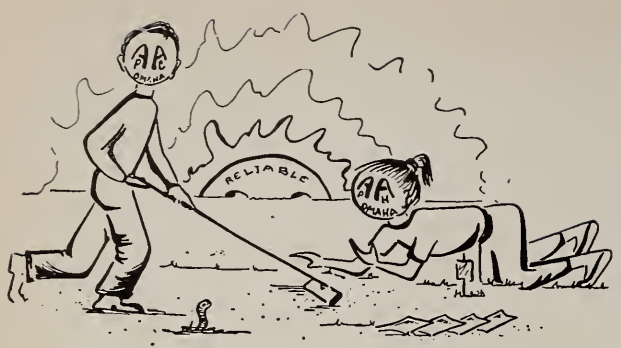
A biochemical compound used to diminish intestinal gas in healthy persons and those patients having digestive disorders ■

KANULASE

Each Kanulase tablet contains Dorase,* 320 units, combined with pepsin, N.F., 150 mg.; glutamic acid HCl, 200 mg.; pancreatin, N.F., 500 mg.; oxbile extract, 100 mg. Dosage: 1 or 2 tablets at mealtime. Supplied: Bottles of 50 tablets.

*DORSEY BRAND OF CELLULASE, EXPRESSED AS DIGESTIVE ACTIVITY UNITS

SMITH-DORSEY • a division of The Wander Company • Lincoln, Nebraska



PROTECTION AGAINST LOSS OF INCOME FROM ACCIDENT & SICKNESS AS WELL AS HOSPITAL EXPENSE BENEFITS FOR YOU AND ALL YOUR ELIGIBLE DEPENDENTS

ALL PREMIUMS COME FROM — PHYSICIANS SURGEONS DENTISTS — ALL BENEFITS GO TO

PHYSICIANS CASUALTY & HEALTH ASSOCIATIONS

OMAHA 31, NEBRASKA

Since 1902

Handsome Professional Appointment Book Sent to you FREE upon request.

Voluntary

Continued

INDIANA TRUDEAU SOCIETY

President—D. F. MacLeod, M.D., West Lafayette.

President-Elect—Paul C. Burnett, M.D., State Hospital, Logansport.

Vice-President—William C. von der Lieth, M.D., Vincennes.

Secretary-Treasurer—Warren S. Tucker, M.D., 414 Hume Mansur Bldg., Indianapolis 4.

Executive Secretary—Chester D. Kelly, 130 E. Washington St., Room 821, Indianapolis 4.

INDIANA TUBERCULOSIS ASSOCIATION

130 E. Washington St., Room 821, Indianapolis 4.

President—R. C. Swan, M.D., Anderson.

First Vice-President—Rev. G. L. Kleespie, Columbia City.

Second Vice-President—J. F. W. Stewart, M.D., Vincennes.

Secretary—Mrs. Geoffrey Carmichael, Bloomington.

Treasurer—Warren S. Tucker, M.D., Indianapolis.

Assistant Treasurer—Joe K. White, Noblesville.

Executive Secretary—Chester D. Kelly, 130 E. Washington St., Indianapolis 4. ◄



INDIANA UNIVERSITY SCHOOL OF MEDICINE

1100 W. Michigan Street, Indianapolis

John D. Van Nuys, M.D., Indianapolis—Dean

HEADS OF DEPARTMENTS

Department of Anatomy—Warren Andrew, M.D., Ph.D., Indianapolis.

Department of Physiology—Ewald E. Selkurt, Ph.D., Indianapolis.

Department of Biochemistry—Donald E. Bowman, Ph.D., Indianapolis.

Department of Public Health—Samuel H. Hopper, Ph.D., Indianapolis.

Department of General Pathology — Edward B. Smith, M.D., Indianapolis.

Department of Microbiology—Edward W. Shrigley, M.D., Ph.D., Indianapolis.

Department of Clinical Pathology—C. G. Culbertson, M.D., Indianapolis.

Department of Orthopedic Surgery—George Garceau, M.D., Indianapolis.

Department of Surgery — Harris B. Shumacker, Jr., M.D., Indianapolis.

Department of Medicine—John B. Hickam, M.D.

Department of Neurology — Alexander T. Ross, M.D., Indianapolis.

Department of Psychiatry—John I. Nurnberger, M.D., Indianapolis.

Department of Radiology—John A. Campbell, M.D., Indianapolis.

Department of Obstetrics and Gynecology—Carl P. Huber, M.D., Indianapolis.

Department of Otorhinolaryngology and Bronchoesophagology—Marlow Manion, M.D., Indianapolis.

Department of Ophthalmology—Fred M. Wilson, M.D., Indianapolis.

Department of Urology—Robert A. Garrett, M.D., Indianapolis.

Department of Pharmacology—(Acting).

Department of Pediatrics—Lyman T. Meiks, M.D., Indianapolis.

Department of Anesthesiology—Vergil K. Stoelting, M.D., Indianapolis.

INDIANA UNIVERSITY MEDICAL CENTER

1100 W. Michigan Street
Indianapolis

Administrator—Mr. Edmund J. Shea.

Medical Director—W. D. Close, M.D.

Director of Clinical Laboratories—J. L. Arbogast, M.D.

Chief Radiologist—J. A. Campbell, M.D. ◄



Pharmaceutical, Biological and Diagnostic Products For The Medical Profession

ORTHO PHARMACEUTICAL CORPORATION

Raritan, New Jersey

INDIANA STATE BOARD OF NURSES' REGISTRATION AND NURSING EDUCATION
307 Ober Building, 38 North Pennsylvania Street, Indianapolis, Indiana

LIST OF INDIANA ACCREDITED SCHOOLS OF NURSING

July 1, 1959

School of Nursing and Hospital, University or College with which School is connected	Location	Director School of Nursing	Daily Avg. Patient Census
xxx Evansville College	Evansville	Miss Mildred C. Boeke, R.N.	
Protestant Deaconess	Evansville	Miss Irma M. Bolte, R.N., Dir. of Nsg. Education	283.56
St. Mary's	Evansville	Sister Catherine, R. N.	292.3
Lutheran	Fort Wayne	Miss Marie E. Moehring, R.N.	289
Parkview-Methodist	Fort Wayne	Miss Marie Kolter, R.N.	235.53
St. Joseph's	Fort Wayne	Sister M. Theodorita, R.N.	248.5
Methodist	Gary	Mrs. Dorothy M. Damewood, R.N.	240
St. Mary Mercy	Gary	Mrs. Barbara Riblon, R.N.	275
xxx Goshen College	Goshen	Miss Orpah B. Mosemann, R.N.	
xxx DePauw University	Greencastle	Mrs. Catherine M. Friddle, R.N.	
St. Margaret	Hammond	Sister M. Huberta, R.N.	339
AD Indiana Central College	Indianapolis	Miss Virginia R. Sims, R.N.	
xxx Indiana University	Indianapolis	Miss Emily Holmquist, R.N., Dean	457.9
Marion County General	Indianapolis	Mrs. Thelma L. Richardson, R.N.	590
Methodist	Indianapolis	Miss Fredericka E. Koch, R.N.	710
St. Vincent's	Indianapolis	Sister Virginia, R.N.	282
St. Elizabeth	Lafayette	Sister M. Florianne, R.N.	235
Ball Memorial	Muncie	Miss Mary Johnson, R.N.	294.52
** xxx St. Mary's College	Notre Dame	Sister M. Bartholomew, R.N.	181
Holy Cross Central	South Bend	Sister M. Nicholas, R.N.	
410 N. Notre Dame Avenue, South Bend 22			
Unit Hospitals of the Central School:			
St. Joseph Hospital	South Bend		181
St. John's Hospital	Anderson		253
St. Joseph Memorial	Kokomo		148
Memorial	South Bend	Miss Florence G. Young, R.N.	231
St. Anthony	Terre Haute	Sister M. Alvera, R.N.	227
Union	Terre Haute	Miss Prudence Appelman, R.N.	212
AD Vincennes University	Vincennes	Miss Genevieve C. Rutski, R. N.	

xxx Collegiate program in nursing.
AD Associate degree program in nursing.
** School is closing



WABASH VALLEY SANITARIUM—HOSPITAL

Lafayette, Indiana
Telephone Riverside 3-1679

A hospital for the treatment of neuro-psychiatric disorders.

Custodial cases are accepted in limited numbers.

— OPEN STAFF —

DONALD R. KINZER
Manager



in infectious disease[17,22,30,36]
in arthritis[18,19,20,29]
in hepatic disease[2,3,4,5,38]
in malabsorption syndrome[1,2,6,27]
in degenerative disease[6,7,19,20,40]
in cardiac disease[23,28,29,38,41]
in dermatitis[24,39]
in peptic ulcer[8,21,38]
in neuroses & psychiatric disorders[25,26]
in diabetes mellitus[31,32,33,38]
in alcoholism[9,11,35,37,38]
in ulcerative colitis[10,14,16]
in osteoporosis[13,19,20]
in pancreatitis[15]
in female climacteric[12,34]

Patients with chronic disease deserve the nutritional support provided by

Theragran-M

Squibb Vitamin-Minerals for Therapy

11 vitamins, 8 minerals
clinically-formulated and potency protected to provide
enough nutritional support
to do some good

with vitamins only
Theragran
also available:
Theragran Liquid
Theragran Junior

1-41 a list of the above references will be supplied on request.

SQUIBB

Squibb Quality—the Priceless Ingredient

"THERAGRAN"® IS A SQUIBB TRADEMARK

INDIANA ACCREDITED PRACTICAL NURSE SCHOOLS

Practical Nursing School of the Fort Wayne Community Schools, Forest Park School——Fort Wayne	Mrs. Dorothy Knoefel, R.N.——
Purdue University, Calumet Center—Hammond	Miss Mary Ruth Maginsky, R.N.——
School of Practical Nursing, Indianapolis Public Schools——Indianapolis	Miss Fern A. Goulding, R.N.——
Grant School of Practical Nursing, Marion City Schools——Marion	Mrs. Geraldine Huber, R.N. (Instructor & Supervisor) ——
Muncie School of Practical Nursing——Muncie	Mrs. Wilma Whetsell, R.N.——
South Bend School of Practical Nursing, School City of South Bend——South Bend	Mrs. Roma Vermande, R.N. (Instructor-Supervisor) ——

* Furnished by INDIANA STATE BOARD OF NURSES' REGISTRATION AND NURSING EDUCATION, 307 Ober Building, 38 North Pennsylvania Street, Indianapolis, Indiana.

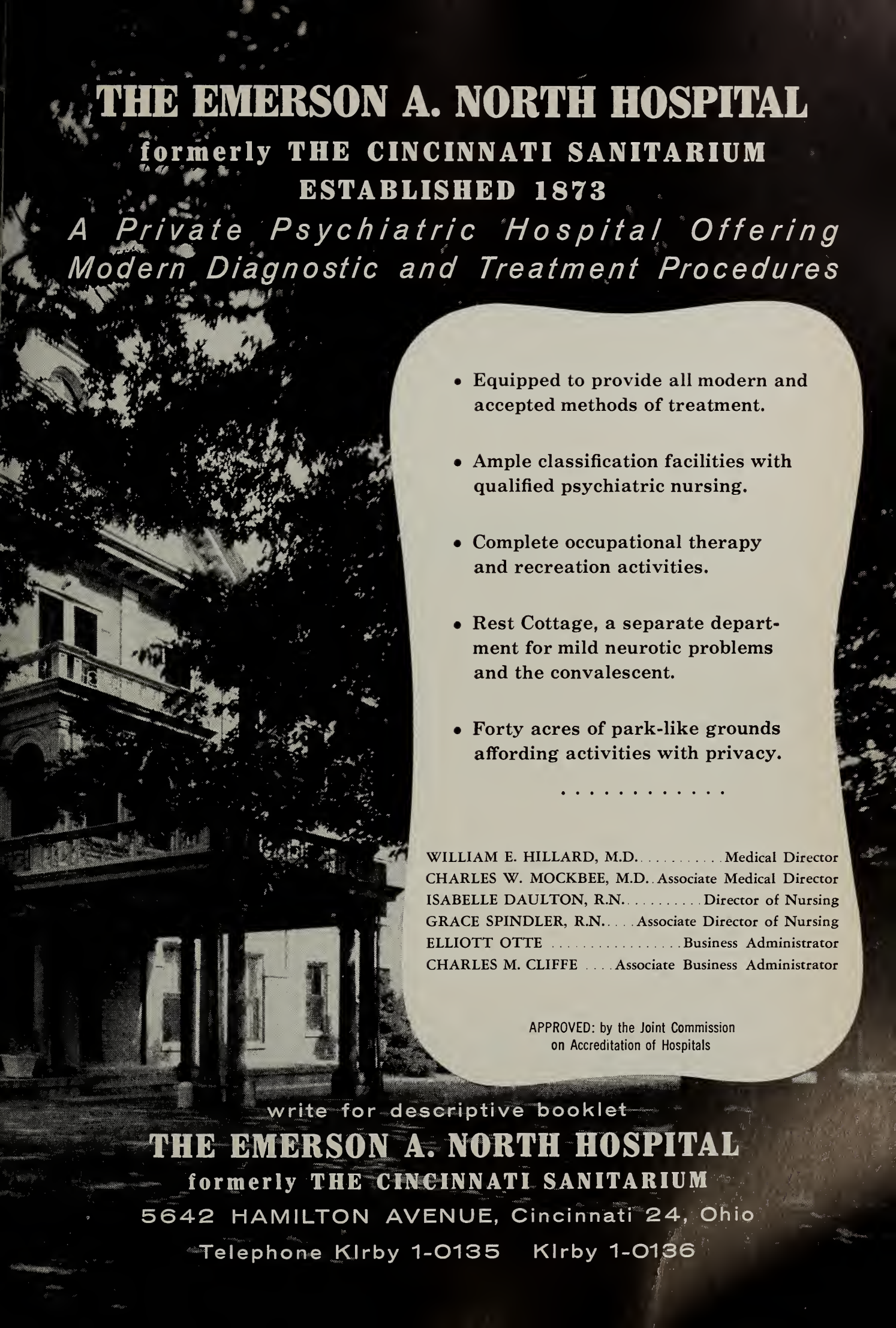


BUY IT BY THE CARTON

PEPSI-COLA NOW COMES IN TWO SIZE BOTTLES

Be Sociable, Have a Pepsi

Pepsi-Cola Bottling Co., Indianapolis, Ind.



THE EMERSON A. NORTH HOSPITAL

formerly THE CINCINNATI SANITARIUM

ESTABLISHED 1873

A Private Psychiatric Hospital Offering Modern Diagnostic and Treatment Procedures

- Equipped to provide all modern and accepted methods of treatment.
- Ample classification facilities with qualified psychiatric nursing.
- Complete occupational therapy and recreation activities.
- Rest Cottage, a separate department for mild neurotic problems and the convalescent.
- Forty acres of park-like grounds affording activities with privacy.

. . . . . .

WILLIAM E. HILLARD, M.D. . . . . Medical Director
CHARLES W. MOCKBEE, M.D. . Associate Medical Director
ISABELLE DAULTON, R.N. . . . . Director of Nursing
GRACE SPINDLER, R.N. . . . . Associate Director of Nursing
ELLIOTT OTTE . . . . . Business Administrator
CHARLES M. CLIFFE . . . . Associate Business Administrator

APPROVED: by the Joint Commission on Accreditation of Hospitals

write for descriptive booklet

THE EMERSON A. NORTH HOSPITAL

formerly THE CINCINNATI SANITARIUM

5642 HAMILTON AVENUE, Cincinnati 24, Ohio

Telephone KIrby 1-0135 KIrby 1-0136

APPROVED HOSPITALS IN INDIANA*

April 1, 1960

ADAMS COUNTY

Adams County Memorial Hospital.
804 Mercer Ave., Decatur.
Thurman I. Drew, Adm.

ALLEN COUNTY

Parkview Memorial Hospital, Inc.
2200 Randalia Dr., Fort Wayne.
Stanley R. Nelson, Adm.

Irene Byron Hospital
R. R. 13, Lima Road North, Fort Wayne
O. T. Kidder, M.D., Adm. & Med. Dir.

The Lutheran Hospital of Fort Wayne.
3024 Fairfield Ave., Fort Wayne.
Edgar C. Kruse, Adm.

St. Joseph Hospital.
730 W. Berry St., Fort Wayne.
Sister M. Odillia, Adm.

BARTHOLOMEW COUNTY

Bartholomew County Hospital.
2400 East 17th St., Columbus.
Miss Olive M. Murphy, R.N., Adm.

BLACKFORD COUNTY

Blackford County Hospital.
503 E. Van Cleve St., Hartford City.
Mrs. Mabel Brown, Adm.

BOONE COUNTY

Witham Memorial Hospital.
1124 N. Lebanon St., Lebanon.
A. L. Maines, Adm.

CASS COUNTY

Memorial Hospital.
1101-1115 Michigan Ave., Logansport.
Howard R. Jones, Jr., Adm.

St. Joseph Hospital.
26th and North Sts., Logansport.
Sister M. Geranda, Adm.

CLARK COUNTY

Clark County Memorial Hospital.
210 Sparks Ave., Jeffersonville.
Mr. William McAlexander, Adm.

CLAY COUNTY

Clay County Hospital.
1206 E. National Ave., Brazil.
Mr. Karl J. Dickerson.

CLINTON COUNTY

Clinton County Hospital.
1300 S. Jackson St., Frankfort
William Russell, Adm.

DAVIESS COUNTY

Daviess County Hospital.
1307 Bedford Road, Washington.
Mr. Lawrence Trousdale, Adm.

DEARBORN COUNTY

Dearborn County Hospital.
State Route 48, Lawrenceburg.
Mr. Robert D. Shaffer, Adm.

DECATUR COUNTY

Decatur County Memorial Hospital.
720 N. Lincoln St., Greensburg.
William D. Gibson, Adm.

DEKALB COUNTY

Dr. Bonnell M. Souder Hospital.
206 W. 7th St., Auburn.
Bonnell M. Souder, M.D., Adm.

Sanders General Hospital.
1007 S. Main St., Auburn.
Jesse A. Sanders, M.D., Adm.

DELAWARE COUNTY

Ball Memorial Hospital.
2401 University Ave., Muncie.
Walter G. Ebert, Adm.

DUBOIS COUNTY

Memorial Hospital of Dubois County.
800 West 9th St., Jasper.
Mother M. Catherine, Adm.

The Stork Memorial Hospital.
530 4th St., Huntingburg.
Sister Mary James, Adm.

ELKHART COUNTY

Elkhart General Hospital.
600 East Boulevard, Elkhart.
Emery K. Zimmerman, Adm.

Goshen General Hospital.
200 High Park Avenue, Goshen.
Mrs. Lois Ulery, R.N., Adm.

FAYETTE COUNTY

Fayette Memorial Hospital.
1941 Virginia Ave., Connersville.
Richards M. Manuel, Adm.

FLOYD COUNTY

Memorial Hospital of Floyd County
1850 State St., New Albany.
William I. Fender, Jr., Adm.

St. Edward Hospital.
703 E. Spring St., New Albany.
Sister M. Leonarda, Adm.

Silvercrest, New Albany.
(Southern Indiana Tuberculosis Hospital)
Joseph H. Geyer, M.D., Adm.

FULTON COUNTY

Woodlawn Hospital.
624 Pontiac St., Rochester.
Miss Bernice I. Rannells, R.N., Adm.

GIBSON COUNTY

Gibson General Hospital.
419 W. State St., Princeton.
Mrs. Dorothy G. Adams, R.N., Adm.

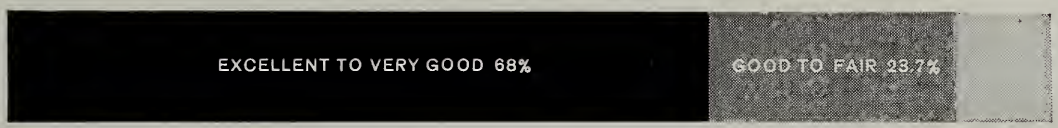
Continued on page 998

* Approved by the Indiana Council for Hospital Licensure and the Indiana State Board of Health.

relieves both stiffness and pain with safety... sustained effect

In 100 consecutive patients with the low back syndrome, Kestler[1] reported that particularly gratifying was the ability of SOMA "to relax muscular spasm, relieve pain, and restore normal movement, thus speeding recovery in a large majority of the patients."

RESULTS WITH SOMA IN THE LOW BACK SYNDROME*



*Investigators' reports to the Medical Department, Wallace Laboratories. (Total of 278 cases)

NOTABLE SAFETY—extremely low toxicity; no known contraindications; side effects are rare; drowsiness may occur, usually at higher dosage

RAPID ACTION—starts to act quickly **SUSTAINED EFFECT**—relief lasts up to 6 hours

EASY TO USE—usual adult dosage is one 350 mg. tablet 3 times daily and at bedtime

SUPPLIED—as white, coated, 350 mg. tablets, bottles of 50; also available for pediatric use: 250 mg., orange capsules, bottles of 50

1. Kestler, O.: In The Pharmacology and Clinical Usefulness of Carisoprodol, Wayne State University Press, Detroit, 1959. 2. Berger, F. M.; Kletzkin, M.; Ludwig, B. J.; Margolin, S., and Powell, L. S.: J. Pharm. Exp. Ther. *127*:66 (Sept.) 1959. 3. Spears, C. E. and Phelps, W. M.: Arch. Pediat. *76*:287 (July) 1959. 4. Phelps, W. M.: Arch. Pediat. *76*:243 (June) 1959. 5. Friedman, A. P.; Frankel, K., and Fransway, R. L.: Papers presented at Scientific Meeting, New York State Society of Industrial Medicine, Inc., New York, Sept. 30, 1959. 6. Kuge, T.: Unpublished reports. 7. Ostrowski, J. P.: Orthopedics *2*:7 (Jan.) 1960.

Literature and samples on request

Also available on request: The Pharmacology and Clinical Usefulness of Carisoprodol, Wayne State University Press, Detroit, 1959. (185 pages)

SOMA™

(carisoprodol Wallace)

WALLACE LABORATORIES, New Brunswick, New Jersey

Approved Hospitals Continued

GRANT COUNTY

Marion General Hospital.
Wabash and Euclid, Marion.
Gordon S. Boughton, Adm.

GREEN COUNTY

Freeman Greene County Hospital.
410 "A" St., N.E., Linton.
Avery Murray, Adm.

HAMILTON COUNTY

Riverview Hospital.
R.R. 4, Noblesville
John Keilholz, Adm.

HANCOCK COUNTY

Hancock County Memorial Hospital.
800 North State Street, Greenfield.
C. L. Morris, Adm.

HARRISON COUNTY

Harrison County Hospital.
Corydon.
Mrs. Pauline Churchill, R.N., Adm.

HENRY COUNTY

Henry County Hospital.
Rural St., New Castle.
Herbert A. Schacht, Adm.

The Clinic.
1319 Church St., New Castle.
Walter M. Stout, M.D., Adm.

HOWARD COUNTY

St. Joseph Memorial Hospital.
1907 W. Sycamore St., Kokomo.
Sister Ann Rita, Adm.

HUNTINGTON COUNTY

Huntington County Hospital.
1215 Etna Ave., Huntington.
Carl S. Smyth, Adm.

JACKSON COUNTY

Jackson County Schneck Memorial.
Bruce and Poplar St., Seymour.
Ralph W. Keyes, Adm.

JASPER COUNTY

Jasper County Hospital.
216-224 S. Cullen St., Rensselaer.
Mrs. Ruth Schumaker, R.N., Adm.

JAY COUNTY

Jay County Hospital.
505 W. Arch St., Portland.
Thomas Broderick, Adm.

JEFFERSON COUNTY

King's Daughters' Hospital.
112 Presbyterian Ave., Madison.
Walter Bailey, Adm.

JOHNSON COUNTY

Johnson County Memorial Hospital.
R.R. 1, Franklin.
George P. Goshorn, Adm.

KNOX COUNTY

Good Samaritan Hospital.
410 S. 7th St., Vincennes.
Albert L. Boulenger, Adm.

Hillcrest Tuberculosis Hospital.
North 2nd St. Road, Vincennes.
J. Frank W. Stewart, M.D., Adm.

KOSCIUSKO COUNTY

Murphy Medical Center.
101 W. Winona Ave., Warsaw.
Mrs. June Schick, Adm.

LAGRANGE COUNTY

LaGrange County Hospital.
West Michigan St., LaGrange.
Miss Edythe L. Gappinger, R.N., Adm.

LAKE COUNTY

James O. Parramore Hospital.
R. R. 5, Crown Point.
Philip H. Becker, M.D., Adm.

The Methodist Hospital of Gary, Inc.
1600 W. 6th Ave., Gary.
Everett A. Johnson, Adm.

Our Lady of Mercy Hospital.
Lincoln Highway, Dyer.
Sister M. Clementia, Adm.

St. Catherine Hospital.
4321 Fir St., East Chicago.
Sister M. Vetusa, R.N., Adm.

St. Margaret Hospital.
25 Douglas St., Hammond.
Sister M. Delphina, R.N., Adm.

St. Mary's Mercy Hospital.
540 Tyler St., Gary.
Sister M. Cornelia, Adm.

LAPORTE COUNTY

Doctor's Hospital.
125 E. 5th St., Michigan City.
Miss Mildred Goers, Adm.
Myron N. Whitford, Dir.

Community Hospital of LaPorte, Inc.
215 Pine Lake Ave., LaPorte.
Mr. L. H. Furlong, Adm.

Holy Family Hospital.
205 "E" St., LaPorte.
Sister M. Justine, Adm.

St. Anthony Hospital.
Wabash and Ann Sts., Michigan City.
Sister M. Regis, Adm.

Warren Hospital, Inc.
719 Franklin St., Michigan City.
Stanley E. Giese, Adm.

LAWRENCE COUNTY

Dunn Memorial Hospital.
1616 23rd St., Bedford.
Mrs. Helen Boyer, R.N., Adm.

MADISON COUNTY

Citizens Nursing Center.
431 Citizens Bank, Anderson.
Miss Clara M. Lenz, R.N., Adm.

Mercy Hospital.
1331 South "A" St., Elwood.
Sister M. Andrea, R.N., Adm.

St. John's Hickey Memorial Hospital.
127 W. 19th St., Anderson.
Sister Mary, Adm.

Continued



because their physician has kept the twins well nourished, healthy, and **free from diaper rash**

with **DESITIN®**
OINTMENT

Protects against irritation of urine and excrement; markedly inhibits ammonia-producing bacteria; soothes, lubricates, stimulates healing.

For samples of Desitin Ointment, pioneer external cod liver oil therapy, write...

DESITIN CHEMICAL COMPANY
812 Branch Avenue, Providence 4, R. I.

Approved Hospitals Continued

MARION COUNTY

Community Hospital of Indianapolis.
16th & Ritter Ave., Indianapolis.
W. C. McLin, Adm.

Marion County General Hospital.
960 Locke St., Indianapolis.
Arvine G. Popplewell, M.D., Adm.

Indiana University Medical Center Hospitals.
1100 W. Michigan St., Indianapolis.
Edmund J. Shea, Adm.

Memorial Clinic of Indianapolis.
3202 N. Meridian St.
Mrs. Mildred Jane Williams, R.N., Adm.

Methodist Hospital of Indiana, Inc.
1604 N. Capitol Ave., Indianapolis.
Jack A. L. Hahn, Adm.

St. Elizabeth's Maternity Hospital and Infant Home.
2500 Churchman Ave., Indianapolis.
Right Rev. August R. Fussenegger, Adm.

St. Francis Hospital.
Sherman Drive and Troy Ave., Beech Grove.
Sister Vincentiana, Adm.

St. Vincent's Hospital.
120 W. Fall Creek Parkway, Indianapolis.
Sister Scholastica, Adm.

Marion County Tuberculosis Hospital.
Sunnyside Sanatorium, R.R. 12, Box 233, Indianapolis.
John D. Miller, M.D., Adm. & Med. Dir.

MARSHALL COUNTY

Community Hospital of German Township, Inc.
411 Grant St., Bremen.
Mrs. Mary Harris, Adm.

Parkview Hospital.
1401 N. Michigan St., Plymouth.
Miss Lela Diefenbaugh, R.N., Adm.

MIAMI COUNTY

Dukes Memorial Hospital.
275 West 12th St., Peru.
Jack G. Fougerousse, Adm.

Wabash Employees Hospital Association.
North Broadway, Peru.
Mr. W. E. Gollings, Adm.
c/o Miss Bernice Pierson, Supervising Nurse

MONROE COUNTY

Bloomington Hospital.
640 S. Rogers St., Bloomington.
John H. Shepherd, Adm.

MONTGOMERY COUNTY

Montgomery County Culver Union Hospital.
308 Binford St., Crawfordsville.
Ralph M. Haas, Adm.

MORGAN COUNTY

Comer Hospital.
130 N. Indiana St., Mooresville.
K. E. Comer, M.D., Adm.

Morgan County Memorial Hospital.
St. Rd. 252, Martinsville.

NOBLE COUNTY

McCray Memorial Hospital.
Hospital Drive, Kendallville.
Elizabeth L. Blaylock, Adm.

ORANGE COUNTY

Orange County Hospital.
Sandy Hook Road, Paoli.
Chesney D. Malone, Adm.

PARKE COUNTY

Indiana State Sanatorium.
R.R. 1, Rockville.
J. V. Pace, M.D., Adm.

PERRY COUNTY

Perry County Memorial Hospital.
Star Route, Tell City, Ind.
Eugene J. Saxton, Adm.

PORTER COUNTY

Porter Memorial Hospital.
814 LaPorte Ave., Valparaiso.
Arthur S. Malasto, Adm.

PUTNAM COUNTY

Putnam County Hospital.
322 Greenwood Ave., Greencastle.
James F. Shepherd, Adm.

RANDOLPH COUNTY

Randolph County Hospital.
Oak Street, Winchester.
Vernon W. Hyer, Adm.

Union City Memorial Hospital Association.
North Columbia St., Union City.
Miss Kathryn E. Larrance, Adm.

RIPLEY COUNTY

Margaret Mary Hospital.
Rosemont Division, Batesville.
Sister M. Felicitas, R.N., Adm.

RUSH COUNTY

Rush Memorial Hospital.
Main at 13th St., Rushville.
Miss Nina Basso, R.N., Adm.

SCOTT COUNTY

Scott County Memorial Hospital.
Highway 31, North, Scottsburg.
James K. Fisler, Adm.

SHELBY COUNTY

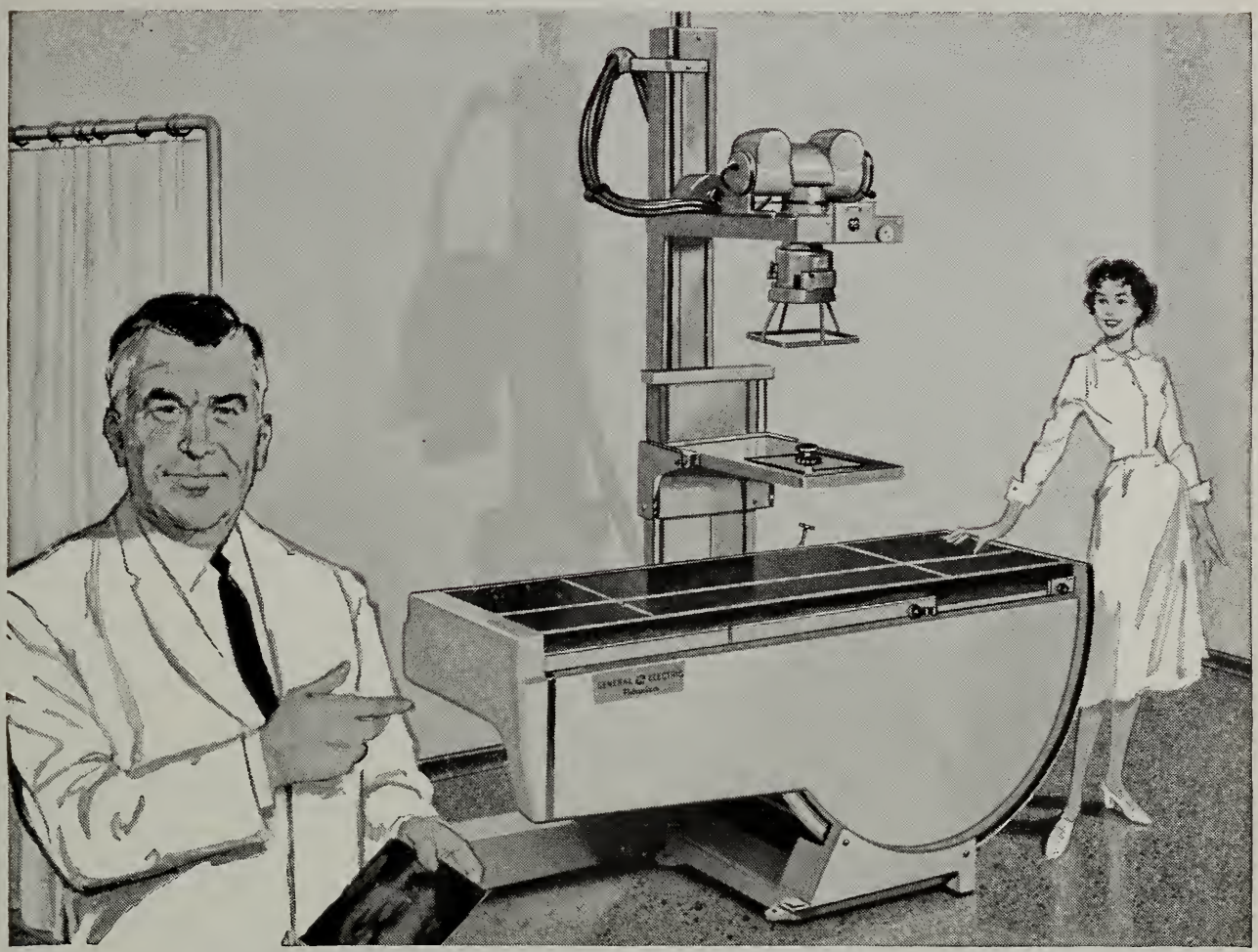
William S. Major Hospital.
150 W. Washington St., Shelbyville.
Richard W. Gerard, Adm.

ST. JOSEPH COUNTY

Healthwin Hospital.
20531 West Darden Road, South Bend.
E. W. Custer, M.D., Adm.

Continued

The choice of confidence...



diagnostic x-ray equipment planned for private practice!

Few who purchase x-ray equipment have time to thoroughly test the quality of materials, workmanship and technical performance offered by all the makes of x-ray units. And happily this is not necessary.

The manufacturer's *reputation* is worth more than anything else to you in choosing x-ray equipment, one of the most complex professional investments you will ever face.

General Electric has created "just what the doctor ordered" in the 200-ma Patrician, in terms of both reasonable cost and operating qualities. Here diagnostic x-ray is ideally tailored to *private practice.* Patrician provides everything you need for radiography and fluoroscopy — and with consistent end results, since precise radiographic calibration is as much a part of the Patrician combination as it is of our most elaborate installations. For complete details contact your G-E x-ray representative listed below.

Progress Is Our Most Important Product

GENERAL ELECTRIC

DIRECT FACTORY BRANCHES

CHICAGO
1061 W. Jackson Blvd. • SEeley 3-0700
CINCINNATI
3056 W. McMicken Ave. • MUlberry 1-7230—31
INDIANAPOLIS
1845 W. 18th St. • MElrose 5-4576
LOUISVILLE
501 W. Oak St. • JUniper 3-9562

RESIDENT REPRESENTATIVES

FORT WAYNE
H. J. Wallace • 918 Oakdale • Kenmore 9749

Approved Hospitals Continued

Memorial Hospital of South Bend.
615 N. Michigan St., South Bend.
Richard W. Trenkner, Adm.

Northern Indiana Children's Hospital.
1234 N. Notre Dame Ave., South Bend.
Donald M. Hippensteel, Supt.

St. Joseph Hospital.
215 W. 4th St., Mishawaka
Sister M. Reginalda, Adm.

St. Joseph's Hospital.
811 E. Madison St., South Bend.
Sister M. Michaeleen, Adm.

South Bend Osteopathic Hospital.
2515 E. Jefferson Blvd., South Bend.
A. F. Kull, D.O., Adm.

STARKE COUNTY

Little Company of Mary Hospital and Home for Chronically Ill, Inc.
San Pierre, Ind.
Mother M. Eugene, Adm.

Starke Memorial Hospital.
Culver Road, Knox.
Lynn L. Landis, Adm.

STEUBEN COUNTY

Cameron Hospitals, Inc.
416 E. Maumee, Angola.
Mrs. Daisy McCallister, R.N., Adm.

Elmhurst Hospital, Inc.
909 W. Maumee, Angola.
Mr. Robert J. Kulsar.

SULLIVAN COUNTY

Mary Sherman Hospital.
320 N. Section St., Sullivan.
S. C. Cunningham, Adm.

TIPPECANOE COUNTY

Indiana State Soldiers Home Hospital
Lafayette
Col. Herman Schmitz, Commandant.

Lafayette Home Hospital, Inc.
2400 E. South St., Lafayette.
Franklin E. Simek, Adm.

St. Elizabeth Hospital.
1021 N. 14th St., Lafayette.
Sister M. Mirella, Adm.

William Ross Sanatorium.
R.R. 6, State Road No. 52, Lafayette.
J. W. Strayer, M.D., Adm.

TIPTON COUNTY

Tipton County Memorial Hospital.
1032 South Main Street, Tipton.
James C. Talley, Adm.

VANDERBURGH COUNTY

Boehne Tuberculosis Hospital.
Upper Mount Vernon Road, Zone 12, Evansville.
Paul D. Crimm, M.D., Adm.

Protestant Deaconess Hospital.
600-700 Mary St., Evansville.
Albert G. Hahn, L.H.D., Adm.

St. Mary's Hospital, Inc.
3700 Washington Ave., Evansville.
Sister Elizabeth, Adm.

Welborn Memorial Baptist Hospital, Inc.
412 S.E. 4th St., Evansville.
Nolan R. Lackey, Adm.

VERMILLION COUNTY

Vermillion County Hospital.
800 S. Main St., Clinton.
Miss Beulah Fisher, R.N., Adm.

VIGO COUNTY

St. Anthony Hospital.
1021 S. 6th St., Terre Haute.
Sister M. Amelia, R.N., Adm.

Union Hospital, Inc.
7th St. at 8th Ave., Terre Haute.
Miss Ellen E. Church, R.N., Adm.

WABASH COUNTY

Wabash County Hospital.
670 N. East St., Wabash.
Richard G. Shedd, Adm.

WARREN COUNTY

The Community Hospital.
412 N. Monroe St., Williamsport.
Mrs. Nellie O. Rudolph, Adm.

WASHINGTON COUNTY

Washington County Memorial Hospital.
Shelby Street, Salem.
Harry M. Voyles, Adm.

WAYNE COUNTY

Reid Memorial Hospital.
Spring Grove, Richmond.
Mr. G. Dale Splitstone.

WELLS COUNTY

Clinic Hospital.
309 S. Main St., Bluffton.
Mrs. Eileen Stipp, Adm.

Wells County Hospital.
1116 S. Main St., Bluffton.
Mrs. Dorothy Elett, R.N., Adm.

WHITE COUNTY

White County Memorial Hospital
Monticello
William R. Saunders, Adm.

WHITLEY COUNTY

Memorial Hospital.
215 E. Van Buren St., Columbia City.
Carl F. Arnston, Adm.

Whitley County Memorial Hospital.
353 N. Oak St., Columbia City
Stanley S. Mullendore, Adm.



Doctors, too, like "Premarin"®

THE doctor's room in the hospital is used for a variety of reasons. Most any morning, you will find the internist talking with the surgeon, the resident discussing a case with the gynecologist, or the pediatrician in for a cigarette. It's sort of a club, this room, and it's a good place to get the low-down on "Premarin" therapy.

If you listen, you'll learn not only that doctors like "Premarin," but *why* they like it.

The reasons are fairly simple. Doctors like "Premarin," in the first place, because it really relieves the symptoms of the menopause. It doesn't just mask them — it replaces what the patient lacks — natural estrogen. Furthermore, if the patient is suffering from headache, insomnia, and arthritic-like symptoms due to estrogen deficiency, "Premarin" takes care of that, too.

"Premarin," conjugated estrogens (equine), is available as tablets and liquid, and also in combination with meprobamate or methyltestosterone.

Ayerst Laboratories • New York 16, N. Y. • Montreal, Canada

Ayerst®

5842

Doctors!

Baker RENT IT FROM Bros.

Baker Brothers offers a complete *home rental service*— a service designed to make your patients more comfortable at home.

•

MODERN and CLEAN EQUIPMENT

•

prompt delivery

•

reasonable rates

•

off-street customer parking

- **Back Rests**
- **Balkan Frames**
- **Bedside Tables**
- **Bicycle Exercisers**
- **Canes**
- **Commodes**
- **Crutches**
- **Fracture Equipment**
- **Hospital Beds**
- **Hydraulic Lifters**
- **Patient Helpers**
- **Side Rails**
- **Walkers**
- **Wheel Chairs**

•

Since 1893—
Home Owned and Operated

WAlnut 4-6244

Baker Brothers

2039 N. Capitol
Indianapolis 2, Indiana

APPROVED MENTAL HOSPITALS IN INDIANA

See State-Operated Mental Institutions, Page 965

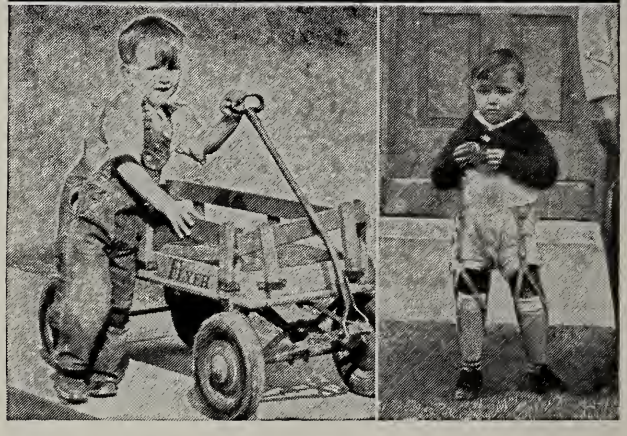
Clearview.
Kratzville Road, Evansville
William J. Bulger, Busn. Mgr.

Ann Taylor Hospital.
2231 Broadway, Indianapolis.
Miss Ann Long, Mrs. May Masters.

Wabash Valley Sanitarium.
Lafayette.
Donald R. Kinzer, Mgr. ◄

PATRONIZE YOUR JOURNAL ADVERTISERS

"... he runs and plays again!"



Hanger Prosthetic Appliances have brightened the present and the future for many amputees. For example, Weaver Nolt says: "My son, Lloyd, was a pathetic figure in a big hospital bed after his legs were amputated because of an accident. Today it's a big and wonderful world again as he gets along so wonderfully on his Hanger Legs. He walks without any help, and runs and pushes his wagon all over the farm. That other day is just a hazy memory, and we are so pleased things are so different than we expected."

Hanger PROSTHESES

1529-33 N. ILLINOIS ST., INDIANAPOLIS 2, IND.
3108 BURNET AVENUE, CINCINNATI 29, OHIO
FAIRFIELD AT PONTIAC, FORT WAYNE, IND.
418 N. MAIN ST., EVANSVILLE, IND.

Preventive medicine has been practiced here at the Home Lawn Mineral Springs for over 60 years

The activities of the Medical Department here at the Home Lawn Mineral Springs are held to sound medical and scientific standards as it works in close harmony with . . .

the department of hydro-therapy where only trained attendants are in charge of the famous mineral water baths and treatments

the department of electro-therapy completely outfitted with modern equipment and operated by an especially trained person

the department of X-ray, cardiograph, and laboratory supervised by competent and dependable operators

the department of food preparation for those requiring special diets supervised by a trained dietitian.

The Medical Department at Home Lawn Mineral Springs is equipped to care for certain types of rheumatism, arthritis, and allied conditions, as well as nutritional diseases, heart conditions, hypertension, gout, and diabetes.

Various types of mineral baths, as directed by the Medical Department, are highly beneficial in keeping your weight at the proper level according to your activity and time in life.

We in America, young and old, are now much more conscious than ever before as to the need of weight control for good health and a happier, longer life.

Treatment baths in the famous mineral waters here at Home Lawn Mineral Springs under medical direction, along with the health building program, have made Home Lawn known over a wide area of the nation, which justifies the slogan . . . "One of the three best known watering places in America."

HOME LAWN MINERAL SPRINGS

Martinsville, Indiana

M. C. PITKIN, M.D., *Medical Director*

J. W. Gibbs, M.D., *Associate*

LICENSED NURSING HOMES IN INDIANA

January, 1960

ADAMS COUNTY

Berne Nursing Home
906 W. Main Street, Berne
Miss Pauline Hostetler, Adm.

ALLEN COUNTY

Crow's Haven
2440 Bowser St., Fort Wayne
Mrs. Meta C. Crow & Lyle Crow, Adms.

Fairfield Convalescent Home
2520 Fairfield Ave., Ft. Wayne
Stephen L. Marshall and Mrs. Hannelore Kline, Adms.

Grace Convalescent Home
1529 California Ave., Ft. Wayne
Mrs. Emma Meyer, Adm.

Lawton Nursing Home
1649 Spy Run Ave., Fort Wayne
Mr. Walter C. Buuck, Adm.

Rock Hill Convalescent Home
1102 Wilt St., Ft. Wayne
Miss Hazel Irene Myers, Adm.

Twin Maples Nursing Home
734 W. Washington Blvd., Fort Wayne
Mrs. Effie Johnston, Adm.

BARTHOLOMEW COUNTY

Chasteen Nursing Home
802 Fourth St., Columbus
Mrs. Niley Armuth, Adm.

Shady Nook Rest Home
R.R. 8, Columbus
Mrs. Louanna Niemoeller, Adm.

Shanklin Nursing Home
705 Sycamore St., Columbus
Mrs. Mildred Shanklin, Adm.

BENTON COUNTY

Mary's Nursing Home
Maple & Elm, Earl Park
Mrs. Mary Belange, Adm.

BLACKFORD COUNTY

Jackson Nursing Home
423 S. Main St., Montpelier
Rolland W. Jackson, Adm.

Jackson Nursing Home
110 E. Huntington St., Montpelier
Rolland W. Jackson, Adm.

Waldo House
511 W. Washington St., Hartford City
Mrs. Martha Waldo, Adm.

BOONE COUNTY

Davis Nursing Home
310 W. Main St., Thorntown
Mrs. Ruth Davis, Adm.

English Nursing Home
1015 N. Lebanon, Lebanon
Mrs. Bessie May English, Adm.

Harris Nursing Home
210 S. Pearl St., Thorntown
Mrs. Maud Harris, Adm.

Indiana Baptist Home, Inc.
R. R. 1, Zionsville
Loren E. Moore, Adm.

CARROLL COUNTY

The Arzula Flora Nursing Home
312 W. Main St., P.O. Box 473, Flora
Miss Ida Arzula Flora, Adm.

Deer Creek Nursing Home
R. R. 1, Camden
Miss Mabel E. Bechdolt, Adm.

Good Will Nursing Home
Corner Main and Monroe Sts., Camden
Mrs. Mildred Shockley, Adm.

Mamie Kennedy Nursing Home
404 S. Center St., Flora
Mrs. Mamie J. Kennedy, Adm.

Restmor
Bringhurst, Indiana
Mrs. Opal Short, Adm.

CASS COUNTY

Douglas Nursing Home
Box 103, Royal Center
Mrs. Viola Douglas, Adm.

Elsie Laymon Nursing Home
1014 Wooland St., Logansport
Mrs. Elsie Laymon, Adm.

Flo Dodt Nursing Home
Royal Center
Mrs. Flo Dodt, Adm.

Huffman Nursing Home
2527 E. Broadway, Logansport
Mrs. Honour Huffman, Adm.

Rest Haven Nursing Home
731 North St., Logansport
Miss Olive S. Jones, Adm.

Webster Home
806 North St., Logansport
Mrs. Nora B. Webster, Adm.

CLARK COUNTY

Maple Court Nursing Home
109 E. Maple Court, Jeffersonville
Goldie and Lola Hollingsworth, Adms.

O'Brien Nursing Home
Allison Lane, R. R. 1, Jeffersonville
Mrs. Mary O'Brien, Adm.

Old Ladies Home, Inc.
330 W. Market St., Jeffersonville
Mrs. Grace Wilson, Adm.

Perkins Nursing Home
1315 Spring St., Jeffersonville
Mrs. Dovie Perkins, Adm.

Twilight Nursing Home #1
210 E. Maple St., Jeffersonville
Mrs. Delilah Jean Goodwin, Adm.

CLAY COUNTY

Leavitt Nursing Home
503 S. Leavitt St., Brazil
Mrs. Marlous I. Karlich, Adm.

Wilson Nursing Home
525 E. Mechanic St., Brazil
Mrs. Mary I. Wilson, Adm.

CLINTON COUNTY

Ashley Nursing & Convalescent Home
R. R. 6, Frankfort
Mr. & Mrs. Francis Hladik, Adms.

Bisel Nursing Home
551 E. Walnut St., Frankfort
Mr. B. H. Bisel, Adm.

Continued

Indiana's Outstanding Medical Address

HUME MANSUR BUILDING

23 EAST OHIO STREET

INDIANAPOLIS

Nursing Homes
Continued

Newsum Nursing Home
1201 E. Washington St., Frankfort
Miss Florence B. Summers &
Miss Westine Newton, R.N., Adms.

Rice Nursing Home
R. R. 1, Michigantown
Clayton and Marie Rice, Adms.

Shoemaker Memorial Home
951 E. Clinton St., Frankfort
Mr. F. J. Goins, Adm.

DAVIESS COUNTY

Colvin's Nursing Home
1109 National Highway, Washington
Mrs. Laura Colvin, Adm.

Godwin Nursing Home
819 Axtell Ave., Washington
Mrs. Lelah Godwin, Adm.

Meyer's Nursing Home
215 W. Oak St., Washington
Mrs. John Meyers, Adm.

DEARBORN COUNTY

Shady Nook Nursing Home
Ridge Ave. & Catalpa St., Lawrenceburg
Mrs. Alta McMullen and
Mr. Alvin McMullen, Adms.

DECATUR COUNTY

Ada Schwind Nursing Home
469 S. Monfort St., Greensburg
Mrs. Ada Schwind, Adm.

Black Nursing Home
202 W. Third St., Greensburg
Mrs. Pearl Black, Adm.

Jessup Nursing Home
Westport, Indiana
Mrs. Myrtle Jessup, Adm.

Michigan Hill Nursing Home
320 S. Michigan Ave., Greensburg
Mrs. Gayle Thompson, Adm.

Pauline Neal Nursing Home
303 Jackson St., Greensburg
Mrs. Pauline Neal, Adm.

Ridout Nursing Home
410 S. Broadway, Greensburg
Mrs. Lila Ridout, Adm.

Slone's Nursing Home
515 W. Main St., Greensburg
Mrs. Marie Slone, Adm.

DEKALB COUNTY

Barkley Nursing Home
610 S. Broadway, Butler
Mrs. Audrey Barkley, Adm.

Betz Nursing Home
R. R. 3, Auburn
Mr. and Mrs. Everett Betz, Adms.

Butler Hotel Rest Home
117 North Broadway St., Butler
Mrs. Dorothy Dicherhoof, Adm.

Garrett Convalescent Home
611 S. Peters St., Garrett
Mrs. Helen E. Boyd, Adm.

Sheehy Nursing Home
402 N. Broadway St., Butler
Mr. and Mrs. J. Edward Sheehy, Adms.

Southview Rest Home
131 Depot St., Butler
Mrs. Leona LeMay, Adm.

DELAWARE COUNTY

Eads Nursing Home
R. R. 7, Muncie
Mrs. Epsy W. Eads, Adm.

Faulkner Rest Home
905 South Grant St., Muncie
Edgar Faulkner, Adm.

Frazee Convalescing Home
R. R. 2, Dunkirk
Mrs. Leatha G. Frazee, Adm.

The Golden Rule
410 N. Madison St., Gaston
Mrs. Eunice A. Messersmith, Adm.

Maple Grove Convalescent Home
1347 East Jackson St., Muncie
Mrs. Pearl B. Harty, Adm.

Morgan-Nickols Convalescent Home
727 Wheeling Ave., Muncie
Mrs. Margaret L. Nichols,
Mrs. Lucy M. Morgan, Adms.

Shady Haven Rest Home
R. R. 6, Muncie
Mrs. Leila C. Wilcox, Adm.

Sylvester Home for the Aged
R. R. 5, Burlington Dr., Muncie
Mrs. Nellie V. Sylvester, RN, Adm.

Woodland Home #1
917 E. Main St., Muncie
Mrs. Carroll Shroyer
Mrs. Hazel Wilson, RN, Adm.

Woodland Home #2
1612 W. Jackson, Muncie
Mrs. Hazel Wilson,
Mrs. Carrol Shroyer, Adms.

DUBOIS COUNTY

Indiana Rest Home
115 East 5th St., Jasper
Mrs. Matilda Sauter, Adm.

Mary Lee's Nursing Home
701 Main St., Jasper
Mrs. Mary Lee Schurz, Adm.

Providence Home
West 9th Street, Jasper
Rev. Phillip Ottavi, Adm.

Stork Memorial Hospital Nursing Home
511 Fourth St., Huntingburg
Sisters of St. Benedict
Sister Mary James, O.S.B., Adm.

ELKHART COUNTY

The Austin Home
526 N. 6th St., Goshen
Mrs. Hazel M. Neibert, Adm.

Florentine Convalescent Home
1005 S. Third St., Elkhart
Mrs. Florentine Warskow, Adm.

Hutchinson Nursing Home
302 S. 6th St., Goshen
Mrs. Irene Hutchinson, Adm.

Ideal Rest Home
925 Monroe St., Elkhart
Mr. & Mrs. John Sills, Adms.

Lockerbie Nursing Home
302 East Lincoln Ave., Goshen
Mrs. Jane Barnes, Adm.

Lu-Ann Nursing Home
952 West Walnut St., Nappanee
Mr. & Mrs. Gareth Sechrist, Adms.

Milleman Convalescent Home
430 W. Marion St., Elkhart
Mr. and Mrs. Harold Milleman, Adms.

Moore Nursing Home
401 S. Main St., Goshen
Ralph and Sophia E. Moore, RN, Adms.

Nicholson Convalescent Home
R.R. 2, Goshen
Mrs. Gracia R. Nicholson, RN, Adm.

Peterson Nursing Home
302 East Lincoln Ave., Goshen
Mrs. Iva Gay Peterson, Adm.

Pleasant View Nursing Home
328 W. Franklin St., Elkhart
Mr. & Mrs. Harry Glant, Adms.

Rest Haven
803 Wolf Ave., Elkhart
Elizabeth L. & Peter A. Calabrese, Adms.

Riley Convalescent Home
527 S. Main St., Goshen
Albert and Eunice Riley, Adms.

Simpson Nursing Home
114 S. 6th St., Goshen
Mr. Richard A. Simpson, Adm.

Thorp Nursing Home
621 East Vistual St., Bristol.
Mrs. Ruth Thorp, Adm.

Weaver Convalescent Home
3004 S. Main St., Goshen
Mrs. Esther Weaver, Adm.

Wilson Nursing Home
901 S. 2nd St., Elkhart
Mrs. Neva B. Wilson, Adm.

FAYETTE COUNTY

Lincoln Manor
903 Lincoln Ave., Connersville
Mr. Chester O'Neal, Adm.

Paula-Mar Rest Home
607 Eastern Ave., Connersville
Mrs. Mary M. Harvey, Adm.

Sycamore Home for the Aged
926 Sycamore St., Connersville
Mrs. Ella V. Curry, Adm.

FLOYD COUNTY

Kingston Home
1317 Culbertson, New Albany
Mrs. Bessie Kingston, Adm.

Turley's Nursing Home
1003 E. Main St., New Albany
Mrs. Anna C. Turley, Adm.

Twilight Nursing Home #2
909-11 E. Spring St., New Albany
Mrs. Delilah Jean Goodwin, Adm.

FOUNTAIN COUNTY

Covington Nursing Home
303 Second St., Covington
Mrs. Nellie Ingram, Adm.

FRANKLIN COUNTY

Elsie Dreyer Nursing Home #3
273 Main St., Brookville
Miss Elsie Dreyer, Adm.

FULTON COUNTY

Miller Nursing Home
719 Madison St., Rochester
Mr. and Mrs. Carl Miller, Adms.

Pontius Nursing Home
426 Jefferson St., Rochester
Mrs. Raymond Pontius, Adm.

Rochester Nursing Home
1118 Main St., Rochester
Gerald & Dorothy Eastburg, R.N., Adms.

GIBSON COUNTY

Church Nursing Home
417 W. Broadway, Princeton
Mrs. Edra E. Church, Adm.

Colonial Nursing Home
314 N. West St., Princeton
Mrs. B. Mitchell, Adm.

Hottel Nursing Home
East Main St., Francisco
Mrs. Ralph L. Hottel, Sr., Adm.

Maxey's Nursing Home
Haubstadt
Mr. & Mrs. Pearless Maxey, Adms.

Oakland City Rest Home
114 Grove St., Oakland City
Mrs. Ruth M. Morton, Adm.

Rowe's Nursing Home
415 West College, Oakland City
Mrs. Dorothy M. Rowe, Adm.

Shady Grove Nursing Home
Francisco
Mrs. Ruth Morris, Adm.

GRANT COUNTY

Butcher Nursing Home
910 N. Rush St., Fairmount
Mrs. Agnes Butcher, Adm.

Calbert's Nursing Home
202-204 N. Washington St., Marion
Geneva Calbert, Mrs. Wanda Whittaker, Adms.

Calbert's Rest Home
221 N. Washington St., Marion
Geneva Calbert, Adm.

Friendship Heights Rest Home
704 S. Main St., Fairmount
Mrs. Margaret Meyer Lyons, Adm.

Jones Nursing Home
P. O. Box 102, Fowlerton
Mr. Carroll Jones, Adm.

Lanter's Nursing Home
1649 W. Second St., Marion
Mrs. Anna Lanter, Adm.

The Naber House
324 S. Main St., Fairmount
Miss Della Bickel, RN, Adm.

Warders Nursing Home
2014 S. George St., Marion
Mrs. Mary A. Warders, Adm.

HAMILTON COUNTY

Arcadia Rest Home
P.O. Box 458, 405 S. East St. Arcadia
Mrs. Florence Sigler, Adm.

The Hamilton Home
St. Rd. 37 South, Noblesville
Mrs. Mary E. McKinley, Adm.

Sunderman Nursing Home
Cass & Harrison Sts., Cicero
Mrs. Belva Sunderman, Adm.

HANCOCK COUNTY

Pleasant Acres
R. R. 12, Box 320, Indianapolis
Mr. and Mrs. Frederick M. Burns, Adms.

Wood's Nursing Home
14 N. Wood St., Greenfield
Mrs. Hazel E. Wood, Adm.

HARRISON COUNTY

Old Capitol Rest Home
408 N. Capitol Ave., Corydon
Mrs. Hazel M. Brengman, Adm.

HENDRICKS COUNTY

Country Manor Nursing Home
R. R. 1, Box 203, Stanley Rd., Plainfield
Mrs. Dorothy A. Root, RN Adm.

Continued

Nursing Homes

Continued

Danville Nursing Home
64 N. High St., Danville
Mrs. Pearl Perkins, Adm.

Golden Rule Nursing Home
147 S. Wayne St., Danville
Mr. and Mrs. Robert Petree, Adms.

Plainfield Nursing Home
404 North Vine St., Plainfield
Mr. Max Norris, Adm.

HENRY COUNTY

"The Boxwoods"
115 N. 10th St., New Castle
Mrs. Margaret Harris, Adm.

New Hope Nursing Home
Lewisville
Mr. and Mrs. Duane Helms,
Mr. and Mrs. Ben King, Adms.

Rest Haven
420 S. Main St., New Castle
Robert John, Adm.

HOWARD COUNTY

Colonial Haven
613 E. Superior St., Kokomo
Mrs. May Kennedy, Adm.

Samaritan Home of Kokomo, Inc.
513 East Vaile Ave., Kokomo
Sister M. Blanche, Adm.

Lucy Cole Nursing Home
332 W. Markland, Kokomo
Mrs. Lucy Cole and
Miss Mary Henderson, Adms.

Pleasant Rest Nursing Home
508 W. Taylor Street, Kokomo
Mr. and Mrs. Homer Johnson, Adms.

Shady Lawn Nursing Home
2306 Apperson Way, North, Kokomo
Mrs. Mae Kennedy, Adm.

Twin Oaks
1200 W. Morgan St., Kokomo
Mr. and Mrs. Davenport, Adms.

HUNTINGTON COUNTY

The Methodist Memorial Home for the Aged
Warren
Rev. D. C. Souder, Exec. Sec.

Moore Home
425 Hasty St., Huntington
Mrs. Maud Moore, Adm.

Roanoke Nursing Home, Inc.
743 North Main Street, Roanoke
H. W. Foy, M.D., President

Town & Country Nursing Home
R. R. 8, Huntington
Mr. and Mrs. H. B. Lunsford, Adms.

JACKSON COUNTY

Roselawn Home
202 W. 6th St., Seymour
Lowell E. Martin, Adm.

Roselawn Home Annex
305 St. Louis Ave., Seymour
Mrs. Esta T. Martin, Adm.

West Side Nursing Home
108 South Pine St., Seymour
Mrs. Jennie West, Adm.

JAY COUNTY

Lewis Nursing Home
190 South Union St., Pennville
Mrs. Edith Lewis, RN, Adm.

McGraw Nursing Home
400 S. Main St., Dunkirk
Mrs. Evelyn McGraw, Adm.

Portland Nursing Home, Inc.
406 W. Arch St., Portland
Mrs. Mary Ellen Hearn, Pres.
Mrs. Irma Wells, Sec'y

JEFFERSON COUNTY

Glore Nursing Home
1830 Marion, North Madison
Mrs. Flora Glore, Adm.

Hilltop Rest Home
352 Miller, North Madison
Mrs. Louise Obertate, Adm.

Madison Nursing Home
726 W. Main St., Madison
Mrs. Ella Shuell, RN, Adm.

Willmann Nursing Home
620 Green Rd., Madison
Mrs. Lorene Willmann, Adm.

JENNINGS COUNTY

Ritz Nursing Home
Scipio
Mrs. Nona Ritz, Adm.

JOHNSON COUNTY

Boilanger Nursing Home
400 Kentucky Ave., Franklin
Mrs. Everly Sandefur, Adm.

Faith Home
P. O. Box 65, Edinburg
Mr. Raymond C. Brown, Adm.

Greenwood Hilltop Nursing Home
R. R. 2, Fry Rd., Greenwood
Mrs. Viola Van Sickle, Adm.

Janie's Nursing Home
651 S. State St., Franklin
Mrs. Janie Johnson, Adm.

Methodist Home for the Aged
Franklin
A. M. Brown, M.D., Supt.

Mickie Nursing Home
750 Madison St., Franklin
Mrs. Mildred K. Trogdon, Adm.

KNOX COUNTY

Ideal Nursing Home
402 Broadway, Vincennes
Mrs. Cora Thornberry, Adm.

Moore's Nursing Home
204 W. 3rd St., Bicknell
Ernest P. Moore, Adm.

Turner Nursing Home
515 Perry St., Vincennes
Clyde and Marylee Turner, Adms.

Vincennes Nursing Home
703 Prairie St., Vincennes
Mr. & Mrs. Joe Junod, Sr., Adms.

KOSCIUSKO COUNTY

Alfran Nursing Home
East Center St., Warsaw
Frank and Alice Wilson, RN, Adms.

Armington Home
519 W. Winona Ave., Warsaw
Mrs. Charles Armington, Adm.

Dunroven Place Rest Home
R. R. 1, Leesburg
Mrs. Al-Aroma Green, Adm.

Kilgore Nursing Home
R. R. 1, Pierceton
Mr. Leroy Kilgore, Adm.

Continued

115,000 Hoosiers Over 65

. . . Including more than 33,000 older than 75, are now protected by Blue Cross-Blue Shield.

. . . 32,000 of the over-65 total are enrolled under group contracts, and 20,000 hold special "left employ" direct pay memberships.

. . . 63,000 have individual or non-group Certificates, including 10,000 added during the 1959 open enrollment campaign.

Blue Cross-Blue Shield, now protecting approximately one-third of the Indiana over-65 population, is solving this problem by making adequate coverage available to all persons in the community.

THE DOCTORS' PLAN—Sponsored by the Indiana State Medical Association

Blue Shield®

110 North Illinois Street, Indianapolis 9, Ind.

ME. 5-9411

Nursing Homes
Continued

Orn Nursing Home
North Main St., Milford
Mrs. Amos Orn, Adm.

Prairie View Rest Home, Inc.
300 Prairie St., Warsaw
Mrs. Grace S. Beaman, Pres.

LAGRANGE COUNTY

Mrs. Marks' Rest Home
R. R. 1, LaGrange
Mrs. Marie B. Marks, Adm.

LAKE COUNTY

Beaton's Nursing Home
521 Pennsylvania St., Gary
Mrs. Laura Beaton, Adm.

Blair Nursing & Convalescent Center
7606 Rhode Island Ave., Hammond
Mrs. Mary Ann Blair, Adm.

Calloway's Nursing Home
1948 Massachusetts St., Gary
Mrs. Tomye D. Calloway, Adm.

Calloway's Nursing Home
1558 Fillmore St., Gary
Mrs. Tomye D. Calloway,
James A. Young, Adms.

Gearlds Rest Home
726 Sibley St., Hammond
Mrs. Vida Gearlds, Adm.

Great Oaks Manor — Conv. & Nursing Home
Route 41, Cook
Mr. & Mrs. William Moodie, Adms.

Green's Home
3960 Massachusetts St., Gary
Mrs. Lillian Green, Adm.

Hilltop Nursing Home
R. R. 2, Box 159, Crown Point
Mrs. Olive Beggs, Adm.

Jayne Bryant Nursing Home
R.R. 7, U.S. 8, Box 223, Crown Point
Mrs. Ellen Jayne Bryant, Adm.

Miller Nursing Home
2301 Adams St., Gary
Miss Ida Miller, Adm.

Mills Rest Home
5011 Maryland St., Gary
Mrs. Audrey Mills, Adm.

St. Ann's Home
5927 Columbia Ave., Hammond
Sister Mary L. Tobin, Adm.

St. Anthony's Convalescent Home
R. R. 1, Box 262, Crown Point
Sister Mary Ottilia, Res. Adm.

S & S Nursing Home
1944 Maryland St., Gary
Mrs. LaGora Sanders, Adm.

Shady Heights
R. R. 1, Dyer
Mrs. Faye McGuire, Adm.

South Side Nursing Home for the Aged
2481 Jefferson, Gary
Mrs. Margaret S. Morgan, Adm.

West End Convalescent Home
1501 Wheeler St., Gary
Henderson D. Hall, Adm.

Willowdale Nursing Home
R.R. 2, Crown Point
Donald D. DuSold, M.D., Adm.

Woodmar Nursing Home
6727 Baring Ave., Hammond
Mrs. Geraldine Wiseley, Adm.

LAPORTE COUNTY

Anderson Sanitarium
504 I St., LaPorte
Carroll and Lula Anderson, Adms.

Hampton Nursing Home
126 F St., Michigan City
Mrs. Mary E. Hampton, Adm.

Schofield Nursing Home
602 Spring Street, Michigan City
Mrs. Florence D. Schofield, Adm.

Waterford Nursing Home
R.R. 3, Box 319, Michigan City
Mrs. Mildred Stout, Adm.

White Tower Nursing Home
209 State Street, LaPorte
Mrs. Jane E. Gittings, Adm.

LAWRENCE COUNTY

Gladys Nursing Home
51 East 16th St., Bedford
Mrs. Gladys Keller, Adm.

Kinder Nursing Home
602 J St., Bedford
Mrs. Mabel Kinder, Adm.

Maicks Nursing Home
321 N. L St., Bedford
Mrs. Minnie Maick, Adm.

Oolitic Rest Home
North Lafayette St., Oolitic
Mrs. Edna Perry, Adm.

Rest Haven Nursing Home
1010 W. Frank St., Mitchell
Mrs. Kathleen King and Mrs. Dorothy Sheeks, Adms.

Sunny Acres Rest Home
R.R. 5, Bedford
Mrs. Mabel Ray, Adm.

MADISON COUNTY

Bradford Nursing Home
625 W. Adams St., Alexandria
Mrs. Alma Bradford, Adm.

Bright Memorial Home
2006 Jackson St., Anderson
Ronald L. Kem, Adm.

Dickey Nursing Home
220 North 9th Street, Elwood
Mrs. Louise Dickey, Adm.

Don Marie Nursing Home
1901 N. "A" St., Elwood
Mrs. Ethel E. Clark, Adm.

Farrington Nursing Home
818 W. Washington St., Alexandria
Mrs. Alma Farrington, Adm.

Goble Home
332 W. 11th St., Anderson
Olive and Oran Goble, Adms.

New Haven Nursing Home
1023 E. 8th St., Anderson
Mrs. Josephine Wade, Adm.

Rahbek Nursing Home
711 W. 5th St., Anderson
Mr. and Mrs. Jack Williamson, Adms.

Sanders Nursing Home
416 W. 12th St., Anderson
Mr. & Mrs. Wm. Sanders, Adms.

Scott's Nursing Home
339 Broadway, Pendleton
Mrs. Ruby Scott, Adm.

Shipley's Nursing Home
2417 Pearl St., Anderson
Mrs. Mildred Shipley, Adm.

MARION COUNTY

Ada's Golden Age Sanitorium
2115 Central Ave., Indianapolis
Mrs. Ada Mohler, Adm.

Alpha Home for Aged
1840 Senate Ave., Indianapolis
Alpha Home Association, Inc.
Mrs. Maude Gaillard, Pres.

Anthony Hall Nursing Home
2135 N. Alabama St., Indianapolis
Albert and Myrtle Hall, Adms.

Booker-Watts Convalescent Home
1409 Bellefontaine St., Indianapolis
Mrs. Geneva B. Watts, Adm.

Booker-Watts Nursing Home
812 E. 14th St., Indianapolis
Mrs. Geneva B. Watts, Adm.

Broad Brook Restorium
1445 Broadway, Indianapolis
Mrs. Nora Brooks, Adm.

Campbell's Nursing Home
2346 Central, Indianapolis
Mrs. Thelma Campbell, Adm.

Central Nursing Home
2262 Central Ave., Indianapolis
Mrs. Bertha Flagle, Adm.

Christen Nursing Home
1930 Sugar Grove Ave., Indianapolis
Mrs. Ethel Christen, Adm.

Dumas Nursing Home
2712 N. Illinois, Indianapolis
Mrs. Mary Lou Dumas, Adm.

Evangelistic Center, Inc., Home for the Aged
3518 Shelby, Indianapolis
Evangelistic Center, Inc.
Rev. E. P. Qualls, Pres.

Frame Nursing Home
373 N. Holmes Ave., Indianapolis
Mr. Bert Frame, Adm.

Garfield Park Nursing Home
2605 Shelby Street, Indianapolis
Mrs. Thelma Bryant, Adm.

Grimes' Nursing Home
4627 Carvel Ave., Indianapolis
Mrs. Bessie C. Grimes, Adm.

Garner Nursing Home
1402 Carrollton Ave., Indianapolis
Mrs. Elizabeth Garner, Adm.

Harris Sanatorium
702-04 N. Alabama St., Indianapolis
John G. Harris, Adm.

Hillside Nursing Home
2370 Hillside Ave., Indianapolis
Mrs. Bennie Mason, Adm.

Huff Sanitarium
115 S. Audubon Rd., Indianapolis
Mrs. Bettina Sullivan, Adm.

Jackson Nursing Home
1812 Central Ave., Indianapolis
Montbrun Nursing Home, Inc.
Mrs. Marie Montbrun, Adm.

Borinstein Home
3516 Central Ave., Indianapolis
Morton Leeds, Ph.D., Adm.

L & B Nursing Home
1645 N. College Ave., Indianapolis
Mrs. Nora Brown, Adm.

Lynhurst Nursing Home
5225 W. Morris St., Indianapolis
Mrs. Ethel L. M. Herron, Adm.

Marie Fred Nursing Home
604 N. Jefferson Ave., Indianapolis
Mrs. Marie Fred, RN, Adm.

Matthews Rest Home
823 Broadway, Indianapolis
Mrs. Ethel Matthews, Adm.

Petty's Nursing Home
2432 Central Ave., Indianapolis
Gailord and Elsie Petty, Adms.

Murt-McCune Nursing Home
1629 College Ave., Indianapolis
Mrs. Emma Murt and Mrs. Catherine McCune, Adms.

New Hope
41 West 32nd St., Indianapolis
Mrs. Julia M. Carelli, Adm.

New View Nursing Home
1429 Carrollton Ave., Indianapolis
Mr. & Mrs. Virgil L. Weaver, Mr. & Mrs. Robert Willard, Adms.

"Northwestern"
2413 Northwestern Ave., Indianapolis
Mrs. Ray Puryear, Adm.

People's Nursing Home
2354-56 N. College Ave., Indianapolis
Rev. James and Marceline Jones, RN, Adm.

Pike Sanitarium
2037 N. Illinois St., Indianapolis
Mrs. Lillian G. Pike Ketchem, Adm.

Pike Sanitarium No. 1
2014 Pennsylvania, Indianapolis
Mrs. Lilian G. Pike Ketchem, Adm.

Pleasant View Rest Home
5000 Southeastern Ave., Indianapolis
Mrs. Laura E. Weber, Adm.

Robinson Private Homes
2250-54 Central Ave., Indianapolis
Mrs. Eunice Robinson, Adm.

Conner Nursing Home
1408 N. Pennsylvania St., Indianapolis
Mrs. Lucy V. Conner, Adm.

Shady Nook
2208 N. Talbot St., Indianapolis
Mrs. Helen Huffine, Adm.

Springer's Nursing Home
6566 W. Washington St., Indianapolis
Millard and Gladys Springer, Adms.

St. Ann's Group
111 West Raymond St., Indianapolis
Mother Mary Ita, Adm.

Sunshine Nursing Home
4416 E. Washington St., Indianapolis
Mrs. Ethel M. Bills, Adm.

Three Sisters Nursing Home
124 W. 26th St., Indianapolis
Miss Harty Springfield, Miss Etta Springfield, and Miss Esther Springfield, Adms.

Vollmer Convalescent Home
2630 College Ave., Indianapolis
Mr. Emory H. Vollmer, Adm.

Continued

Nursing Homes

Continued

Mrs. Waddle's Private Home
2112 N. Delaware St.,
Indianapolis
Mrs. Mabel S. Waddle, Adm.

Ward Nursing Home
1518 N. Senate Ave.,
Indianapolis
Mrs. Willa Mae Murray, Adm.

Weber Convalescing Home
43 S. Ritter Ave., Indianapolis
Mrs. Laura E. Weber, Adm.

Wert Nursing Home
1716-18 N. New Jersey,
Indianapolis
Mrs. Edith M. Wert, Adm.

Wooldridge Nursing Home
624 E. 12th St., Indianapolis
Mr. and Mrs. Albert Wooldridge,
Adms.

MARSHALL COUNTY

I.B.M. Nursing Home
1029 W. Jefferson St., Plymouth
Mrs. Iva B. Miller, Adm.

Landis Nursing Home
115 S. Maple Ave., Argos
Mrs. Nerla Landis, Adm.

Landis Nursing Home
145 S. Michigan, Argos
Mrs. Nerla Landis, Adm.

Myers Nursing Home
R. R. 3, Box 159, Bremen
Mrs. Pearl Myers, Adm.

MARTIN COUNTY

O'Maley Rest Home
R. R. 4, Loogootee
Fred W. O'Maley and
Florence O'Maley, Adms.

MIAMI COUNTY

Church of the Brethren Home for Aged People
Mexico
Church of the Brethren
Home for Aged People, Inc.
Homer A. Schrock, Supt.

Converse Nursing Home
405 E. Walnut St., Converse
Mrs. Effie May Bell, Adm.

The Miami Home
77 E. 3rd St., Peru
Mr. and Mrs. Charles McDaniel,
Adms.

Parkview Rest Home
402 Armstrong Ave., Peru
Mrs. Zella Armstrong, Adm.

Peru Nursing Home
906 W. Main St., Peru
Mrs. Margaret Harris and
Mrs. Maxine Watts, Adms.

MONROE COUNTY

Ellettsville Nursing Home
R.R. 7, Ellettsville
Mrs. Louise E. Robinson, Adm.

Percifield Nursing Home
1031 W. 6th St., Bloomington
Mrs. Myrtle Percifield, Adm.

MONTGOMERY COUNTY

Ben Hur Home
1375 S. Grant, Crawfordsville
Richard and Martha Williams,
Adms.

Hart Memorial Home
R. R. 1, Crawfordsville
Mrs. Myrtle Johnson

Hazel Small Rest Home
N. Vine St., Wayntown
Mrs. Hazel Small, Adm.

Rudisill Nursing Home
1304 Grant Ave., Crawfordsville
Owen G. Rudisill, Adm.

Shahan Nursing Home
613 Kentucky St.,
Crawfordsville
Miss Eileen M. Shahan, Adm.

Westbrook Nursing Home
R. R. 4, Crawfordsville
Miss Mary E. Brooks, Adm.

MORGAN COUNTY

Cherry Nursing Home
60 E. Harrison St., Martinsville
Mrs. Zepha Cherry, Adm.

NOBLE COUNTY

Golden Rule Nursing Home
R. R. 1, Pierceton
Mr. and Mrs. H. F. Mock, Adms.

Jaquay's Rest Home
324 Silver St., Kendallville
Mrs. Leone Jaquay, Adm.

Kondas Nursing Home
R. R. 1, Albion
Betty J. Carter, Adm.

Lutheran Old People's Home, Inc.
612 E. Mitchell St., Kendallville
Rev. Herbert L. Wiese,
Res. Adm.

Sacred Heart Home
Avilla
Sister Anna Marie, Res. Adm.

Saint Vincent Home for the Aging
R. R. 1, Ligonier
Sister M. Agatha, Res. Adm.

ORANGE COUNTY

The Gorge Retreat and Sanitarium
R. R. 2, Box 228, French Lick
Miss Gertrude Haynes, RN, and
Mrs. Myrtle Simpson, RN,
Adms.

OWEN COUNTY

Donna Nursing Home #2
R. R. 2, Spencer
Mr. and Mrs. Clyde Poff,
Mr. and Mrs. Norman Tirsway, Adms.

Gosport Nursing Home
W. Main St., Gosport
Mrs. Mary F. Wampler, Adm.

Reapp Nursing Home
P. O. Box 87, Spencer
Mrs. Jennie C. Reapp, Adm.

PARKE COUNTY

Allen Nursing Home #1
712 Madison St., Montezuma
Mrs. Sylvia Allen, Adm.

Allen Nursing Home #2
303 Howard Ave., Rockville
James and Sylvia Allen, Adms.

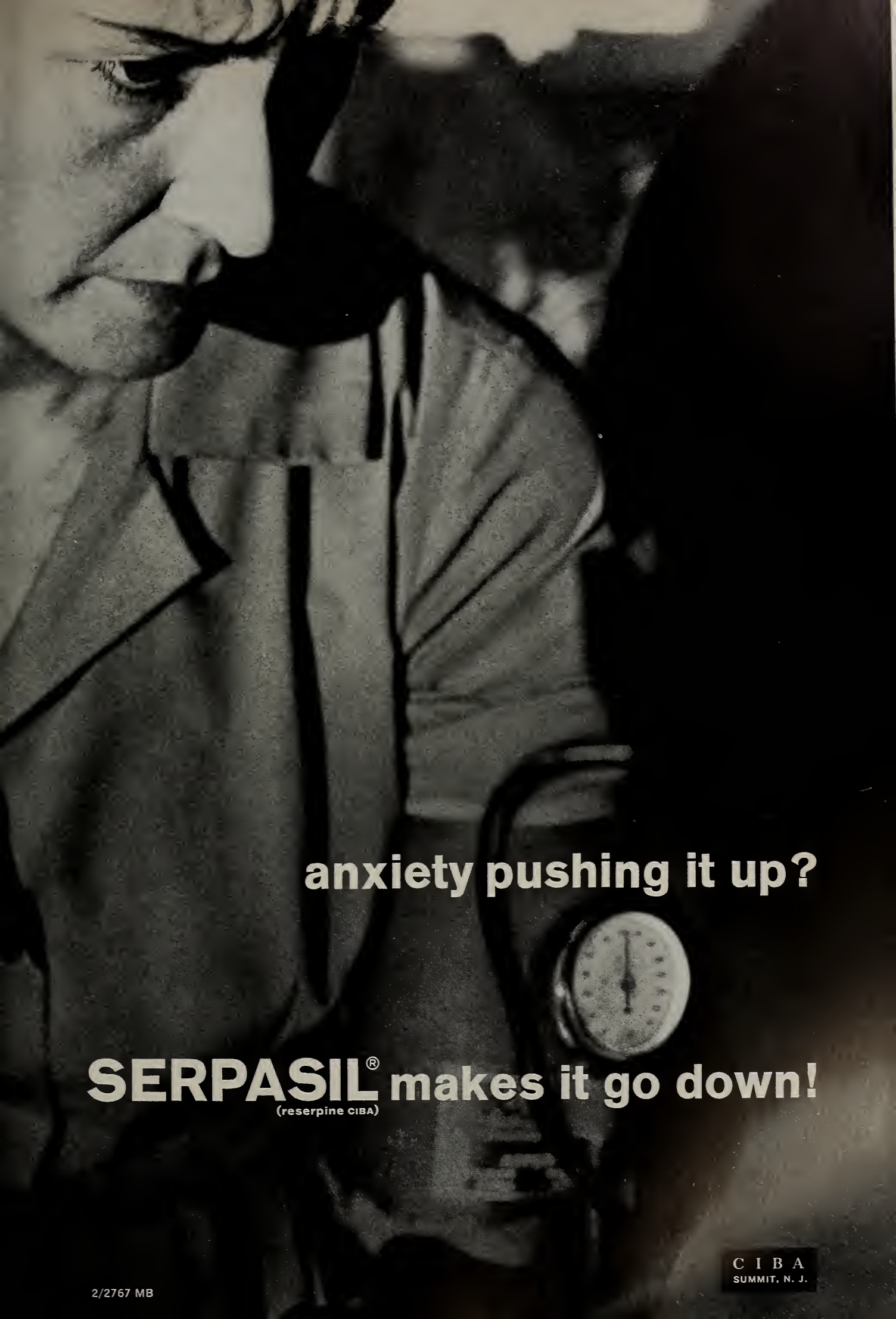
Allen Nursing Home #3
517 Ohio St., Rockville
Mr. & Mrs. James Allen, Adms.

Britton's Parke County Nursing Home
R. R. 2, Rockville
Mrs. Helen Britton, Adm.

Friendship House
Bloomingdale
Mrs. Hazel Kesterson, Adm.

Layman Nursing Home
603 S. Washington, Montezuma
Mrs. Mildred Layman, Adm.

Continued


anxiety pushing it up?
SERPASIL® makes it go down!
(reserpine CIBA)
CIBA
SUMMIT, N. J.
2/2767 MB

Nursing Homes
Continued

Sanders Nursing Home
Mecca, Indiana
Mrs. Edith Sanders, Adm.

Wabash Valley Nursing Home
934 N. Jefferson St., Montezuma
Mrs. Mary E. Phillips. Adm.

PIKE COUNTY

Fay's Convalescent Home
210 S. 14th St., Petersburg
Mrs. Fay France, Adm.

Petersburg Nursing Home
411 Walnut St., Petersburg
Mrs. Mabel Ward, Adm.

PORTER COUNTY

Valparaiso Nursing Home
359 Greenwich St., Valparaiso
Mrs. Marie Goble, Adm.

POSEY COUNTY

Mt. Vernon Nursing Home
831 Mulberry St., Mount Vernon
Leo Green, Adm.

Burton Nursing Home
North St., Cynthiana
Mr. and Mrs. Robert Burton, Adms.

L & R Nursing Home
215 E. Church St., New Harmony
Mr. & Mrs. Leo W. Green, Adms.

PUTNAM COUNTY

Craver Nursing Home
Avenue E, Greencastle
Mrs. Hannah Craver, Adm.

Donna Nursing Home
Main St., Cloverdale
Mr. and Mrs. Clyde Poff, Mr. and Mrs. Norman Tirsway, Adms.

Ruark Nursing Home
R. R. 1, Fillmore
Mrs. Elsie C. Ruark, Adm.

RANDOLPH COUNTY

Lamb's Nursing Home
R. R. 4, Union City
Mrs. Bernice A. Lamb, Adm.

Crotinger's Nursing Home
317 Columbia St., Union City
Mrs. Ruby Crotinger, Adm.

Golden Rule Rest Home
300 S. Meridian St., Winchester
Mr. and Mrs. Lester D. Puterbaugh, Adms.

Lamb's Nursing Home
R. R. 4, Union City
Mrs. Bernice A. Lamb, Adm.

Parrott's Home
304 W. Sherman St., Lynn
Mrs. Mary M. Parrott, Adm.

Samuels Rest Home
640 W. Pearl St., Union City
Mr. & Mrs. Russel Samuels, Adms.

Shady Lawn Nursing Home
R. R. 3, Winchester
Mrs. Marjorie Stewart, Adm.

RIPLEY COUNTY

The Conyers Convalescent Home
North Main St., Milan
Alfred J. Colson, Adm.

Elsie Dreyer Nursing Home #1
South Main St., Sunman
Miss Elsie Dreyer, Adm.

Elsie Dreyer Nursing Home #2
R. R. 1, Sunman
Miss Elsie Dreyer, Adm.

Gilland Nursing Home #1
310 Craven St., Osgood
Mr. and Mrs. Dan Gilland, Adms.

Gilland Nursing Home #2
120 E. Ripley St., Osgood
Mr. & Mrs. Dan Gilland, Adms.

Gilland Nursing Home No. 3
Glasgow and Willson, Osgood
Mr. and Mrs. Dan Gilland, Adm.

Health and Hospitality Center
Carr St., Milan
Alfred J. Colson, Adm.

The Homestead
North Main St., Milan
Alfred J. Colson, Adm.

Twilight Haven
High Street, Versailles
Mrs. Barbara Lambert, Adm.

RUSH COUNTY

Clifton Nursing Home
424 N. Perkins St., Rushville
Mrs. Mary J. Clifton, Adm.

Cohee Rest Home
314 E. 10th St., Rushville
Mrs. Harvey Cohee, Adm.

Jackson Nursing Home
114 E. 5th St., Rushville
Mrs. Goldie Jackson and Mrs. Marjorie Pearsey, Adms.

Richardson Rest Home
314 E. 10th St., Rushville
Mrs. Catherine Richardson, Adm.

Rushville Nursing Home
321 N. Morgan St., Rushville
Mrs. Marjorie Fordyce, Adm.

Stewart Nursing Home
230 E. 7th St., Rushville
Mrs. Louise Stewart, Adm.

SHELBY COUNTY

Maples Convalescent Home
R. R. 1, Fountaintown
Mr. Max D. McGraw, Adm.

Shelbyville Rest Home
125 W. Washington, Shelbyville
Thomas E. Butler, Adm.

Tyner Nursing Home
Fountaintown
Mrs. Thelma Tyner, Adm.

Waldron Nursing Home
Main St., P. O. Box 188, Waldron
Mrs. Evelyn V. Nasby, RN, Adm.

SPENCER COUNTY

Boyd Nursing Home
513 Walnut St., Rockport
Mrs. Mamie Boyd, Adm.

Ophelia's Rest Home
807 Main St., Rockport
Mrs. Ophelia Moore, Adm.

ST. JOSEPH COUNTY

Alexandrian, Inc.
118-124 S. Williams St., South Bend
Alexandrian, Inc.
Cornelius Pitt, Pres.

Barbara Morrow Home
1107 S. Main St., South Bend
Mrs. Barbara Morrow, Adm.

Dina's Nursing Home
1209 S. Union St., Mishawaka
Mrs. Dina Nove Linson, Adm.

Dor-A-Lin, Inc.
1024 N. Notre Dame Ave., South Bend
Mr. Franklin Finkenbinder, Adm.

Elderly Folks Home
67200 U. S. Highway 31, Lakeville
Mrs. Louise Clements, Adm.

Gugle Home
714 West Oak St., South Bend
Mrs. Myrtle Gugle, Adm.

Hall's Nursing Home
702 S. Columbia St., South Bend
Mr. and Mrs. Wilbur Hall, Adms.

Haven Hubbard Memorial Home
New Carlisle
Mearl L. Dustin, Supt.

Henson Home
1021 W. Wash. St., So. Bend
Mrs. Rose M. Henson, Adm.

Hillview Nursing Home
601 Russell St., Mishawaka
Mrs. Rosabelle Buck, Adm.

Jeffrey Nursing Home
909 West 27th St., South Bend
Glenn A. Cover, Jr., Adm.

Krogh Nursing Home
109 N. Cedar St., Mishawaka
Mrs. Joyce Wood, Adm.

River Park Nursing Home
2706 Wall St., South Bend
Mr. and Mrs. W. Wertz, Adms.

Rockhill Nursing Home
1526 Lincoln Way West, South Bend
Mrs. Lillie A. Rockhill, Adm.

Sunnybrook Nursing Home
605 Portage Ave., South Bend
Mrs. Pauline Luther, Adm.

Terry King Nursing Home #1
816 Colfax, South Bend
Mrs. Helen Laisure, Adm.

Terry King Nursing Home #2
832 W. Colfax, South Bend
Mrs. Helen Laisure, Adm.

Walkerton Nursing Home
500 Roosevelt Road, Walkerton
Mrs. Doris Klapp, Adm.

Whiteman Nursing Home
1145 Napier St., South Bend
Mrs. Betty Whiteman, Adm.

Williams Nursing Home
1844 East Calvert Street, South Bend
Mrs. Alma Williams, Adm.

STARKE COUNTY

Healthmore
Hamlet, Indiana
Mrs. Berniece Zellers, RN, Adm.

Karowski Nursing Home
408 S. Heaton St., Knox
Mrs. Leo Karowski, Adm.

Little Company of Mary Home for the Aged
San Pierre, Starke Co.
Mother M. Patricia, Adm.

Ruff Nursing Home
Culver Road, Knox
Mrs. Alcinda Ruff, Adm.

STEUBEN COUNTY

Adams Nursing Home
314 W. Broad St., Angola
Mrs. Lois June Adams, Adm.

Angola Rest Home, Inc.
306 N. Wayne St., Angola
Mrs. Ruth G. Libby, President

Underwood Nursing Home
Box 242, Defiance St., Pleasant Lake
Mrs. Mary Underwood, Adm.

TIPPECANOE COUNTY

Burnett's
221 S. Ninth St., Lafayette
Mrs. Maude L. Golden, Adm.

Campbell Nursing Home
641 New York St., Lafayette
Mrs. Alma Campbell, Adm.

Pickett Nursing Home
1021 N. 7th St., Lafayette
Mrs. Verna I. Pickett, Adm.

Indiana Knights of Pythias Home, Inc.
1501 South 18th Street, Lafayette
Mr. Clarence Hole, Adm.

Laura M. Bowles Convalescent Home
147 Ford St., Clarks Hill
Mrs. Laura M. Bowles, Adm.

Pleasant Valley Guest Haven
Battle Ground
Mrs. Ruth Hays, Adm.

Scott Nursing Home
1100 N. 9th St., Lafayette
Mrs. Goldie Scott, Adm.

Scott Nursing Home for Men
614 N. 8th St., Lafayette
Mrs. Goldie Scott, Adm.

St. Anthony
2304 Cason, Lafayette
Poor Sisters of St. Francis Seraph of the Perpetual Adoration, Inc.
Sister M. Emilie Weesendarp, Pres.

TIPTON COUNTY

The Higgins Home
R. R. 1, State Road 19, Tipton
Mr. and Mrs. Robert D. Higgins, Adms.

UNION COUNTY

Lemmons Nursing Home
208 Line St., Liberty
Mrs. Neva P. Lemmons, Adm.

Llewellyn Nursing Home
Mound and Center Sts., West College Corner, Ohio
Mrs. Vera Llewellyn, Adm.

VANDERBURGH COUNTY

Bethany Rest Home
316 N. Wabash Ave., Evansville
Mrs. Masterson, Mary Ashworth, Adms.

Bethel Sanitarium, Inc.
800 Mary Street, Evansville
Mrs. Louise Kuiken, Adm.

Bethel Sanitarium, Inc.
6015 Kratzville Rd., Evansville
Mrs. Louise Kuiken, R.N., Adm.

Bethel Sanitarium, Inc., Annex
5827 Kratzville Rd., Evansville
Mrs. Louise Kuiken, R.N., Adm.

Boehne Convalescent Nursing Home
Station B, Evansville
Paul D. Crimm, M.D., Adm.

Braun's Nursing Home
909 First Ave., Evansville
Mr. and Mrs. Roy Braun, Adms.

Dorsey Nursing Home
1714 S. Governor St., Evansville
Mrs. Laura Dorsey, Adm.

Continued

Nursing Homes
Continued

Anna Evans Nursing Home
605 Oak St., Evansville
Mrs. Anna Evans, Adm.

Gee's Rest Home
807-11 S. E. 3rd St., Evansville
Mrs. Thelma Shaw, Adm.

Gertha's Nursing Home
605 Oakley St., Evansville
Mrs. Gertha Hendrickson, Adm.

Ingle Smith Home
521 S. E. 1st St., Evansville
Mrs. Della Ingle Smith, RN, Adm.

Kueber Nursing Home
816 First Avenue, Evansville
Mrs. Catherine Kueber, Adm.

M & R Nursing Home
1100 N. Read St., Evansville
Mrs. Muriel Sprinkle, Adm.

Newton Rest Home & Annex
921-23 S. Elliott St., Evansville
Mrs. Gwendolyn Newton, Adm.

Pine Haven Nursing Home
3400 Stocker Dr., Evansville
Mrs. Anita M. Stocker, Adm.

Regina Pacis Home
3900 Wash. Ave., Evansville
Rev. James R. Deneen, Adm.

Stinson Rest Home
315 S. E. 2nd St., Evansville
Mrs. Mildred Stinson, Adm.

Tri-State Community Rest Home
821 Judson Street, Evansville
Tri State Community Hospital Assn.
Mrs. Lena A. George, Adm.

VERMILLION COUNTY

Layman Nursing Home
432 S. 5th St., Clinton
Mrs. Mildred Layman, Adm.

Dana Convalescent Home
Dana
John J. Barton, Adm.

VIGO COUNTY

Calvary Nursing Home
421 N. 5th St., Terre Haute
Mrs. Oakie Lawson, Adm.

Cook Nursing Home
2058 N. 7th St., Terre Haute
Mrs. Grace E. Cook, Adm.

Curtis Rest Home
1452 Chestnut, Terre Haute
Mrs. Alma Curtis, Adm.

Foos Nursing Home
418 S. 8th St., Terre Haute
Mrs. Lydia E. Foos, Adm.

Mary Etta Nursing Home
1524 Third Ave., Terre Haute
Mrs. Mamie Mason, Adm.

Sharps Nursing Home
1432 N. Center St., Terre Haute
Mrs. Hazel M. Sharps, Adm.

Sullivan Nursing Home
705 S. 7th St., Terre Haute
Mrs. Grace F. Sullivan, Adm.

Trainer Nursing Home
1915 N. 11th St., Terre Haute
Mrs. Geneva Trainer, Adm.

Wallace Nursing Home
502 N. 8th St., Terre Haute
Mrs. Evelyn Wallace, Adm.

Wallace Sanitarium
2144-8th Ave., Terre Haute
Mrs. Evelyn Wallace, Adm.

WABASH COUNTY

The Estelle Peabody Memorial Home
North Manchester
William Visser, Res. Adm.

Dunfee Nursing Home
1250 Pike St., Wabash
Mrs. Florence Dunfee, Adm.

Parrett Nursing Home
213 E. Hill St., Wabash
Mr. & Mrs. Wilmer Parrett, Adms.

WARRICK COUNTY

Baker's Rest Haven
503 West Walnut, Boonville
Mrs. Viola Baker, Adm.

Hollis Nursing Home #1
R. R. 5, Boonville
Mrs. Loraine Hollis, Adm.

Shady Rest
201 E. Williams St., Chandler
Mrs. Pearl Bradfield, Adm.

WASHINGTON COUNTY

Williams Nursing Home
R. R. 3, Scottsburg
Mrs. Kathleen Williams, Adm.

WAYNE COUNTY

Bowman's Rest Home
500 W. Main St., Cambridge City
Mrs. Esther Bowman, Adm.

Friendship Home
306 S. 10th St., Richmond
Paul Mendenhall, Adm.

Gains Nursing Home
R. R. 2, Richmond
Mrs. Emma Gains, Adm.

Golden Rule Nursing Home
322 N. 10th St., Richmond
Mrs. Hilda Stull, Adm.

Golden Rule Nursing Home #1
48 S. 7th St., Richmond
Mrs. Hilda Stull, Adm.

Mary E. Hill Nursing Home
2308 Zoar Ave., Richmond
Howard Alexander, Adm.

Pinehurst Nursing Home
R. R. 1, Centerville
Mrs. Gertrude E. Johnson, Adm.

Rhyne Nursing Home
40 Waterfall St., Richmond
Miss Inez Rhyne, Adm.

Schiely's Nursing Home
801 West Main St., Hagerstown
Mr. Clifford Schiely, Adm.

Twin Pine Rest Home
Main St., Economy
Mrs. Elizabeth Johnson, Adm.

WELLS COUNTY

Clark's Nursing Home
522 E. South St., Bluffton
Mrs. Clara Clark, Adm.

Cooper Rest Home
306 W. Wabash Ave., Bluffton
John & Janet E. Cooper, R.N., Adms.

Davis Nursing Home
627 S. Marion St., Bluffton
Mrs. Helen Davis, Adm.

Southview Rest Home
R. R. 3, Box 306, Bluffton
Mrs. Cora N. Anderson, Adm.

WHITE COUNTY

Archibald Memorial Home
R. R. 2, Brookston
Paul Delucenay, Adm.

Monticello Nursing Home, Inc.
226 N. Illinois St., Monticello
Gerald L. and Dorothy A. Eastburg, Adms.

WHITLEY COUNTY

The Bakle Home
R. R. 1, Columbia City
Mrs. Alice S. Fritz, RN, Adm.

Irvin Nursing Home
604 W. Van Buren St.,
Columbia City
Mrs. Marguerite Irvin, Adm.

South Whitley Rest Home, Inc.
306 Columbia St., South Whitley
Robert E. Bresnahan and
Katherine A. Bresnahan, RN,
Adms. ◄

"Only when people make some kind of financial sacrifice for their schools do they take an active and wholesome interest in education."

GIVE GENEROUSLY to AMEF

THE HARDING SANITARIUM

WORTHINGTON
OHIO

For the Diagnosis and Treatment of Psychiatric Disorders
and with
Limited Facilities for the Aging

GEORGE T. HARDING, M. D.
HARRISON S. EVANS, M. D.
Medical Directors

CHARLES W. HARDING, M.D.
Clinical Director

GEORGE T. HARDING, Jr., M. D.
HERNDON P. HARDING, M. D.
ARNOLD L. NIELSEN, M.D.
ROBERT L. SMITHWOOD, M. D.
W. W. WINSLOW, M.D.

GRACE M. COLLET, Ph.D.
VERNON W. SHAFER, Ph.D.
Clinical Psychologists

MARY JANE McCONAUGHEY, M.S.W.
BENJAMIN E. WHEATLEY, M.S.W.
Psychiatric Social Workers

PAULINE L. TOOILL, R. R. L.
Medical Record Librarian

JAMES L. HAGLE, M. B. A.
Administrator

ESTHER L. SIMPSON, R. N.
Director of Nurses

Phone: Columbus TUXEDO 5-5381

Deaths of Indiana Physicians in 1959

(Compiled by James B. Maple, M.D., Necrologist)

(M) Member I.S.M.A.; (S) Senior Member; (R) Retired

Name	Age	Date of Death	Address	Cause of Death
Collins, James N. (M)	63	Jan. 3	Indianapolis	Myocardial infarction
Waltermire, Tell C.	77	Jan. 5	Indianapolis	Diabetes mellitus
Stalker, John M.	76	Jan. 10	Borden	Coronary thrombosis
Rossow, Russell J. (M)	56	Jan. 10	Evansville	Probable intracerebral hemorrhage. Intracerebral neoplasm
Owen, Abraham M. (M)	58	Jan. 12	Bloomington	Cerebral hemorrhage
Hine, Ulis B.	60	Jan. 26	Indianapolis	Myocardial infarction
King, William F. (S)	84	Jan. 27	Indianapolis	Fall, fractured pelvis
Strangland, Arthur K.	78	Jan. 27	Highland	Congestive heart failure
Boyd, Clarence E. (R)	79	Jan. 27	Paoli	Acute pulmonary edema Art. heart disease. Diabetes mellitus. Nephrosclerosis with uremia
Hilldrup, Don G. (M) (R)	71	Jan. 28	Indianapolis	Acute myocardial failure, postoperative
Dragoo, Farrol A. (M)	54	Feb. 1	Middletown	Interstitial pulmonary fibrosis. Hamman-Rich syndrome
Buckner, Doster (M)	66	Feb. 2	Ft. Wayne	Carcinoma of the stomach
Duggan, James A. (M)	69	Feb. 10	South Bend	Hemorrhage from the colon, diverticulitis
Line, Homer E. (M)	76	Feb. 12	Chili	Coronary occlusion
Muncie, Henry L. (S)	79	Feb. 14	Brazil, R. R. 2	Myocarditis, chronic nephritis
Teaford, Benjamin J. (R)	81	Feb. 23	Corydon	Carcinoma of the pancreas
Kretsch, Russell W. (M)	61	Feb. 23	Hammond	Hypertensive arteriosclerotic heart disease
Ellerbrook, George E. (M)	50	Feb. 25	Vevay	Coronary thrombosis
Clark, Fred O. (M)	53	Feb. 27	Syracuse	Auto-train collision, fracture of skull
Rininger, Harold C. (M)	52	Feb. 28	Evansville	Barbiturate intoxication
Byers, Norman R. (R)	64	Mar. 9	Bedford	Bronchopneumonia. Cardiac decompensation
Moran, Noel D. (M)	56	Mar. 15	Versailles	Coronary occlusion
Coultas, Porter J. (S)	76	Mar. 20	Tell City	Pneumonia
Williamson, Ralph A.	69	Mar. 20	Anderson	Peritonitis, ruptured diverticulum
Bloomer, Joseph R. (S)	77	Mar. 21	Rockville	Generalized arteriosclerosis
Ehrman, Calder D. (S)	80	Mar. 21	Rockport	Carcinoma of the colon
Macer, Clarence G. (M)	73	Mar. 24	Evansville	Acute coronary thrombosis
Bowser, Hershel P. (R)	63	Mar. 28	Goshen	Cerebral hemorrhage
Patten, Vernon C. (S)	88	Mar. 29	Morristown	Cerebral thrombosis. Generalized arteriosclerosis
Amick, Charles L. (M)	74	Apr. 5	Goshen	Coronary thrombosis
Martin, William B. (M)	51	Apr. 5	LaPorte	Pulmonary hemorrhage. Bronchogenic carcinoma
Fender, Asa H. (M)	46	Apr. 11	Worthington	Pulmonary edema. Carcinoma of the lungs
Burdge, Aaron D. (M)	87	Apr. 25	Warren	Diabetes mellitus. Myocardial failure
Rothchild, Charles J. (S)	77	Apr. 28	Fort Wayne	Coronary occlusion. Arteriosclerotic heart disease

Name	Age	Date of Death	Address	Cause of Death
Baker, Robert E. (S)	98	May 3	Orleans	Myocardial failure. C.V.D. Diabetes mellitus
Murphy, Harry E. (M)	64	May 8	Franklin	Acute leukemia
Edlavitch, Baruch M. (S)	74	May 18	Fort Wayne	Cerebral thrombosis
Glackman, John C., Sr. (M)	78	May 21	Rochester	Auto wreck
Lemon, Herbert K. (S)	86	May 23	Logansport	Coronary occlusion
Young, Lemon R.	50	May 28	Indianapolis	Coronary occlusion
Smelser, Herman W. (M)	67	May 29	Connersville	Coronary occlusion. Diabetes mellitus
Matthews, Charles B. (S)	86	May 30	Hammond	Hypertensive arteriosclerotic heart disease
Clauser, Eldo H. (M)	69	May 31	Muncie	Carcinomatosis, carcinoma of the sigmoid colon
Dunning, Lehman M. (S)	75	June 3	Indianapolis	Coronary occlusion. Arteriosclerotic heart disease
Thompson, Will A. (S)	81	June 4	Richmond	Arteriosclerotic heart disease
Keith, F. E. (S)	86	June 6	St. Bernice	Arteriosclerotic heart disease
Poland, Maynard F.	61	June 12	Indianapolis	Carcinomatosis
Meyer, Milo G. (M)	54	June 23	Long Beach	Carcinomatosis
Shultz, Harry M. (S)	86	June 28	Logansport	Uremia. C.V.R.D.
Larrison, Glen D.	70	June 29	Morocco	Coronary occlusion. Coronary sclerosis
Garland, James J.	85	July 5	Indianapolis	Hypostatic pneumonia. Acute myocarditis
Clements, Albert F. (M)	64	July 9	Evansville	Carcinomatosis from carcinoma of rectosigmoid
Hofmann, Andrew (S)	81	July 9	Munster	Struck by auto, died of shock, multiple injuries
Cummings, David J. (S)	81	July 26	Brownstown	Ventricular fibrillation. C.V.R. disease
Williams, Harold O. (M)	69	Aug. 1	Kendallville	Coronary arterial thrombosis
Johnson, Cecil C. (M)	70	Aug. 2	Rensselaer	Auto accident
Fuqua, Harold B. (M)	50	Aug. 13	Terre Haute	Bronchopneumonia. Reticulum cell sarcoma
Lowery, Gerald S.	73	Aug. 15	Indianapolis	Chronic glomerulo nephritis
McDevitt, Daniel R. (M)	62	Aug. 15	Indianapolis	Cerebral hemorrhage. Cerebral arteriosclerosis
DuVall, William N. (S) (R)	86	Aug. 20	Mishawaka	Cerebral hemorrhage
Kilgore, Byron, Sr. (S)	77	Aug. 29	Indianapolis	Acute myocardial infarction. Generalized atherosclerosis
Craft, William F. (S)	73	Sept. 8	Linton	Gunshot wound.
Hinshaw, H. Jean (M)	30	Sept. 16	LaPorte	Skull fracture from a fall
Curry, Claude A. (M)	65	Sept. 20	Terre Haute	Hypertensive C.V.R. disease
Frybarger, Clarence E.	70	Sept. 21	Andrews	Coronary occlusion
Carpenter, John L. (M)	59	Sept. 22	Alexandria	Massive intestinal hemorrhage
Denny, Edgar C. (S)	75	Sept. 24	Milton	Acute myocardial infarction. Arteriosclerotic heart disease
Woodcock, Charles E. (R) (S)	72	Oct. 2	Greenwood	Coronary occlusion
Wood, Charles	79	Oct. 5	Westport	Carcinoma of the throat
Ludwig, Oscar D. (S)	79	Oct. 13	Indianapolis	Arteriosclerotic heart disease
Hahn, E. Vernon (M)	67	Oct. 16	Indianapolis	Cerebral hemorrhage. Cerebral atherosclerosis

1959 Deaths Continued

Name	Age	Date of Death	Address	Cause of Death
Stygall, James H. (S)	72	Oct. 18	Indianapolis	Coronary occlusion
Shortridge, Wilbur H.	52	Oct. 28	Seymour	Coronary occlusion. Arteriosclerosis
Arford, Roxford D. (S)	73	Nov. 7	Middletown	Cerebral vascular thrombosis
Kennedy, Robert O. (S)	80	Nov. 7	Rushville	Arteriosclerotic heart disease
Miller, Minor W. (M)	72	Nov. 17	Evansville	Acute gastric retention
Calvin, Jessie C. (S)	91	Nov. 22	Fort Wayne	Renal insufficiency. Generalized arteriosclerosis
Briscoe, Clarence E. (S)	83	Nov. 25	New Albany	Acute myocardial infarction. Arteriosclerosis
Bear, Lowery H. (S)	91	Nov. 26	Vevay	Coronary occlusion
Hathaway, Clayton B. (M)	59	Nov. 30	Butler	Coronary occlusion
Brown, Asa W.	82	Dec. 8	Bluffton	Metastatic carcinoma of the prostate
Piazza, Leonard F. (M)	55	Dec. 17	Michigan City	Auto wreck. Skull fracture
Stewart, Milton B. (S)	86	Dec. 17	Logansport	Cerebral hemorrhage
Morrison, Lindsey (S)	89	Dec. 18	Hammond	Uremia. Carcinoma of the prostate
Braunlin, William H. (S)	77	Dec. 22	Marion	Auto accident. Crushing chest injuries
Hiestand, Harley J. (S)	78	Dec. 23	Pennville	Complete heart block. Arteriosclerotic heart disease
Wallace, Lew E.	82	Dec. 25	Seymour	Carcinoma of the prostate ◄

Approved

PROFESSIONAL LIABILITY INDIVIDUAL INSURANCE

by

The No. 1 Malpractice Insurer

Unparalleled Experience ● Specialized Service ● Saving in Cost

THE

MEDICAL PROTECTIVE COMPANY

FORT WAYNE, INDIANA

Professional Protection Exclusively since 1899

INDIANAPOLIS OFFICE: Kenneth W. Moeller, Rep.

5950 Indianola Avenue Tel. CLifford 5-6525

PRESIDENTS OF THE INDIANA STATE MEDICAL ASSOCIATION SINCE ITS ORGANIZATION

Medical Convention	Elected	Served
*Livingston Dunlap, Indianapolis	1849	1849
Medical Society		
*William T. S. Cornett, Versailles	1849	1850
*Ashahel Clapp, New Albany	1850	1851
*George W. Mears, Indianapolis	1851	1852
*Jeremiah H. Brower, Lawrenceburg	1852	1853
*Elizur H. Deming, Lafayette	1853	1854
*Madison J. Bray, Evansville	1854	1855
*William Lomax, Marion	1855	1856
*Daniel Meeker, LaPorte	1856	1857
*Talbot Bullard, Indianapolis	1857	1858
*Nathan Johnson, Cambridge City	1858	1859
*David Hutchinson, Mooresville	1859	1860
*Benjamin S. Woodworth, Ft. Wayne	1860	1861
*Theophilus Parvin, Indianapolis	1861	1862
*James F. Hibberd, Richmond	1862	1863
*John Sloan, New Albany	1863	----
*John Moffet (acting), Rushville	1863	1864
*Samuel L. Linton, Columbus	1864	----
*Wilson Lockhart (acting), Danville	1864	1865
*Myron H. Harding, Lawrenceburg	1865	1866
*Vierling Kersey, Richmond	1866	1867
*John S. Bobbs, Indianapolis	1867	1868
*Nathaniel Field, Jeffersonville	1868	1869
*George Sutton, Aurora	1869	1870
*Robert N. Todd, Indianapolis	1870	1871
*Henry P. Ayres, Ft. Wayne	1871	1872
*Joel Pennington, Milton	1872	1873
*Isaac Casselberry, Evansville	1873	----
*Wilson Hobbs (acting), Knightstown	1873	1874
*Richard E. Houghton, Richmond	1874	1875
*John H. Helm, Peru	1875	1876
*Samuel S. Boyd, Dublin	1876	1877
*Luther D. Waterman, Indianapolis	1877	1878
*Louis Humphreys, South Bend	1878	----
*Benj. Newland (acting), Bedford (v.p.)	1878	1879
*Jacob R. Weist, Richmond	1879	1880
*Thomas B. Harvey, Indianapolis	1880	1881
*Marshall Sexton, Rushville	1881	1882
*William H. Bell, Logansport	1882	1883
*Samuel E. Mumford, Princeton	1883	1884
*James H. Woodburn, Indianapolis	1884	1885
*James S. Gregg, Ft. Wayne	1885	1886
*General W. H. Kemper, Muncie	1886	1887
*Samuel H. Charlton, Seymour	1887	1888
*William H. Wishard, Indianapolis	1888	1889
*James D. Gatch, Lawrenceburg	1889	1890
*Gonsolvo C. Smythe, Greencastle	1890	1891
*Edwin Walker, Evansville	1891	1892
*George F. Beasley, Lafayette	1892	1893
*Charles A. Daugherty, South Bend	1893	1894
*Elijah S. Elder, Indianapolis	1894	----
*Charles S. Bond (acting), Richmond	1894	1895
*Miles F. Porter, Ft. Wayne	1895	1896
*James H. Ford, Wabash	1896	1897
*William N. Wishard, Indianapolis	1897	1898
*John C. Sexton, Rushville	1898	1899
*Walker Schell, Terre Haute	1899	1900
*George W. McCaskey, Ft. Wayne	1900	1901
*Alembert W. Brayton, Indianapolis	1901	1902
*John B. Berteling, South Bend	1902	1903
*Jonas Stewart, Anderson	1903	1904
*George T. MacCoy, Columbus	1904	1905
*George H. Grant, Richmond	1905	1906
*George J. Cook, Indianapolis	1906	1907
*David C. Peyton, Jeffersonville	1907	1908
*George D. Kahlo, French Lick	1908	1909
*Thomas C. Kennedy, Shelbyville	1909	1910
*Frederick C. Heath, Indianapolis	1910	1911
*William F. Howat, Hammond	1911	1912
*A. C. Kimberlin, Indianapolis	1912	1913
*John P. Salb, Jasper	1913	1914
*Frank B. Wynn, Indianapolis	1914	1915
*George F. Keiper, Lafayette	1915	1916
*John H. Oliver, Indianapolis	1916	1917
*Joseph Rilus Eastman, Indianapolis	1917	1918
*William H. Stemm, North Vernon	1918	1919
*Charles H. McCully, Logansport	1919	1920
*David Ross, Indianapolis	1920	1921
*William R. Davidson, Evansville	1921	1922
*Charles H. Good, Huntington	1922	1923
*Samuel E. Earp, Indianapolis	1923	1924
*Eldridge M. Shanklin, Hammond	1924	1925
*Charles N. Combs, Terre Haute	1925	1926
*Frank W. Cregor, Indianapolis	1926	1927
George R. Daniels, Marion	1926	1928
*Charles E. Gillespie, Seymour	1927	1929
*Angus C. McDonald, Warsaw	1928	1930
*Alois B. Graham, Indianapolis	1929	1931
Franklin S. Crockett, Lafayette	1930	1932
*Joseph H. Weinstein, Terre Haute	1931	1933
*Everett E. Padgett, Indianapolis	1932	1934
*Walter J. Leach, New Albany	1933	1935
Roscoe L. Sensenich, South Bend	1934	1936
*Edmund D. Clark, Indianapolis	1935	1937
Herman M. Baker, Evansville	1936	1938
*Edmund M. Van Buskirk, Ft. Wayne	1937	1939
Karl R. Ruddell, Indianapolis	1938	1940
*Albert M. Mitchell, Terre Haute	1939	1941
Maynard A. Austin, Anderson	1940	1942
Carl H. McCaskey, Indianapolis	1941	1943
*Jacob T. Oliphant, Farmersburg	1942	1944
*Neslen K. Forster, Hammond	1943	1945
*Jesse E. Ferrell, Fortville	1944	1946
*Floyd T. Romberger, Lafayette	1945	1947
Cleon A. Nafe, Indianapolis	1946	1948
Augustus P. Hauss, New Albany	1947	1949
*C. S. Black, Warren	1948	1950
Alfred Ellison, South Bend	1949	1951
*J. William Wright, Indianapolis	1950	1952
Paul D. Crimm, Evansville	1951	1953
Wm. Harry Howard, Hammond	1952	1954
Walter L. Portteus, Franklin	1953	1955
Walter U. Kennedy, New Castle	1954	1956
Elton R. Clarke, Kokomo	1955	1957
M. C. Topping, Terre Haute	1956	1958
Kenneth L. Olson, South Bend	1957	1959
Earl W. Mericle, Indianapolis	1958	1960

*** Deceased.**

CONSTITUTION and BYLAWS
of the
Indiana State Medical Association

CONSTITUTION

ARTICLE I.—NAME OF THE ASSOCIATION

The name and title of this organization shall be the Indiana State Medical Association.

ARTICLE II.—PURPOSE OF THE ASSOCIATION

The purposes of this Association shall be to federate and bring into one compact organization the medical profession of the State of Indiana, and to unite with similar societies of other states to form the American Medical Association; to extend medical knowledge and advance medical science; to elevate the standard of medical education and to secure the enactment and enforcement of just medical laws; to promote friendly intercourse among physicians; to protect its members against imposition; and to enlighten and direct public opinion in regard to the great problems of medical care, and public health, so that the profession shall become more capable and honorable within itself and more useful to the public in the prevention and cure of disease and in prolonging and adding comfort to life.

ARTICLE III.—COMPONENT SOCIETIES

Component societies shall consist of those county medical societies which hold charters from this Association.

ARTICLE IV.—COMPOSITION OF THE ASSOCIATION

Section 1.—This Association shall consist of Active Members, Associate Members, Senior Members and Honorary Members.

Sec. 2.—*Active Members.*—The active members of this Association shall be the members of the component county medical societies, and no county medical society shall grant active membership therein on a basis that does not include membership in the Indiana State Medical Association.

Sec. 3.—*Associate Members.*—Members of the Indiana State Dental Association in good standing are, by virtue of their membership therein, made associate members of the Indiana State Medical Association.

Sec. 4.—*Senior Members.*—Senior members shall be physicians of the State of Indiana who have attained the age of seventy years and have held membership in the Indiana State Medical Association for twenty years or more, and who, upon their application, have been certified to the executive secretary as eligible for such membership by the county societies of which they are members. Eligibility to senior status shall begin the year after the member reaches the age of seventy.

All members who, previous to the adoption of this amendment to the constitution, were certified as honorary members on the basis of the above qualifications, shall hereafter be classified as senior members.

Sec. 5.—*Honorary Members.*—Honorary members shall consist of teachers, scientists and others who have rendered highly meritorious service to the profession of medicine, and of physicians and surgeons of distinction, upon whom the Association may, through vote of the House of Delegates, desire to confer such membership as a special honor.

Sec. 6.—*Rights and Privileges of Members.*—Active members and senior members shall have the same rights and privileges except as follows:

a. Senior members shall not be required to pay membership dues in the State Association.

b. If senior members desire to receive THE JOURNAL of the State Association, they shall pay the regular subscription price therefor.

c. Honorary members hereafter elected shall hold such membership as an honor and distinction and shall have the right to attend meetings of the Association. They shall have the privilege of participating in discussions but shall have no right to vote or to hold office. They shall not be required to pay membership dues in the State Association.

ARTICLE V.—HOUSE OF DELEGATES

The House of Delegates shall be the legislative and business body of the Association and shall consist of (1) Delegates elected by the component county societies; (2) the Councilors; and (3) the ex-presidents of the Indiana State Medical Association. The following shall be *ex officio* members: the President, the President-elect, the Executive Secretary, the Treasurer of this Association, and the delegates to the American Medical Association, all without power to vote, except in case of a tie vote, when the President or person presiding shall cast the deciding vote.

ARTICLE VI.—COUNCIL

The Council shall consist of (1) the Councilors, and (2) *ex officio* the President, President-elect, and Treasurer with power to vote. Besides its duties mentioned in the Bylaws, it shall constitute the Board of Trustees of this organization, having full charge and control of all the property of the Association. It shall have full authority and power of the House of Delegates between sessions of the House of Delegates, except that it shall not make changes in the laws governing the Association nor exercise legislative functions, except as stated in the Bylaws, and at all times shall be the finance committe of the Association. Seven Councilors shall constitute a quorum.

ARTICLE VII.—SECTIONS AND DISTRICT SOCIETIES

The House of Delegates may provide for a division of the scientific work of the Association into appropriate sections; and for the organization of such Councilor District Societies as will promote the best interests of the profession, such societies to be composed exclusively of members of component county societies. Councilor districts shall be defined by the House of Delegates.

ARTICLE VIII.—CONVENTION AND MEETINGS

Section 1.—The Association shall hold an Annual Convention during which there shall be held such general and section meetings as the Association through its duly constituted officers and committees may provide for.

Sec. 2.—The House of Delegates shall select the place two years in advance for holding the annual convention. The time for the convention shall be fixed by the Council, and the Council shall have the power also to change the place for holding the convention where conditions may create difficulties in holding a successful convention at the place designated by the House of Delegates.

Sec. 3.—Special meetings of either the Association or the House of Delegates shall be called by the President on petition of twenty delegates or fifty members.

ARTCLE IX.—OFFICERS

Section 1.—The officers of this Association shall be a President, a President-elect, an Executive Secretary, a Treasurer, and thirteen Councilors, each of whom shall be a member, except the Executive Secretary, who need not necessarily be either a physician or a member.

Sec. 2.—The officers, except the Councilors and the Executive Secretary, whose election has been provided for hereinafter, shall be elected annually. The terms of elected Councilors shall be for three years and approximately one-third of the number shall be elected annually. No Councilor shall be eligible to serve longer than two consecutive three-year terms, effective with the beginning of his next election following the adoption of this amendment.

All of these officers shall serve until their successors are elected and installed. Provided, that if any elected Councilor fails, without reason acceptable to the Council, in any one calendar year to attend a majority of the meetings of the Council, he shall thereby cease to be a Councilor, and the Executive Secretary shall thereupon take action in accordance with Section 4 of this article.

Sec. 3.—The officers of this Association with the exception of the Executive Secretary shall be elected by the House of Delegates as the first order of business of the last day of the Annual Convention, and no person shall be elected to any such office who is not in attendance on that Annual Convention and who has not been a member of the Association for the preceding two years.

Sec. 4.—The Councilors shall be elected by the respective district societies. If any district fails to meet and elect its Councilor by the time of expiration of the incumbent's term of office, the Executive Secretary of the Association shall cause a special meeting to be called by said district society for the purpose of such election.

Sec. 5.—Each Councilor district shall elect an alternate Councilor whose term of office shall be the same as the Councilor, namely three years. The alternate Councilor shall be elected in a year during which there is no Councilor elected.

The duties of the alternate Councilor shall be:

1. To represent the Councilor district in the absence of the regularly elected Councilor.
2. To vote only in the absence of the regularly elected Councilor either in the House of Delegates or in Council meetings where he represents the regularly elected Councilor.
3. The alternate Councilor shall not have the power of discussion if the regularly elected Councilor is present.

Sec. 6.—Any officer may be removed from office after a hearing before the Council, on thirty days' notice, on charges in writing, upon a vote of three-fourths of the members of the Council.

Sec. 7.—In event of the death, resignation, removal, or disability of the President, the President-elect shall succeed to the presidency. In the event of the death, disability, resignation or removal of both the President and the President-elect, the chairman of the Council shall become President pro tem and as such shall, within a period of sixty days, call a special session of the members of the House of Delegates for the purpose of electing members to fill these vacancies, who shall serve until the next regular meeting of the House of Delegates, at which time both a President and a President-elect shall be elected, both of whom shall take office immediately upon their election.

Sec. 8.—A vacancy in the office of Treasurer shall be filled by an election by the Councilors at the next regular meeting of the Council following the occurrence of such vacancy.

Sec. 9.—In the event of a vacancy occurring from any cause, except expiration of the term of office, in the office of any district councilor, the duly elected alternate councilor from the same district shall succeed to the office of councilor in that district for the unexpired term of said councilor.

In the event vacancies occur in any councilor district in the offices of both councilor and alternate councilor, the vacancies shall be filled by an election by the members of the association within the councilor district in which such vacancies occur. A call for such elections shall be issued by the executive secretary of the State Association follow-

ing conference with the officers of the district organization. The call shall state the time and place of holding the election and shall be sent registered mail to the county secretary as filed in the State secretary's office of each component society within the district. Such call shall be mailed within ten days after the State secretary has learned of the vacancies. The election may be held at a special or regular meeting in which other business than the election may be transacted. Such election shall be held within fifteen days after the secretary of the State Association shall have mailed such call.

Sec. 10.—None of the officers shall receive compensation except the Executive Secretary, who shall be employed by the Council, and the Council shall fill any vacancy in that office.

ARTICLE X.—RECIPROCITY OF MEMBERSHIP WITH OTHER STATE SOCIETIES

In order to broaden professional fellowship, this Association is ready to arrange with other State Medical Associations for an interchange of certificates of membership so that members moving from one state to another may avoid the formality of re-election.

ARTICLE XI.—INCOME AND EXPENSES

Funds for carrying on the activities of this Association shall be raised by the following means:

a. Membership dues to be collected by the component county societies in connection with the dues for such component societies. The amount of the dues of each component society shall be fixed by the society itself; and the amount of dues for this Association shall be fixed from time to time by the House of Delegates.

b. Voluntary contributions.

c. Revenues derived from the Association's publications.

d. Any other manner approved by the House of Delegates.

Funds may be appropriated by the House of Delegates to defray the expenses of the Association, for publications, and for such other purposes as will promote the welfare of the profession. All motions and resolutions appropriating funds must be referred to the Council for approval before final action is taken thereon.

ARTICLE XII.—REFERENDUM

Section 1.—A General Meeting of the Association may, by a two-thirds vote of the members present, order a general referendum on any question pending before the House of Delegates, and when so ordered the House of Delegates shall submit such question to the members of the Association, who may vote by mail or in person, and if the members voting shall comprise a majority of all members of the Association, a majority of such vote shall determine the question and be binding on the House of Delegates.

Sec. 2.—The House of Delegates may, by a two-thirds vote of its own members, submit any question before it to a general referendum, as provided in the preceding section, and the result shall be binding on the House of Delegates.

ARTICLE XIII.—THE SEAL

The Association shall have a common Seal, with power to break, change or renew the same at pleasure.

ARTICLE XIV.—AMENDMENTS

The House of Delegates may amend any article of this Constitution by a two-thirds vote of the delegates present at any Annual Convention, provided that such amendment shall have been presented in open meeting at the previous Annual Convention, and that it shall have been published twice during the year in THE JOURNAL of this Association.

BYLAWS

CHAPTER I.—MEMBERSHIP

Section 1.—The term "Member" as used in these Bylaws unless otherwise indicated shall mean both active and senior members of component county medical societies who hold either the Degree of Doctor of Medicine or Bachelor of Medicine.

Sec. 2.—Any physician who is a member in good standing of a component county society and who has paid to this Association his annual dues is a member in good standing of the Indiana State Medical Association, provided, however, that he is a citizen of the United States of America, or has filed his declaration of intention of becoming a citizen and his first citizenship papers are in full force and effect.

Sec. 3.—No person who is under sentence of suspension or expulsion from a component society, or whose name has ben dropped from its roll of members, shall be entitled to any of the rights or benefits of this Association, nor shall he be permitted to take part in any of its proceedings until he has been relieved of such disability.

Sec. 4.—Each member in attendance at the Annual Convention shall register by indicating the component society of which he is a member. When his right to membership has been verified, by reference to the roster of his society, he shall receive a badge, which shall be evidence of his right to all the privileges of membership at that convention. No member shall take part in any of the proceedings of an Annual Convention until he has complied with the provisions of this section.

CHAPTER II.—GENERAL MEETINGS

Section 1.—General Meetings shall mean all meetings planned for attendance by all registered members, and shall include those meetings in which guests of registered members or the general public are also invited. The address of the President may be delivered in a General Meeting,

and the programs of General Meetings shall be arranged by the Executive Committee except where scientific papers are included, in which event the scientific part of the program shall be arranged by the Committee on Scientific Work, with the sanction and approval of the officers.

Sec. 2.—The General or Section Meetings may recommend to the House of Delegates the appointment of committees or commissions for scientific investigation of special interest and importance to the profession and public.

Sec. 3.—All scientific papers read before the Association or any of the sections shall become its property and shall not be published in any but the official publications of this Association, except by consent of the officers and the Editorial Board of this Association. Each such paper shall be deposited with the Executive Secretary when read.

Sec. 4.—The Council shall appropriate from the funds of the Association for such an amount as in the discretion of the Council shall be reasonably needed for that purpose, and no commitments shall be made for expenses in excess of the amount appropriated for such Convention. The funds so appropriated shall, upon the approval of the Executive Committee, be expended at the direction of the Committee on Convention Arrangements appointed by the President for the Convention for which the appropriation is made. All money in excess of that expended for actual expenses incurred shall revert each year to the treasury of the Association.

CHAPTER III.—SECTIONS

Section 1.—During the Annual Convention the Association in addition to the general meetings may hold the following section meetings:

a. Surgical.

b. Medical.

c. Eye, Ear, Nose, and Throat.

d. Anesthesia.

e. General Practice.

f. Obstetrics and Gynecology.

g. Preventive Medicine and Public Health.

h. Radiology.

i. Any other sections that hereafter may be provided for by the House of Delegates.

Sec. 2.—The officers of each section shall be a Chairman, a Vice-Chairman, and a Secretary, and they shall preside over the meetings of the sections and shall be responsible to the Committee on Scientific Work for the section speakers and papers.

Sec. 3.—The election of officers of the sections shall be the last order of business of the last meeting of the sections during the Annual Convention.

Sec. 4.—No section meeting shall be allowed to conflict with a general meeting.

CHAPTER IV.—HOUSE OF DELEGATES

Section 1.—The House of Delegates may meet on the day before the date set for the beginning of the general registration of the attendance at the Annual Convention. It may adjourn from time to time as may be necessary to complete its business, provided that its hours shall conflict as little as possible with the General or Section Meetings. It shall meet on the last day of the Annual Convention for the election of officers for the ensuing year, and for the completion of any business previously introduced. The order of business shall be arranged as a separate section of the program.

Sec. 2.—Each component county society shall be entitled to send to the House of Delegates each year one delegate for every fifty members and one for each major fraction thereof; but, irrespective of the number of members, each component society which has made its annual report and paid its assessments, as provided in this Constitution and Bylaws, shall be entitled to one delegate, except that where a component society is made up of physicians of more than one county, each county shall be entitled to at least one delegate and one alternate delegate who shall be a resident of the county he represents as a delegate or alternate delegate and who shall be selected by the physicians residing in such county.

The number of Delegates to which each Component Society is entitled shall be based upon the number of members on record in the office of the Executive Secretary in good standing with current dues fully paid as of December 31 of the preceding year.

The names of duly elected delegates and alternates from each component society shall be sent to the Executive Secretary of this Association annually on or before December first prior to the Annual Convention at which such delegates are to serve. No one shall be entitled to a seat in the House of Delegates unless his credentials as a delegate or alternate, properly signed by the secretary of his county society, be presented to the Committee on Credentials at the time of the Annual Convention.

Sec. 3.—Fifty delegates shall constitute a quorum.

Sec. 4.—The House of Delegates shall:

a. Elect representatives to the House of Delegates of the American Medical Association in accordance with the Constitution and Bylaws of that body.

b. Divide the State into Councilor Districts, specifying what counties each district shall include, and when the best interests of the Association and profession will be promoted thereby, organize in each district a medical society, and all members of component county societies, and no others, shall be members of such district societies.

c. Have authority to appoint committees for special purposes from among members of the As-

sociation who need not be members of the House of Delegates. Such committees shall report to the House of Delegates, and the members of such committees may be present and participate in the debate on their reports.

d. Approve all memorials and resolutions issued in the name of the Association before the same shall become effective.

Sec. 5.—Funds may be appropriated by the House of Delegates, subject to approval by the Council, for such purposes as will promote the welfare of the Association and the profession.

Sec. 6.—At the first meeting the President shall announce the membership of the reference committees, as hereinafter provided for, and any other committees considered by him necessary to expedite the business of the Association.

Sec. 7.—All resolutions to be presented to the House of Delegates for action shall be prepared and mailed to the Executive Secretary of the Association so that he will receive them not later than forty-five days prior to the meeting of the House of Delegates to which the resolutions will be presented for action.

Provided, that this sub-section of the Bylaws may be suspended with respect to any resolution upon a two-thirds majority vote of the House of Delegates.

CHAPTER V.—ELECTION OF OFFICERS

Section 1.—The election of officers shall be the first order of business of the House of Delegates after the reading of the minutes on the last day of the Annual Convention.

Sec. 2.—All elections shall be by ballot, and a majority of the votes cast shall be necessary to elect. In case no nominee receives a majority on the first ballot, the nominee receiving the lowest number of votes shall be dropped and a new ballot taken.

Sec. 3.—Any person known to have solicited votes for or sought any office within the gift of this Association shall be ineligible for any office for two years.

Sec. 4.—The President, President-elect, and the Treasurer shall serve from the termination of the annual meeting of the House of Delegates in which the President-elect and Treasurer are elected until the termination of the succeeding annual meeting of the House of Delegates.

CHAPTER VI.—DUTIES OF OFFICERS

Section 1.—The president, or a member designated by him, shall preside at all general meetings of the Association and of the House of Delegates. The President shall appoint all committees not otherwise provided for; he shall deliver an annual address at such time as may be arranged by the Executive Committee, and shall perform such other duties as custom and parliamentary usage may require. He shall be the real head of the profession of the state during his term of office, and as far as practicable, shall visit by appointment the various sections of the state and assist the Councilors in building up the county societies and in making their work more practical and useful.

Sec. 2.—The President-elect's term of office shall be for one year, at the completion of which he succeeds to the presidency. While President-elect, he shall assist the President in the discharge of his duties.

Sec. 3.—The Treasurer shall give bond at the expense of the Association in such an amount as shall be required by the Council. He shall receive all bequests and donations to the Association and shall demand and receive all funds due the Association except accounts due THE JOURNAL in the conduct of its business. The funds of the Association shall be deposited in a depository or depositories designated by the Executive Committee, and withdrawals from such funds shall be made on checks or drafts signed by the Treasurer and the Chairman of the Council. He shall present to the House of Delegates annually a report of the receipts and expenditures, and the state of the funds in his hands, and shall subject his accounts to an annual audit by a Certified Public Accountant.

Sec. 4.—The Executive Secretary shall be the directing manager of the Association's headquarters and JOURNAL offices, and shall supervise the work of all salaried employees in the Association offices. Such supervision shall be subject to directives from the House of Delegates, the Council, the Executive Committee, and the President of the Association. He shall discharge the administrative functions of the Association not within the duties of other officers or of committees to perform. He shall assist, at their request, all officers and committees, and shall keep himself informed in regard to non-professional matters affecting the medical profession, for the purpose of keeping himself qualified to perform the services herein mentioned. He shall be responsible for the execution and carrying out of the policies of the Association and in that connection shall perform all specific tasks committed to him by the committees, the Council, and the officers of this Association. The amount of his salary shall be fixed by the Executive Committee on approval of the Council.

Sec. 5.—The necessary expenses of the above officers incurred in the line of duty herein imposed may be allowed by the Council, but excepting the Executive Secretary, this shall not include the expenses of attending the Annual Convention.

CHAPTER VII.—COUNCIL

Section 1.—The Council shall meet as follows: 1. January, April, and July of each year on dates and at places fixed by the Council. 2. On the day

preceding the first day for the scientific meetings of the Annual Convention of the Association. 3. On the last day of the Annual Convention of the Association after the adjournment of the House of Delegates. 4. At such other times as necessity may require, subject to the call of the Chairman, or on petition of three Councilors. It shall hold no meeting that will conflict with any meeting of the House of Delegates. It shall elect a Chairman, and a Clerk, who, in the absence of the Executive Secretary of the Association, shall keep a record of its proceedings. It shall, through its Chairman, make an annual report to the House of Delegates. It shall organize itself at the meeting following the final session of the House of Delegates by electing its chairman who shall serve for one year. The chairman of the Council shall be elected by secret ballot. The number of terms of the chairman shall be limited to not more than three in succession.

Terms of councilors shall begin with the first meeting of the Council following the final session of the House of Delegates at the Annual Session.

Sec. 2.—Each Councilor shall be organizer, peacemaker, and censor for his district. He shall visit the counties in his district at least once a year for the purpose of organizing component societies where none exist; for inquiring into the condition of the profession, and for improving and increasing the zeal of the county societies and their members. He shall make an annual report of his work and of the condition of the profession of each county in his district, the same to be published in the number of THE JOURNAL which is issued immediately preceding the Annual Convention. The House of Delegates may take such action, if any, as it deems appropriate upon such reports. The necessary expenses incurred by such Councilor in the line of the duties herein imposed may be allowed by the Council on a properly itemized statement, but this shall not be construed to include his expense in attending the Annual Convention of the Association.

Sec. 3.—The Council shall, through its officers and otherwise, give diligent attention to and foster the scientific work and spirit of the Association, and shall study and strive constantly to make each Annual Convention a stepping stone to future ones of higher interest.

Sec. 4.—The Council shall, in connection with the House of Delegates, consider and advise as to the interests of the profession and of the public in those important matters wherein it is dependent upon the profession, and shall use its influence to secure and enforce all proper medical and public health legislation and to diffuse popular information in relation thereto.

Sec. 5.—The Council shall make careful inquiry into the condition of the profession of each county in the state and shall have authority to adopt such methods as may be deemed most efficient for building up and increasing the interest in such county societies as already exist, and for organizing the profession in counties where societies do not exist. It shall especially and systematically endeavor to promote friendly intercourse among physicians of the same locality and shall continue these efforts until every physician in every county of the state who can be made reputable has been brought under medical society influence.

Sec. 6.—The Council shall encourage postgraduate and research work, as well as home study, and shall endeavor to have the results utilized and intelligently discussed in the county societies.

Sec. 7.—The Council shall, upon application, provide and issue charters to county societies organized to conform to the spirit of this Constitution and Bylaws.

Sec. 8.—In sparsely settled sections it shall have authority to organize the physicians of two or more counties into societies to be designated by hyphenating the names of two or more counties so as to distinguish them from district and other classes of societies; and these societies, when organized and chartered, shall be entitled to all the privileges and representation provided herein for county societies, until such counties may be organized separately.

Sec. 9.—The Council shall be the Board of Censors of the Association. It shall consider all questions involving the rights and standings of members whether in relation to other members, to the component societies, or to this Association. All questions of an ethical nature brought before the House of Delegates or the General or Section Meetings shall be referred to the Council without discussion. It shall hear and decide all questions of discipline affecting the conduct of members of component societies on which an appeal is taken from the decision of an individual Councilor, and its decision in all such matters shall be final.

Sec. 10.—The Council shall provide for and superintend all publications of the Association, and shall have authority to appoint an editor and such assistants as it deems necessary, and fix the amounts of their salaries. The proceedings of the Council for the year shall be reported to the House of Delegates at the Annual Convention and be published in the number of THE JOURNAL which immediate precedes the Annual Convention.

Sec. 11.—In the interim between the meetings of this Association the Council shall be the executive body of the Association with full power to fill vacancies or transact any business that emergencies or the welfare of the Association may require.

Sec. 12.—The Council shall at its meeting following the close of the House of Delegates elect two members of the Association, at large, or of the Council, who, with the President, the President-elect, the Treasurer, and the Chairman of the Council, shall constitute and be known as the

Executive Committee. If such members of the Executive Committee be not members of the Council they shall not have the power of vote in the Council.

CHAPTER VIII.—ORGANIZATION OF ACTIVITIES AND RESPONSIBILITIES

Section 1.—The work of the Association, the performance of which is not provided for elsewhere in the Constitution or Bylaws, and is not carried on in the meetings of the Council or of the House of Delegates, or by Special Committees created by the Executive Committee, the Council, or the House of Delegates, shall be performed by the following standing committees and commissions:

The Executive Committee
The Grievance Committee
The Student Loan Committee
The Medical-Legal Review Committee
The Commission on Convention Arrangements
The Commission on Constitution and Bylaws
The Commission on Legislation
The Commission on Public Information
The Commission on Governmental Medical Services
The Commission on Public Health
The Commission on Voluntary Health Agencies
The Commission on Medical Economics and Insurance
The Commission on Inter-Professional Relations
The Commission on Medical Education and Licensure
The Commission on Special Activities

The difference between committees and commissions is shown in the provision of these Bylaws pertaining to their work and composition.

Sec. 2.—Unless otherwise provided in these Bylaws, the committees shall be appointed by the President with the chairman of each committee designated by him, and the number constituting each committee shall be as indicated in the section of these Bylaws pertaining to each particular committee.

Sec. 3.—Each commission will consist of fifteen members appointed by the President, with at least one member from each councilor district. The original appointees in each commission shall be divided into three groups by lot. The first group shall serve three years; the second, two years; and the third, one year. Thereafter, each incoming President shall appoint five members of each commission to fill the vacancies resulting from the expiration of the terms of members, and such appointments shall be for three years. The President shall also appoint members to fill the unexpired term where any vacancy occurs through death, resignation or otherwise.

Sec. 4.—The President shall have the power, with the approval of the Council, to remove any member of any committee or commission where such member, for any reason, does not or cannot work at attempting to perform the duties pertaining to membership on such committee or commission.

Sec. 5.—Unless otherwise provided in these Bylaws, no member of either a committee or a commission shall serve on the same committee or commission more than two consecutive terms, but this shall not prevent him serving more than two terms if the term of another member intervenes. The time given to the serving of an unexpired term shall not be considered in determining the period within which a member may serve consecutively.

Sec. 6.—Within sixty days after the meeting of the State Convention, the President will call all commissions and committees into a joint meeting in which he will give a statement of the duties and responsibilities of all committees and commissions, call special attention to any immediate problems confronting the Association, and assign such problems or parts thereof to appropriate committees and commissions. Then this joint meeting will divide into meetings of the separate commissions, at which time the commissions and committees will organize by the election of chairman, vice-chairman and secretary, unless ohterwise provided for in these Bylaws. In these meetings the commissions may provide for such subcommittees within the separate commissions as they may deem advisable. Each committee or commission shall have the right to call upon other committees, commissions or members of the profession for counsel and advice with respect to its work.

Sec. 7.—Each committee and commission shall have the privilege and is encouraged to have joint meetings with any like committee or commission of the Auxiliary where such like committee or commission exists, for the purpose of coordinating their activities to make them more effective in the medical service of the public and the intent of the Association.

Sec. 8.—Each committee and commission shall have the duty and responsibility of keeping constantly and currently informed on the matters within the area of its special interest and activity; of studying the conditions within that area with the purpose of finding possibilities of improvement; of finding the best solutions it can to the specific problems referred to it; of contributing in its area to the achievements of the Association as a whole in the protection and improvement of the health of the whole human family; and finally of making all its efforts useful by passing on to the Association in the most effective manner possible the results of its studies and activities in its own area of special interests.

Sec. 9.—The President and Executive Secretary shall be *ex officio* members of all the foregoing committees and commissions without voting rights where their inclusion on the committee or commission is not otherwise provided for in these Bylaws.

CHAPTER IX.—THE EXECUTIVE COMMITTEE

Section 1.—The Executive Committee, constituted as provided in Section 12 of Chapter VII of these Bylaws, shall hold its first meeting immediately following the meeting of the Council held at the close of the last meeting of the House of Delegates in the annual convention, and shall organize by electing its chairman. Its secretary shall be the Executive Secretary of the Association. It shall meet with the Executive Secretary on the call of the Chairman, or of any three members, to plan and execute such work as may be necessary for the welfare of the Association and the conduct of the Executive Secretary's office. It shall have all jurisdiction with respect to medical defense activities of the Association and shall be governed by the rules it adopts concerning that activity and by the Bylaws of this Association. It shall make decisions for the Association, including matters pertaining to THE JOURNAL, during the intervals between the meetings of the Council, and shall report its actions to the Council.

Sec. 2.—It shall prepare a budget for the ensuing fiscal year; and all expenditures of the Association, except those otherwise provided for under the Constitution and Bylaws, shall be governed by the budget. No expense not provided for in the budget or otherwise under the Constitution and Bylaws shall be incurred by any officer, commission or committee. A committee, commission or officer may submit a request for funds to meet unusual expenses not included in the annual budget, and the Executive Committee shall have the power, by a two-thirds vote, to amend the budget to provide such funds.

CHAPTER X.—THE GRIEVANCE COMMITTEE

Section 1.—The Grievance Committee shall be composed of nine physicians, three of whom may be past presidents of the Association, and all of whom shall be appointed by the President. Not more than two physicians shall be appointed from any one councilor district. No member shall hold any elective office in the State Association during tenure on this committee. Of the nine physicians first appointed, three shall serve for a period of one year; three for two years; and three for three years. Thereafter, three shall be appointed each year for a three-year term to fill the vacancies caused by the expiration of terms. Any vacancy occurring in this committee, other than by expiration of term, shall be filled by an interim appointee to serve the balance of the unexpired term. This committee shall organize itself by electing a chairman, a vice-chairman and a secretary.

Sec. 2.—This provision regarding the constitution of the Grievance Committee shall be construed to mean that the present committee of that name is continued in that position with the terms of its members expiring and new members to be appointed on the basis of this provision being operative and effective as of the dates of their respective original appointments; and it is not to be construed as having the effect of creating a new committee, all of whose members are to be appointed upon this amendment being adopted and becoming effective.

Sec. 3.—In addition to the above provided organization and membership of the committee, the President of the Association shall appoint an accredited psychiatrist as a consultant for the committee, whose tenure of office shall be on an annual basis. The appointment of the psychiatrist may be made from any councilor district of the Association, irrespective of the membership of the committee including another member or members from the same councilor district. He shall have the same rights and privileges as other members of the committee except that he shall not have the right to vote.

Sec. 4.—The duties of this committee shall be to receive complaints, appeals or suggestions from physicians or laymen concerning professional conduct. It shall attempt to find the facts regarding any matter brought to its attention, through procedures proper and appropriate to that end, and shall attempt to adjust differences between patients and physicians, and between physicians. It may, if it believes the facts justify such action, cite a member of the Association to the Council of the State Association. It shall, subject to the approval of the Council, draw up a set of rules and regulations governing its procedure and official actions.

CHAPTER XI.—THE COMMISSION ON CONVENTION ARRANGEMENTS

Section 1.—The Commission on Convention Arrangements, with the advice and assistance of the Executive Secretary, shall provide suitable accommodations for meetings of the Association, including the House of Delegates, Council, and of their respective committees, the scientific and technical exhibits, and in conjunction with the Executive Secretary, shall have general charge of all the arrangements. Its chairman shall report an outline of the arrangements to the Executive Secretary of the Association for publication in THE JOURNAL and in the official programs, and shall make additional announcements during the session as occasion may require. The arrangements and the character of any and all technical exhibits must meet with the approval of the Executive Committee of the Association.

Sec. 2.—It shall, with the approval of the Executive Committee, prepare a program for scientific work for the annual convention in which shall be included the respective programs for section meetings which shall be prepared through cooperation with the officers of the various sections; and it shall, with the approval of the Executive Committee, arrange for scientific exhibits as a part of the annual convention.

Sec. 3.—The general, scientific and sectional programs, and the financial arrangements to provide for them must be approved by the Executive Committee before being officially announced.

CHAPTER XII.—THE STUDENT LOAN COMMITTEE

Section 1.—The Student Loan Committee shall be constituted as follows:

(a) The President of Indiana State Medical Association
(b) One Councilor of the Association to be appointed by the President
(c) One general practitioner to be appointed by the President
(d) One specialist to be appointed by the President
(e) The Treasurer of Indiana State Medical Association
(f) The Dean of Indiana University School of Medicine
(g) One of the attorneys of Indiana State Medical Association to be appointed by the President

Sec. 2.—This committee shall have authority to make loans to medical students in accordance with the terms and conditions under which funds are made available for that purpose. The committee shall organize itself at its first meeting following the annual convention of the Association, by the election of a chairman and a secretary. The committee shall adopt its own rules and regulations, subject to the approval of the Council. The secretary shall have the duty and responsibility of keeping minutes of all transactions of the committee, and shall file a copy of such minutes, as well as a copy of all papers pertaining to any application or loans, in the Headquarters Office of the Association.

CHAPTER XIII.—THE MEDICAL-LEGAL REVIEW COMMITTEE

Section 1.—The Medical-Legal Review Committee shall consist of three members whose duty it shall be to meet in joint session and work with a similar committee to be appointed by the President of the State Bar Association. This committee of the Medical Association shall function as the medical representatives provided for in the Joint Inter-Professional Code of the State Medical Association and the State Bar Association to carry out the purposes of that Code. Its duties shall be as stated in that Code in the form in effect from time to time as approved by the Association.

CHAPTER XIV.—THE COMMISSION ON CONSTITUTION AND BYLAWS

Section 1.—The Commission on Constitution and Bylaws shall keep in contact with the developments and changes in procedures in carrying on the work of this Association; shall suggest revisions necessary to keep the Constitution and Bylaws always in accord with the practices and procedures best adapted to the functioning of the Association; and shall keep the practices and procedures of the Association consistent with the provisions from time to time contained in the Constitution and Bylaws—to the end that all members of the profession, by reference to the Constitution and Bylaws, may be able to obtain accurate information regarding procedure and practice within the Association, and that hampering of such procedure and practice by obsolete provisions in the Constitution and Bylaws may be avoided.

CHAPTER XV.—THE COMMISSION ON LEGISLATION

Section 1.—The Commission on Legislation shall study all legislation, both state and national, and all local legislative trends and movements, as to their effect upon the practice of medicine and the protection of the public health; shall keep the profession informed at all times concerning the matters within its area of responsibility; shall conduct investigations of legislative proposals; and shall maintain liaison with members of the State Legislature and of the United States Congress, and with the legislative activities of the American Medical Association. It shall strive to implement and make effective the legislative proposals adopted by the Association.

CHAPTER XVI.—THE COMMISSION ON PUBLIC INFORMATION

Section 1.—The Commission on Public Information shall collect and organize for dissemination to the public all matters of public interest within the field of medicine, including the activities of other commissions in which the public interest would be involved, and including also the achievements in the advancement of medicine which would be of interest to the public; shall disseminate all such information through the use of whatever media the Commission may find adaptable to that purpose so that such information may be brought to the public in the most effective and convincing manner; and shall develop and maintain the relations of the medical profession with the public in such a way as to give the lay public a better knowledge and understanding of the aims, objects and value of the profession to the public.

CHAPTER XVII.—THE COMMISSION ON GOVERNMENTAL MEDICAL SERVICES

Section 1. — The Commission on Governmental Medical Services shall concern itself and assume special responsibility in obtaining information and giving counsel and advice to the Association with respect to all matters in which medical service comes into contact with any existing or proposed functions of government, including civil defense, rehabilitation of persons handicapped by abnormality or disease, medical service in welfare departments, maternal and child health programs sponsored through governmental agencies, medical care of military manpower, plans and programs for medical care of veterans, medical care for dependents of those in uniformed services of the

Government, plans and programs of the Government for medical care now existing or which may hereafter be adopted by any special group, government programs for elimination of venereal disease and other communicable diseases, and all programs and plans for medical care to be provided through municipal, state or federal governments.

CHAPTER XVIII.—THE COMMISSION ON PUBLIC HEALTH

Section 1.—The Commission on Public Health shall assemble and study information regarding industrial medical practice, rural health, preventive medicine, placement of physicians, traffic safety, conservation of hearing and vision; and shall bring such information, and the possibility of progress and advancement in such fields, to the attention of the medical profession, with suggestions for improvements as the commission finds such possibilities.

CHAPTER XIX.—THE COMMISSION ON VOLUNTARY HEALTH AGENCIES

Section 1.—The Commission on Voluntary Health Agencies shall maintain liaison between all voluntary health agencies and the Association; shall study and counsel in regard to planning all educational and other activities of such agencies; and shall keep the Association fully informed at all times regarding present and contemplated programs of these agencies.

CHAPTER XX.—THE COMMISSION ON MEDICAL ECONOMICS AND INSURANCE

Section 1.—The Commission on Medical Economics and Insurance shall study and improve forms used in medical and hospital insurance; shall continuously be interested in all types of plans for prepayment of medical and hospital expense, and for provision for medical and hospital service through all types of group activity; shall maintain liaison with labor with respect to labor's problems involving medical and hospital care, and Workmen's Compensation problems; and shall seek improved solutions of professional liability or malpractice problems, tax problems in relation to medical practice, and problems involving physician retirement plans.

CHAPTER XXI.—THE COMMISSION ON INTER-PROFESSIONAL RELATIONS

Section 1.—The Commission on Inter-Professional Relations shall study to find all the best methods of maintaining on the highest and most satisfactory levels physicians' professional relations with hospitals, nurses, dentists, pharmacists, pharmaceutical manufacturers, veterinarians, nursing homes, and all other professional groups with which the practice of medicine comes into contact.

CHAPTER XXII.—THE COMMISSION ON MEDICAL EDUCATION AND LICENSURE

Section 1.—The Commission on Medical Education and Licensure shall maintain liaison with, and try to be of assistance to, medical schools and the licensing board; and shall keep in contact with, and endeavor to assist in improving, undergraduate education, postgraduate education, intern training, resident training, preceptor instruction, and public school health education.

CHAPTER XXIII.—THE COMMISSION ON SPECIAL ACTIVITIES

Section 1.—The Commission on Special Activities shall organize and promote support for the American Medical Education Fund, assistance to physicians, blood banks, and all miscellaneous activities not falling within the area of responsibilities of other commissions or committees.

CHAPTER XXIV.—REFERENCE COMMITTEES

Section 1.—Immediately after the organization of the House of Delegates at each Annual Convention, the President shall announce the membership of the reference committees to serve during the convention for which they are appointed. Appointments to these reference committees shall be made by the President in time for them to be published in THE JOURNAL and the Handbook prior to such Annual Convention.

The President shall have the power to appoint substitutes from among the members present for absent appointees.

Each committee shall consist of five members, at least three of whom shall be members of the House of Delegates. The chairman shall be named by the President from among those who are members of the House of Delegates. To these committees shall be referred all reports, resolutions, measures and propositions presented to the House of Delegates, except such matters as properly come before the Council, and the recommendations of these committees shall be submitted to the next meeting of the House of Delegates for acceptance in the original or modified form or for rejection.

Sec. 2.—The following Reference Committees are hereby constituted to which shall be referred all matters as indicated by the titles of the committees:

(1) Sections and Section Work
(2) Rules and Order of Business
(3) Medical Education and Hospitals
(4) Legislation
(5) Public Relations
(6) Hygiene and Public Health
(7) Amendments to the Constitution and By-laws
(8) Reports of Officers
(9) Credentials
(10) Insurance
(11) Miscellaneous Business

Where a report, resolution, measure, or proposition deals with more than one subject matter, reference thereof may, in the discretion of the President, be made (a) to as many reference Committees as are necessary to cover all subjects included therein; or (b) to only one Reference Committees as are necessary to cover all subjects

the scope of its reference the most important part of the matter referred.

No report of any Reference Committee shall be rejected on the ground that it covers something not included in the matters which such Committee was created to consider.

Sec. 3.—The time and place of meetings of all reference committees shall be publicly posted, and all meetings of all reference committees shall be open to all members of the Association.

Officers and chairmen of all committees whose reports are referred to reference committees shall have the right to appear and be heard before the respective committees to which such references are made, in regard to their reports.

CHAPTER XXV.—COUNTY SOCIETIES

Section 1.—All county societies now in affiliation with this Association or those which may hereafter be organized in this state, which have adopted principles of organization not in conflict with this Constitution and Bylaws, shall, on application, receive a charter from and become a component part of this Association. The acceptance or retention of this charter shall be regarded as a pledge on the part of said component society to conduct itself in harmony with the letter and spirit of this Constitution and Bylaws and other rules and resolutions of this Association.

Sec. 2.—Charters shall be issued only upon approval of the Council and shall be signed by the President and Executive Secretary of this Association. The Council shall have authority to revoke the charter of any component society whose actions are in conflict with the letter and spirit of this Constitution and Bylaws.

Sec. 3.—Only one component medical society shall be chartered in any county. Where more than one county society exists, friendly overtures and concessions shall be made, with the aid of the Councilor for the district if necessary, and all of the members brought into one organization. In case of failure to unite, an appeal may be made to the Council, which shall decide what action shall be taken.

Sec. 4.—Each county society shall be judge of the qualifications of its own members, but, as such societies are the only portals to this Association and to the American Medical Association, every reputable and legally registered physician who does not practice or claim to practice, nor lend his support to, any exclusive system of medicine, shall be entitled to membership. Before a charter is issued to any county society, full and ample notice and opportunity shall be given to every physician in the county to become a member.

Sec. 5.—Any physician who may feel aggrieved by the action of the society of his county in refusing him membership, or in suspending or expelling him, shall have the right to appeal to the Council, and its decision shall be final.

Sec. 6.—In hearing appeals the Council may admit oral or written evidence as in its judgment will best and most fairly present the facts, but in case of every appeal, both as a board and as individual Councilors in district and county work, efforts at conciliation and compromise shall precede all such hearings.

Sec. 7.—When a member in good standing in a component society moves to another county in this state his name, on request, shall be transferred without cost to the roster of the county society into whose jurisdiction he moves, provided the transfer is approved by majority vote of the membership of said society to which the membership is proposed.

Sec. 8.—A physician living on or near a county line may hold his membership in that county most convenient for him to attend, on permission of the society in whose jurisdiction he has his office or has the major part of his practice.

Sec. 9.—Each component society shall have general direction of the affairs of the profession in its county, and its influence shall be constantly exerted for bettering the scientific, moral and professional status of every physician in the county; and systematic efforts shall be made by each member, and by the society as a whole, to increase the membership until it embraces every qualified and honorable physician in the county.

Sec. 10.—At the annual business meeting for election of other officers, in advance of the Annual Convention of this Association, each county society shall elect delegates and alternates to represent it in the House of Delegates of this Association, and the secretary of the society shall send a list of such delegates and alternates to the Executive Secretary of this Association annually on or before August first.

Sec. 11.—The secretary of each component society shall keep a roster of all its members and of the non-affiliated registered physicians of the county, in which shall be shown the full name, address, college and date of graduation, date of license to practice in this state, and such other information as may be deemed necessary. In keeping such roster the secretary shall note any changes in the personnel of the profession by death, or by removal to or from the county, and in making his annual report he shall be certain to account for every physician who has lived in the county during the year.

The secretary of each component society shall prepare and send to the Councilor of his district a quarterly report briefly stating the activities of his county society including meetings, programs, changes in officers and personnel of membership. A copy of this quarterly report to the Councilor shall also be sent to the Executive Secretary of the State Association. The State Association shall supply each county secretary a form for these reports.

Sec. 12.—The fiscal year of the Association shall be from October 1 to September 30 of the succeeding year. The dues shall be collected by the calendar year and payable in advance.

The secretary of each component society shall forward the dues for his society, together with the roster of officers and members and list of non-affiliated physicians of the county, to the Executive Secretary of this Association, on or before January 1 of each year and he shall promptly report thereafter the names of any new members elected to membership in his society, and promptly forward to the Executive Secretary of this Association the dues for such new members.

The dues shall be the same for all members and entitle the members to all benefits, including the publications of this Association, from the time of paying the dues to the close of the year only. Provided, however, that physicians elected to their first membership in this Association during the first nine months of any year shall pay the regular annual dues for that year; and those elected to their first membership after October 1 of any one year shall pay $10.00 as dues for the remainder of that year. Interns and residents shall pay $10.00 a year annual dues during their term of service in the hospital.

In the event the county society remits a member's dues for good cause, the secretary of the county medical society shall recommend in writing to the councilor of his district the remission of the state association dues of said member of the society, showing good cause why such recommendation should be granted. The councilor in turn may present the recommendation to the Council, which shall have the power to remit such dues.

Sec. 13.—Any county society which fails to pay its dues or make the report required by February 1 of each year shall be held suspended, and none of its members or delegates shall be permitted to receive any of the publications of the Association or participate in any of the business or proceedings of the Association or of the House of Delegates until such requirements have been met.

Sec. 14.—Each county society shall be held responsible for the faithfulness in the performance of duty on the part of its secretary in making reports and remitting dues to the Association.

Sec. 15.—Each component society shall have its own Constitution and Bylaws, which shall not be in conflict with the Constitution or Bylaws either of this Association or of the American Medical Association. An up-to-date copy thereof shall be filed with the Executive Secretary of the Indiana State Medical Association not later than May 1 of each calendar year, or where such copy is so on file and no change has been made, then it shall be sufficient to file a certificate to that effect with said Executive Secretary.

CHAPTER XXVI.—COUNCILOR DISTRICT MEDICAL SOCIETIES

Section 1.—A Councilor District Medical Society, hereinafter called the District Society, shall be a society whose members consist of the members of the County Medical Societies in the Counties which constitute the Councilor District, provided such members of County Medical Societies have paid their membership dues in the District Society.

Sec. 2.—The State shall be divided into thirteen (1) Councilor Districts with the boundary lines and numbers of each District to be as follows:

First District — Posey, Vanderburgh, Warrick, Spencer, Perry, Pike and Gibson Counties.

Second District—Knox, Daviess, Martin, Monroe, Owen, Greene and Sullivan Counties.

Third District — Dubois, Crawford, Harrison, Floyd, Clark, Scott, Washington, Orange and Lawrence Counties.

Fourth District—Jackson, Jennings, Jefferson, Switzerland, Ohio, Dearborn, Ripley, Decatur, Bartholomew and Brown Counties.

Fifth District—Clay, Vigo, Vermillion, Parke and Putnam Counties.

Sixth District—Shelby, Rush, Fayette, Franklin, Union, Wayne, Henry and Hancock Counties.

Seventh District—Morgan, Johnson, Marion and Hendricks Counties.

Eighth District—Madison, Delaware, Randolph, Jay and Blackford Counties.

Ninth District — Fountain, Montgomery, Boone, Hamilton, Tipton, Clinton, Tippecanoe, Warren, Benton and White Counties.

Tenth District — Newton, Jasper, Porter and Lake Counties.

Eleventh District — Carroll, Howard, Grant, Huntington, Wabash, Miami and Cass Counties.

Twelfth District—Wells, Adams, Whitley, Allen, Noble, DeKalb, LaGrange and Steuben Counties.

Thirteenth District—Pulaski, Fulton, Kosciusko, Marshall, Starke, LaPorte, St. Joseph and Elkhart Counties.

Sec. 3.—Each District Society shall adopt a Constitution and Bylaws, which shall not conflict with the Constitution and Bylaws of the State Association, and only one District Society shall exist within any one Councilor District. The authorized District Society in each Councilor District shall receive a charter from the State Association, and the Secretary of the District Society shall have custody of the charter.

Sec. 4.—Each District Society shall organize by electing a President, a Secretary, and a Treasurer and a Councilor and Alternate Councilor as the current Councilor term and Alternate Councilor term for the district expires, and such others as may be provided for in its Constitution and Bylaws. The office of Secretary and Treasurer may be held by the same physician. The Councilor shall

continue to have the same duties and terms as are set forth in the Constitution and Bylaws of this Association.

Sec. 5.—The dues of the District Society, in an amount fixed by the District Society to meet the District Society needs, shall be collected by the Secretaries of the component County Societies and delivered to the Treasurer of the District Society. The Secretary of each District Society shall report to the office of the State Association the names and addresses of the members of his District Society, together with a copy of the minutes of each meeting of the District Society.

Sec. 6.—Each District Society shall meet at least once each year at a time and place to be fixed by the District Society. On or before January 1st of each year each District Society shall notify the headquarters of the State Association of the time and place of the annual District meeting for that year; but if no such notification has been received in the headquarters on or before the January meeting of the Council, the Councilor shall fix the time and place of the District meeting, and notice of such meeting shall be sent to the members of the County Medical Societies in such District.

Sec. 7.—Whenever a District Society is to elect a Councilor and/or Alternate, the headquarters office of the State Association shall so notify the individual members of such District Society not later than the first of March of the year in which the election is to occur.

Sec. 8.—The District Society shall send to the headquarters office of the State Association a copy of its program showing the time and place of its meetings, early enough that the headquarters office may notify all members within the District of the meeting at least thirty (30) days prior to the date thereof.

CHAPTER XXVII.—MISCELLANEOUS

Section 1.—The deliberations of this Association shall be governed by parliamentary usage as contained in Robert's Rules of Order, when not in conflict with this Constitution and Bylaws.

Sec. 2.—The Principles of Medical Ethics of the American Medical Association shall govern the conduct of members in their relations to each other and to the public.

CHAPTER XXVIII.—MEDICAL DEFENSE

Section 1.—One dollar and twenty-five cents out of the annual dues of each member of the Association shall be set aside as a special fund for medical defense.

Sec. 2.—The administration of medical defense of this Association shall be intrusted to the Executive Committee, which shall constitute the Medical Defense Committee of the Association.

Sec. 3.—This Committee shall have full authority governing all matters pertaining to this Chapter. In order to secure to any physician sued or against whom claim is made a fair and full presentation of his defense, the Committee shall have power to enter into an agreement with such physician to furnish to him funds with which to employ and pay one attorney of his choice and such other expenses as the Committee may approve as necessary to a fair and full presentation of his defense. Provided, always, that the attorney selected by the physician must be of good reputation and standing in his profession and the terms of employment, including the fees to be paid, must be approved by the Committee in each case in advance of such agreement. Provided, further, that the Executive Committee shall set a limit to the amount which may be so expended in connection with any one claim or case.

Sec. 4.—The Treasurer of the Indiana State Medical Association shall be custodian of the defense fund, separately kept, and shall give such additional bond as may be demanded by the Medical Defense Committee. Payments out of this fund shall be made only upon approval of the Executive Committee, by checks signed by the Treasurer and the Chairman of the Council.

Sec. 5.—The Medical Defense Committee shall make an annual report to the House of Delegates of the cases in which it has been of service to members and furnish an account of the money received and expended, such report to be published in THE JOURNAL of the Indiana State Medical Association at the time and in the manner that reports of other committees of the Association are published.

Sec. 6.—This Association shall not be liable for any damage awarded, but shall be liable only for such expenses for the legal defense of its members as may be incurred in accordance with the terms of these Bylaws.

Sec. 7.—The Association shall not undertake the defense of a member in any case in which the member who applies for medical defense by the Association has failed to pay his annual dues for the year in which services were rendered which are the basis of the suit; and medical defense by the Association shall not be available in any suit based on services rendered during any period of delinquency in the payment of dues. Dues are payable on January 1, and become delinquent on February 1 of each year. The membership card of this Association, duly signed and dated by the Executive Secretary, shall be considered the only *bona fide* evidence of payment of dues or membership in this Association.

The Indiana State Medical Association shall in no case provide medical defense against any action for alleged malpractice against any physician unless such physician was a member of this Association in good standing at the time the services which are the basis of the suit were rendered.

Sec. 8.—A member desiring to avail himself of the services of the Medical Defense Committee

in connection with litigation brought or threatened must send to the Executive Secretary of the Association for an application blank. After completing the data concerning the case he shall submit to a local committee of his county medical society—to be composed of the President, Secretary and one other member in good standing who may be nominated by the defendant—a full statement of the question at issue, including the diagnosis and treatment of the case and the names of physicians, nurses and other persons having knowledge of the same, who may be summoned as witnesses.

Sec. 9.—The committee of the county medical society shall immediately, after an investigation of all the circumstances and facts, transmit its report, with recommendations, to the Medical Defense Committee of this Association.

Sec. 10.—In the event that the county committee shall fail to recommend the case as one worthy of the recognition of this Association, a direct appeal may be made to the Medical Defense Committee of this Association, whose decision shall be final.

Sec. 11.—Suits brought against the estate of a deceased member shall be defended as if that member were alive; provided that such member was in good standing in the Association at the time of his death and that services for which indemnity is asked were rendered while the deceased was a member in good standing.

Sec. 12.—Medical defense shall not be available to members living outside of the State of Indiana at the time services were rendered for which indemnity is claimed.

Sec. 13.—The Medical Defense Committee shall have power to adopt such other rules, not in conflict with the foregoing, as in their judgment may seem necessary.

Sec. 14.—Medical defense as provided for by this Association shall be available to members under the terms stated in these Bylaws only in the defense of civil action for alleged malpractice, and shall not be available if such alleged malpractice occurred when the member was under the influence of any intoxicant or narcotic while rendering the service in question.

CHAPTER XXIX.—DIVISION OF FEES

This Association does not countenance or tolerate fee-splitting, division of fees, or commission paying directly or indirectly, and any member found guilty shall be expelled from membership.

CHAPTER XXX.—INVESTMENT OF SURPLUS FUNDS

Section 1.—The investment of all surplus funds of this Association shall be under the direct control and management of the Executive Committee subject to instructions in regard thereto which may be given by the Council at its option. The Executive Committee shall have the right and is encouraged to obtain the advice and counsel of the investment departments of any bank or trust company of Indianapolis in regard to the discharge of the duties covered by this chapter of the Bylaws.

CHAPTER XXXI.—AMENDMENTS

Section 1.—These Bylaws may be amended at any Annual Convention by a majority vote of all the delegates present at that convention, after the amendment has lain on the table for one day.

Sec. 2.—Upon the adoption of this Constitution and Bylaws all previous Constitutions and Bylaws are hereby repealed.

Poison Control Centers in Indiana

City	Name and Address	Telephone	Director
Anderson	Poison Control Center St. John's Hickey Memorial Hospital 127 West 19th St.	3-3391	Sister Mary, Administrator
East Chicago	Poison Control Center St. Catherine Hospital 4321 Fir St.	EXport 7-3080	Jack Troy, M.D.
Elkhart	Poison Control Center Elkhart General Hospital 600 East Blvd.	3-5350 Ext. 224	C. Richard Yoder, M.D.
Evansville	The Protestant Deaconess Hospital 600 Mary Street	HArrison 5-7171	Edward J. Wolfgang, Chief Pharmacist
Hammond	Poison Control Center St. Margaret Hospital 25 Douglas Street	Westmore 2-2300	Herbert I. Arbeiter, M.D.
Indianapolis	Poison Control Center General Hospital 960 Locke Street	MElrose 6-6331 Ext. 211 or 212	Richard W. Dyke, M.D.
	Poison Control Center Methodist Hospital (Emergency Room) 1604 N. Capitol Avenue	WAlnut 4-6411	Merle Backistow, M.D.
	*Poison Information Center Indiana State Board of Health 1330 W. Michigan Street	MElrose 4-8433 Ext. 226	
Marion	Poison Control Center Marion General Hospital Wabash and Euclid Avenue	North 4-2313 Ext. 44 or 45	A. B. Snowhite, M.D.
Whiting	Poison Control Center Whiting Clinic 1900 Indianapolis Blvd.	Whiting 2075	Jack M. Troy, M.D.

*Informational services only.

The following have some poison treatment facilities:

Evansville	Welborn Memorial Baptist Hospital, Inc. 412 S.E. Fourth St.	3-5350	C. Richard Yoder, M.D.
	St. Mary's Hospital, Inc. 3700 Washington Avenue	GReenleaf 7-1541	

Fort Wayne	The Lutheran Hospital 3024 Fairfield Avenue	HArrison 1241
	Parkview Memorial Hospital, Inc. 2200 Randalia Drive	EAstbrook 7341
Frankfort	Clinton County Hospital 1200 S. Jackson Street	4451
Franklin	Johnson County Memorial Hospital R. R. 1	REdfield 6-6111
Mishawaka	St. Joseph Hospital 811 E. Madison Street	BLackburn 9-2431
Richmond	Reid Memorial Hospital Spring Grove	2-4091
South Bend	Memorial Hospital 615 N. Michigan Street	CEntral 4-9041
	Northern Indiana Children's Hospital 1234 Notre Dame Ave., North	CEntral 4-2101
	St. Joseph Hospital 811 E. Madison Street	CEntral 4-2151

INTEGRITY



● Serving Indianapolis since 1898, Shirley Brothers' reputation for integrity has grown with its consistently high professional standards and its completeness of service for all.

● Your call to Shirley Brothers — at any hour of the day or night—will receive courteous, fast attention.

● The Shirley integrity, plus modern facilities and the beautiful appointments of its five chapels, make every tribute "truly a remembered service."

Phone MElrose 4-5408

TRULY A REMEMBERED SERVICE

Shirley Brothers

FUNERALS

CENTRAL CHAPEL—
Illinois at Tenth Street
IRVING HILL CHAPEL—
5377 E. Washington St.
DREXEL CHAPEL—
4565 E. Tenth St.
WEST CHAPEL—
2002 W. Michigan St.

DISEASE PREVENTION by Immunization and Chemoprophylaxis*

Disease	*Agent Used*	*Recommended For*	*Method of Administration*	*Type of Immunity*	*Duration of Protection*	*Booster Injection*
Cholera	Cholera Vaccine	Adults	—0.5 cc. subcutaneously followed by 1.0 cc. in 7 days.	Active	6 months	0.12-1.0 cc. according to age every six months in endemic areas.
		Children: 6 months to 2 years 3-6 years 7-10 years 11 years and older	Three subcutaneous injections given 7-10 days interval. (1) 0.06 cc.; (2) 0.12 cc.; (3) 0.12 cc. (1) 0.12 cc.; (2) 0.25 cc.; (3) 0.25 cc. (1) 0.25 cc.; (2) 0.5 cc.; (3) 0.5 cc. Adult schedule			
Diphtheria	Diphtheria Antitoxin	All early cases	Usually intramuscular if seen within 48 hours of onset. *Warning:* Test for sensitivity to horse serum. May be used intravenously in severe nasopharynx cases. Dosage dependent on degree of toxicity rather than age and weight. 10,000 units to 75,000 units.	Passive	Short	Additional antitoxin given dependent upon illness and toxicity.
Diphtheria	Diphtheria Toxoid (fluid or alum precipitated or aluminum phosphate adsorbed, for adult use)	Children older than 11 years and adults	Two intramuscular injections of 0.5 cc. each, four to six weeks apart for primary immunization or if individual has not had a booster dose of vaccine for 3 years.	(If toxoid is given then active immunity develops.)	Indefinite	0.5 cc. every year.
Diphtheria	Diphtheria-Pertussis-Tetanus alum precipitated or aluminum hydroxide (or aluminum phosphate) adsorbed diphtheria and tetanus toxoids; containing 12 protective antigenic units of vaccine per 1.5 cc. (DPT)	Children under 5 years	(1) First dose of 0.5 cc. deep intramuscularly—follow injection with 0.1-0.2 cc. air. Given 1-3 months age. (2) Second dose of 0.5 cc. deep intramuscularly one month after first dose. (3) Third dose of 0.5 cc. deep intramuscularly one month after 2nd dose. (4) If 1st dose given earlier than 3 months of age, then give fourth dose 2-3 months after series completed.	Active	Indefinite	D. P. T. booster of 0.5 cc. at 12 to 18 months and 4-5 years. After 5 years booster dose of 0.5 cc. Diphtheria Tetanus Toxoid every 3 years to age 11 years.
Diphtheria	Diphtheria Tetanus Toxoid alum precipitated or aluminum hydroxide (or aluminum phosphate) adsorbed.	Children over 5 years and up to 10 years	(1) First dose of 0.5 cc. deep intramuscularly, follow injection with 0.1-0.2 cc. air. (2) Second dose of 0.5 cc. deep intramuscularly—follow injection with 0.1-0.2 cc. air.	Active	Indefinite	Diphtheria Tetanus booster 0.25 cc. to 0.5 cc. *Caution:* Do not give to children past 10 years of age.
Diphtheria	Diphtheria Toxoid Pertussis Vaccine Tetanus Toxoid Fluid	Rapid immunization of children under 10 years	Three doses of 0.5 cc. given subcutaneously at intervals of 3-4 weeks. In face of epidemic injections may be given at one week intervals.	Active	Antigenic response lower than with the alum preparations and does not last as long	0.5 cc. every 2 years.

Diphtheria	Diphtheria Toxoid Tetanus Toxoid Fluid	Rapid immunization under 10 years	Three doses 0.5 cc. given subcutaneously at intervals of 3-4 weeks. In face of epidemic injections may be given at intervals of one week.	Active	Antigenic response lower than with alum preparations and does not last as long.	0.5 cc. every 2 years.
Hepatitis, Infectious (Epidemic)	Immune Serum Globulin (Gamma Globulin)	All exposed in household, institution, etc.	Dosage: 0.01 cc. per pound of body weight. Given intramuscularly.	Passive	Brief	Repeat each exposure.
Influenza	Polyvalent Vaccine	Use during epidemics		Active (in 70% + immunized)	Short: 3-4 months	Repeat primary injection.
		Children	Give total of 1.0 cc. in the course of one week.			
		Adults	1.0 cc. subcutaneously. *Warning:* Precautions must be taken in individuals sensitive to egg protein. *(Note:* There is less chance of local or systemic reaction if only 0.1 cc. is given intradermally.)			
Measles (Rubeola)	Immune Serum Globulin (Gamma Globulin)	Complete passive immunity children under one year; children ill with chronic disease or healthy child whose siblings are ill with chronic disease	Dosage 0.2 cc. per pound of body weight given prior to 6th day after exposure. Given intramuscularly.	Passive	Very brief	Repeat each exposure.
		Incomplete immunity or modification in all other children	Dosage 0.05 cc. per pound of body weight before 6th day after exposure; if given after 6th day use dose of 0.1 cc. per pound of body weight. Given intramuscularly.	Partial passive. Child has modified disease and develops active immunity	For life if disease was modified and not prevented.	
Measles, German (Rubella)	Immune Serum Globulin (Gamma Globulin)	Pregnant females exposed during the first trimester	Dosage: 0.1 cc. per pound of body weight. Given intramuscularly.	Passive	Very brief	Repeat each exposure if pregnant.
Meningococcic Meningitis	Sulfadiazine	Control of exposed persons in community groups Children up to 11 yrs.	0.5 m. twice daily for 2 days.	None Chemical prophylaxis only	Very brief—for one exposure only.	Repeat following each exposure.
		Adults (and children 12 yrs. or over)	1.0 gm. twice daily for 2 days.			
Mumps	Mumps Vaccine	Adults exposed to case and with negative history of having had mumps	*Warning:* Check on sensitivity to egg protein. Two injections given 5 to 10 days apart of 1.0 cc. each subcutaneously.	Active	Brief	Previously immunized persons may be given booster dose of 0.5 to 1.0 cc. subcutaneously.

Disease	Agent Used	Recommended For	Method of Administration	Type of Immunity	Duration of Protection	Booster Injection
Pertussis	Pertussis Vaccine saline suspended (See Double and Triple antigens under "Diphtheria")	Children during epidemic	A total of 12 N. I. H. units divided into 3 equal doses of 4 N. I. H. units (0.5 cc.) given subcutaneously at intervals of one week.	Active	Indefinite	1 year after primary series, 2 years after primary series and then every three years to 6 or 7 years of age.
	Pertussis Vaccine alum precipitated or aluminum hydroxide adsorbed (See Double and Triple antigens under "Diphtheria")	Routine immunization of infants when DPT is contraindicated	A total of 12 N. I. H. units divided into 3 equal doses of 4 N. I. H. units (0.5 cc.) injected intramuscularly at intervals of 4 to 6 weeks.	Active	Indefinite	18 months—3-4 years. 6-7 years usually given as DPT.
		Exposure Recall		Active	Indefinite	4 NIH units (0.5 cc.) saline suspension subcutaneously if child has not had immunization past 2 years.
Plague	Plague Vaccine—a suspension of 2000 million killed Pasteurella per milliliter	Epidemics and areas with high endemic rate. Adults: Children: 6 months-2 years 2 years-6 years 6 years-10 years	Two injections subcutaneously 7-10 days apart. First injection 0.5 cc.; second, 1.0 cc. 0.06 cc.; 0.12 cc; 0.12 cc. 0.12 cc.; 0.25 cc.; 0.25 cc. 0.25 cc.; 0.50 cc.; 0.50 cc.	Active Active	Partial protection for period of 4-6 mos. Partial protection for period of 4-6 mos.	1.0 cc. every 4 months as long as danger of epidemic exists. Booster dose for children is same as first dose of initial series.
Poliomyelitis	Poliomyelitis (Salk) Vaccine	All Ages	Two injections each 1.0 cc. given intramuscularly at interval of 1 month. Third injection of 1.0 cc. given 7 months after second.	Active	Not known	Booster dose of 1.0 cc. recommended 8 to 12 months after 3rd dose. Additional booster doses advised if in epidemic area.
Rabies	Rabies—hyperimmune serum 1000 units per pound of body weight Rabies Vaccine 7-14 doses	*Licks* of abraded skin or mucosa by proven rabid, suspicious, escaped, killed or unknown animal	Hyperimmune serum within 24-72 hours of exposure. Follow within 24 hours with Rabies Vaccine.	Passive immunity from hyperimnune serum	Few weeks	Repeat initial dose hyperimmune serum.
		Bites of healthy animal, multiple, or face or head bites	Hyperimmune serum. Start vaccine but stop if animal remains normal for 3 days.	Active immunity from rabies vaccine	Indefinite	Rabies vaccine prepared according to Semple method—should not repeat full course—one to 3 injections probably sufficient. More hazardous Egg embryo vaccine—give one injection.
		Bite of healthy animal, other than head or neck	No treatment. If animal becomes suspicious during 14 days observation give serum and vaccine at first suspicious signs.			

		Bites—animal rabid, escaped, killed, unknown or any bites by any wild animal	Start treatment immediately, using hyperimmune serum followed by 7-14 doses vaccine, depending upon whether single or multiple bites and location.			
Rocky Mountain Spotted Fever	Rocky Mountain Spotted Fever Vaccine	Not routinely recommended since advent of specific antibiotic therapy. May be used in areas of high incidence among persons of high risk.	Adults: 3 injections each 1.0 cc. subcutaneously or intramuscularly at intervals of one week. Children—under 10 years three injections each 0.5 cc. subcutaneously or intramuscularly at intervals of one week.	Active	One year	1.0 cc. booster annually
Smallpox	Smallpox Vaccine (Vaccinia virus)	Children and adults	Begin at 5-12 months. Administered by multiple pressure technique skin over insertion of left deltoid.	Active	Indefinite, average 3 years	Repeat every 4th year.
Tetanus	Tetanus Antitoxin	All cases of puncture wounds and animal bites when person has not been immunized or more than 2 years since last booster.	*Caution:* Skin test first for serum sensitivity. Intramuscular injection of 10,000 units antitoxin.	Passive	10 days	Repeat with each injury. Because of hazard to horse serum active immunization with toxoid preferred.
	Tetanus Toxoid, depot (alum precipitated or adsorbed) (See Double and Triple antigens under "Diphtheria")	All	Two doses, each 0.5 cc. given intramuscularly, at least one and preferably 2-3 months interval.	Active	At least 4 years	0.5 cc. end first year, then—booster every 2-4 years. Satisfactory recall response after 10 years but is too slow in case of injury. Emergency booster if injured.
	Tetanus Toxoid, Fluid (See Double and Triple antigens under "Diphtheria")	All	Three doses, each 0.5 cc., subcutaneoulsy or intramuscularly at one month and preferably 2-3 months between doses.	Active	At least 4 years	0.5 cc. end first year, then—booster every 2-4 years. Satisfactory recall response after 10 years but is too slow in case of injury. Emergency booster if injured.
Typhoid Fever	Typhoid Vaccine Triple vaccine containing 1000 million S. typhosa and 250 million each of paratyphoid A and B per cc.	All persons living in or traveling to areas where disease is endemic or insanitary conditions exist.	*Adults* Three doses, each 0.5 cc. subcutaneously not less than 7 days or more than 28 day intervals between doses. An alternate method is: 0.1 cc.; 0.15 cc. and 0.2 cc. given intradermally not less than 7 nor more than 28 days between doses. *Children* 6 mo.-2 yr.—(1) 0.06 cc.; (2) 0.12 cc.; (3) 0.12 cc. 2 yr.- 6 yr.—(1) 0.12 cc.; (2) 0.25 cc.; (3) 0.25 cc. 6 yr.-10 yr.—(1) 0.25 cc.; (2) 0.50 cc.; (3) 0.50 cc.	Active	Indefinite—usually at least one year	Persons traveling or living in insanitary areas should receive booster of 0.1 cc. intradermally or 0.5 cc. subcutaneously annually. Children's annual booster the same dose as initial dose of each series.

Disease	Agent Used	Recommended For	Method of Administration	Type of Immunity	Duration of Protection	Booster Injection
Typhus Fever	Typhus Fever Vaccine	All persons traveling to or living in areas where epidemic typhus exists.	*Adults* Two doses, each 1.0 cc. at intervals of 7-10 days given subcutaneously. Allergy to egg or chicken protein only contraindication. *Children* Three doses each: 6 mos.-2 yrs.: 0.12 cc. 2 yrs.- 6 yrs.: 0.25 cc. 6 yrs.-10 yrs.: 0.50 cc.	Active	Relative 3-6 months	*Adults* Routine every 6 months dose of 1.0 cc. given subcutaneously or whenever threat of outbreak occurs. *Children* Same dose as in initial series.
Yellow Fever	Yellow Fever Vaccine* (Obtainable only at U. S. P. H. S. Hospital or Yellow Fever Immunization Depots. See footnote where obtainable in Indiana.)	All persons traveling in or through or living in endemic areas. Should receive vaccine 10 days before arrival in area.	One dose 0.5 cc. of a 1:10 dilution of concentrated vaccine, freshly prepared. Given subcutaneously. Should not be given to person ill with virus disease or at same time cowpox virus is given. Children's dose—same as adult.	Active	6 years or longer	As required at present every 6 years repeat immunization. In presence of epidemic repeat primary immunization.

*While many contraindications are listed for various biologicals it should be recognized that in the interest of brevity it was impossible to give all details. In case of doubt consult standard reference for detailed description of biological in question and/or pharmaceutical company's circular accompanying original package of biological.

All of the biologicals listed may be obtained through normal supply channels with the exception of Yellow Fever Vaccine. Because of hazards if yellow fever vaccine is improperly handled it can only be obtained from U. S. P. H. S. depots. In Indiana this depot is:

Indiana University Medical Center
1040 West Michigan Street
Indianapolis
Fridays, 11 a.m. to 12 noon CDT by appointment
Telephone: MElrose 5-8441, Ext. 2511; 2512

Elkhart County Health Department
200 Harrison Street
Elkhart, Indiana
1st or 3rd Wednesday each month 2 p.m.
Telephone 26525

Physicians having patients requiring yellow fever immunization should advise person to call or write the above, as inoculations are given by appointment only on one day a week. There is a fee to cover vaccine and administration.

(Revised)

A. L. Marshall, Jr., M.D., *Director*
Division of Communicable Disease Control
Indiana State Board of Health



"The pace that kills"

. . . an appropriate description of life in our modern, dynamic world. And an even truer picture of today's busy medical schedules. The prescription? Give your heart a rest daily . . . discover all-over restfulness by reclining in CONTOUR's body-cradle comfort with six point support. Head, legs and feet are always elevated above your body's center of gravity.

For complete rest and relaxation

CONTOUR'S orthopedically correct rest-posture diminishes strain on the heart, and can be an especially valuable adjunct to recommended therapy for your cardiac patients. CONTOUR also offers "thermonic" heat and "viveration" massage.

PROTECT YOURS AND YOUR PATIENTS' HEALTH — IT'S LIFE'S MOST VALUABLE ASSET!

THE ORIGINAL PATENTED Contour® CHAIR LOUNGE

2162 N. Meridian St.
WA 3-1526

10 N. Illinois St.
ME 4-8219

Indianapolis, Indiana



The Women's Auxiliary

REPORTS TO I.S.M.A.

The other day, while rummaging through a drawer, I chanced across a letter that my grandmother sent to my mother shortly after mother's marriage. I had almost forgotten of its existence. The ink was faded, the paper yellow and quite brittle, but even 75 years couldn't dim the lovely thoughts and their importance. In it my grandmother very concisely outlined the duties and obligations of a wife to her husband. Some of the advice, when exposed to the light of our modern times, seems quite amusing—like taking great care that your husband's supply of celluloid collars doesn't run out. But it was in the letter's closing that I found the most thought-provoking comment. My grandmother said, "Make your marriage a partnership. Always participate in your husband's activities—never be an outsider looking in."



If I ever had any doubts concerning my grandmother's wisdom, I'm sure this letter dispelled them. And what was true then, I think, is doubly true now, especially when we consider women's expanded role in our present day society. We want to belong. We want to participate. And the Woman's Medical Auxiliary gives us this opportunity. As president of the auxiliary, however, I wish to emphatically state that ours *is not* a social organization. Our members do not join for social reasons—we have other clubs for that purpose. As auxiliary members we participate because we desire to be a part of YOUR activities, and also because we feel we can be of vital service to the medical profession and the community.

You might well ask—What is the Woman's Auxiliary? I can best answer that by saying, we are an arm, a third arm if you like. Our purpose is to implement your policies, to help promote health improvement and health education. As you well know, the medical profession is faced with ever-increasing problems. Our desire is to help you solve these problems, to lighten your burdens.

Thirty-eight years ago this May a small group of women formed the parent body of the Woman's Auxiliary and through hard work and unrelenting effort lifted our Auxiliary into a place of prominence and leadership among women's organizations in the United States. We are proud of our founders—and we want to be proud of ourselves. Our aim is to advance even more.

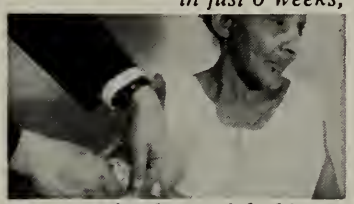
Continued

New Dianabol converts protein to working weight in wasting or debilitated patients

Mrs. M. R., 75-year-old underweight patient:



Puts on 13¼ needed pounds in just 6 weeks;



gains 1" on right biceps;



forces mercury column 14 mm. higher in cuff-compression test of muscle strength;



feels better than she has in 2 years.

Photos used with permission of the patient.

Dianabol is a new tissue-building agent with distinct advantages over previous compounds of this type.

By aiding the deposition, synthesis, and utilization of protein, Dianabol affords these benefits in the underweight elderly patients with or without serious disease and in patients who are chronically ill or convalescent:

- Rebuilds tissue and improves appetite, thus promoting lean weight gain.
- Restores tone to weak, flabby musculature.
- Speeds healing of wounds; hastens postoperative recovery and convalescence from a variety of diseases.
- Strengthens skeletal structure; often relieves pain and increases mobility in osteoporosis.
- Improves general physical status; helps to revive a sense of well-being.

Economical, convenient to administer, and almost without virilizing effects, Dianabol overcomes the disadvantages that have restricted use of tissue-building compounds in the past. Older patients, whose funds are often limited, will particularly welcome the low cost of Dianabol therapy—in most cases only 9 to 17 cents a day.

Complete information available on request.
SUPPLIED: *Tablets,* 5 mg. (pink, scored); bottles of 100.



Dianabol®
(methandrostenolone CIBA)

New, orally effective tissue builder

Converts protein to working weight in wasting or debilitated patients

CIBA
SUMMIT, NEW JERSEY

2/2788MB

But we need your help. It is your cooperation and understanding that we seek. Our auxiliary membership has not kept pace with the Indiana State Medical Association. Two-thirds of the doctors' wives in Indiana are now auxiliary members working hard to promote the medical profession's cause — but that still leaves one-third unaccounted for, those who are not yet members. Possibly your wife is one of these. Encourage her! Suggest that she join. Let her get her feet wet and see how she likes it. Membership in the auxiliary is our schoolroom for learning—our textbook for partnership.

The year ahead promises to be challenging and interesting. It may prove the turning point wherein the medical profession can follow the same independent course which has provided this country with the finest medical personnel and facilities in the world. Don't deprive us of this potential talent which stands by your side. By encouraging your wife to become an auxiliary member you are contributing to your own success.

As women, we have been daughters, wives and mothers in that order. Now we desire to be partners.

Ina. Rigley

About our Cover

Asclepius, son of Apollo, was the divine physician, worshiped as the god of medicine in Greek mythology. At his temple in Epidaurus the priests cared for the sick and about the shrine flocked those needing his ministration.

The god appeared at night to his patients, not so often in his own form as in the form of the serpent that was sacred to him.

It was in this form that Asclepius came to Rome at the time of the plague. It is told that the serpent left the ship and swam to an island in the Tiber. His worship was established, and to this day a city hospital still stands there.

Cover art and research by Miss Susan Welsh, Indianapolis.

everything surgical for physicians and hospitals

WHY—Curtis & French?

We sell only nationally advertised merchandise.

We service all equipment that we distribute.

We offer loaner service in case of an emergency, on most equipment used in Medical offices.

We offer the only complete stock of Scientific Supplies in state.

We stock and display Sklar, Stille and imported instruments.

We maintain a complete Truss and Garment department.

Our service is only complete when we deliver, set up, check, and demonstrate to you, the Doctor.

Curtis & French, Inc.

1108 N. Pennsylvania
Indianapolis 2, Indiana
MElrose 5-3387

1632 Wabash Avenue
Terre Haute, Indiana
Crawford 6755

2223 So. Preston
Louisville, Kentucky
MElrose 7-6962

NEEDED: A PHARSIGHTED PHAROAH

A. W. CAVINS, M.D.
Terre Haute

HERE ARE PARTS of another editorial from the pen of "J. J. L.," in the *Journal of the Florida Medical Association* for March, 1960. Here are information, philosophy, prediction and exhortation, all in a few words. The original editorial is entitled "The Seven Lean Kine," and its application will be obvious.

"How Joseph interpreted Pharoah's [sic] dreams and thus prevented a great calamity from befalling the Egyptians is a Bible story well recounted. What is not known is how the great Pharoah living in the midst of plenty was able to convince himself and his people that only by sacrifice in times of great prosperity would they survive. Would that this quality possessed by Pharoah which prevented a surfeited life from blinding him and his people to the dangers of the morrow were known to the American physician of today.

"It is expected that this session of the Congress will pass definite legislation relating to care of the aged. It is most likely that the highly publicized Forand bill will be supplanted by legislation framed by the Department of Health, Education, and Welfare. Such a bill will then be referred to Congressional committees before whom various concerned and unconcerned persons will make long and erudite statements. Before the committee's version of the bill is returned to the Congress, the American Medical Association will send copies of it to the various state medical societies who will pass it on to the county medical societies where an apathetic membership will be called into emergency session to consider action on something of which it knows nothing. By the time the local medical societies have opposed whatever it was they were to consider, the committee's bill will probably have passed the Congress anyway. No crystal ball is needed for this prediction, as it merely represents a repetition of a Medicare incident of recent years.

"Physicians, as they engage in small groups in hospital corridors, will grumble about the imminence of socialized medicine. They will damn labor for getting more fringe benefits which include medical care of a type not to their liking. They will label as communists those social workers and planners whose job it is to get adequate medical care for all. They will curse insurance companies for not selling health policies which would give their patients total medical coverage for a token premium. They will call two-faced their elected representatives who have passed such a bill even though the physician probably does not even know his representative's name. Thus it has been—thus it will probably be. But some of the ones whom the physician condemns are those who have really prevented socialized medicine from occurring even if because of their own vested interests. Insurance companies would lose their millions of health, accident and hospitalization policies and other associated business. Labor would lose control of tremendous amounts of money which their health and pensions plans have accumulated for their treasuries.

* * *

"What American medicine needs today is a Joseph and a Pharoah. A Joseph to interpret in simple piercing language the deficiencies in present-day medical practice which are causing public discontent. A Joseph to plan for the future with concrete workable ideas. A Pharoah to make these plans voluntarily acceptable to the physicians whose gratification of the moment blinds them to tomorrow's necessities. Our years of plenty are at hand. The seven fat-fleshed kine are about to be devoured."

Agree, or not, here is food for thought. ◄

Indiana State Board of Health
DIVISION OF COMMUNICABLE DISEASE CONTROL

Disease	Mar. 1960	Feb. 1960	Jan. 1960	Mar. 1959	Mar. 1958
Animal Bites	340	224	225	378	163
Chickenpox	885	1068	879	915	485
Conjunctivitis	190	152	82	110	47
Diphtheria	1	2	1	0	6
Dysentery, Unspecified	121	50	67	13	12
Impetigo	70	76	88	65	14
Infectious Hepatitis	143	91	57	34	22
Infectious Mononucleosis	23	19	16	18	5
Influenza	3720	11387	2177	10674	1547
Measles (Rubeola-Rubella)	1835	940	578	843	3704
Meningitis, Meningococcal	3	2	1	5	1
Meningitis, Other	6	12	9	9	14
Mumps	600	298	256	362	840
Pertussis	28	39	39	108	42
Pneumonia	286	341	272	196	130
Poliomyelitis	1	0	0	0	1
Streptoccal Infections	1501	1048	668	1536	663
Tinea Capitis	19	38	12	20	18

...MALNUTRITION OR
LEG CRAMPS DURING PREGNANCY?

OUTMODED AS GODEY'S FASHIONS!

℞ NEW

PRENALIN-O®

PRENATAL SUPPLEMENT

1. Oyster Shell Calcium - Phosphorus Free!
2. New Form of Iron!
3. Dry Filled Capsule - Sure, Quick Absorption!
4. Economical Once-A-Day Dosage!
5. Wider Range Nutritional Support!
6. Relieves Troublesome Leg Cramps!



EACH dry filled capsule (lavender and white) provides:

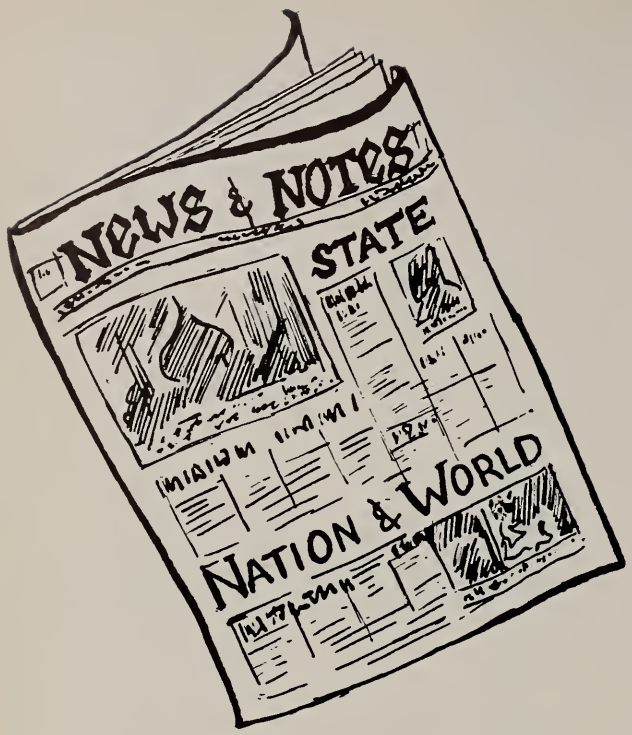
Ferrous Fumarate (Iron)	150 mg.	Vitamin B-12 (Cobalamin conc. NF)	2 mcg.
Oeep sea oyster shell (Calcium)	600 mg.	Folic Acid	0.25 mg.
Vitamin C	50 mg.	Niacinamide	10 mg.
Vitamin A	4000 USP Units	Vitamin K (Menadione)	0.25 mg.
Vitamin O	400 USP Units	Rutin	10 mg.
Vitamin B-1	2 mg.	Sodium Molybdate	3 mg.
Vitamin B-2	2 mg.	Fluorine (Calcium Fluoride)	0.25 mg.
Vitamin B-6	0.8 mg.	Iodine (Potassium Iodide)	0.15 mg.

SAMPLES ON REQUEST

TUTAG

S. J. TUTAG & CO.

DETROIT 34, MICHIGAN



Indiana Doctor Named President-Elect National Blue Shield Plans Association

William H. Howard, M.D., Hammond, was elected president-elect of the National Association of Blue Shield Plans at their annual meeting held in Los Angeles April 6. Dr. Howard is also president of Indiana Blue Shield and has served on the Blue Shield Board since 1946.

Dr. Howard will assume the president's post of the National Association of Blue Shield Plans at their next annual meeting.

A native of Remington, Ind., Dr. Howard received his M.D. degree from Indiana University in 1922, following service in the U. S. Navy during World War I. His rotating internship and residence in surgery were taken at the then Indianapolis City Hospital, now Marion County General Hospital.

Dr. Howard opened his office in Hammond in 1925, specializing in gynecology. Since that time he has been active in many committees and commissions of the Indiana State Medical Association, and served as president of the ISMA in 1953-54. He is also past president of the Lake County Medical Society.

Other offices held include: chairman of the Permanent Study Committee on Health Insurance, 1944; vice-chairman of the Surgical Section of ISMA, 1943, and chairman in 1944; member of the Committee on Prepayment Medical and Surgical Care, 1945; vice-president of Mutual Medical Insurance, Inc., 1953; commissioner of National Blue Shield Medical Care Plans, 1953; and president of the staff, St. Margaret's Hospital, Hammond, 1958.

I.U. Grad Named Markle Scholar

Twenty-five young medical scientists, all faculty members of medical schools in the United States and Canada, have been appointed Markle Scholars in Medical Science by the John and Mary R. Markle Foundation of New York.

Dr. Hubert C. Pirkle, assistant professor of pathology at the University of Louisville School of Medicine, who graduated from Indiana University School of Medicine, is one of the appointed scholars whose appointments begin in 1960 and continue to 1965.

Each appointment carries with it a $30,000 grant to be paid to the medical school where the scholar will teach and do research. The grant will be paid at the rate of $6,000 a year and will be used to supplement the scholar's support and to aid his research for the next five years.

The Scholar grants have been made annually since 1948, when the program was begun to help relieve the shortage of faculty members in medical schools and to strengthen medical education by offering young teachers and investigators academic security and financial help early in their careers.

During the 13 years of the program, the Foundation has made appropriations of $8,300,000 toward the support of over 280 doctors in 77 medical schools.

Groedel Medal to be Presented in Indianapolis

Dr. John B. Youmans, technical director of Research to the Office of the Army Surgeon General, will be awarded the Groedel Medal, the highest award of the American College of Cardiology, the Army Surgeon General's Office has announced.

Dr. Youmans will be presented the silver medal May 27 at the meeting of the American College of Cardiology in Indianapolis, at which time he will address the College on "The Humanities in Medicine," an obligation incurred by those who receive the medal struck in honor of Franz M. Groedel (1881-1951), the founder and first president of the College of Cardiology.

Camp 'Jim' Riley Opens Sixth Year For Physically Handicapped Children

On June 19 the James Whitcomb Riley Memorial Association will open its sixth season of summer camping for Indiana's physically handicapped children in 2,300-acre Bradford Woods near Martinsville.

Some 200 boys and girls are expected to enroll for the two non-profit sessions—June 19 to July 1 and July 17 to July 29—which are sponsored by Riley Memorial with the cooperation of the professional staff of Riley Hospital and Indiana University recreation leaders.

Any physically handicapped boy or girl, aged 8 through 14, is eligible to apply. All applications must be accompanied by a written endorsement of the physician who has the child under care.

All types of disabilities have been represented among the some 1,000 children who have been encamped during the last five seasons: post-polio, those with congenital defects, cerebral palsied, accident cases and many others. Wheelchair cases can be taken in limited number.

24-Hour Medical Care

The youngsters are headquartered in the especially-designed facilities of Camp "Jim" Riley which include: fully-equipped infirmary where a doctor and two nurses are on 24-hour duty; three large heated cottages which serve as living areas; a modern dining lodge; temperature controlled pool; craft shelters and auxiliary buildings.

The camp program itself—planned by a nationally-known director—is tailored to fit the physical abilities of the children as described by the home doctor. Outdoor education is stressed, although fun is not forgotten, in a daily schedule of hikes, nature studies, swimming, craft work, cook-outs and related activities.

Counselors, many of whom return year after year, are mostly at the college level and are assigned on a basis of one to every three or four children.

Application blanks, the doctor's approval form and full information may be obtained from: Riley Memorial Association, 129 East Market Building, Indianapolis 4.

Irvin H. Scott, M.D., Sullivan, has been elected president of the American Fracture Association.



Photo by L & M Professional Photographers, San Juan, Puerto Rico

Hoosier Heads Radium Group

JESSHILL LOVE, M.D. (left), Indianapolis, radiation therapist, receives congratulations on his assumption as president of the American Radium Society from Theodore R. Miller, M.D., New York City, retiring president. Ceremony took place in San Juan, P. R., during Society's recent 42nd Annual Meeting (March 17-19).

Oregon Cancer Conference in July

The Second Annual Oregon Cancer Conference is being held July 7 and 8, 1960, in Portland.

An outstanding list of guest lecturers for the Conference includes Dr. Oscar Creech, Jr., of New Orleans, professor and chairman of the Department of Surgery at Tulane University School of Medicine; Dr. J. Hartwell Harrison of Boston, clinical professor of Genito-Urinary Surgery at Harvard Medical School, and Dr. Henry Jaffe of Los Angeles, director, Division of Radiation Therapy and Nuclear Medicine at Cedars of Lebanon Hospital.

Dr. I. S. Ravdin of Philadelphia, professor of surgery at the University of Pennsylvania Medical School, and Dr. R. Wayne Rundles of Durham, North Carolina, of the Department of Medicine at Duke University Medical Center, are on the program.

In addition to their individual presentations, each guest speaker will participate in one or more panel discussions.

A block of rooms has been reserved at the Sheraton Hotel for physicians wishing to attend the Conference. A copy of the complete program and hotel reservation forms may be obtained by writing to Roscoe K. Miller, Executive Secretary, Oregon State Medical Society, 2164 SW Park Place, Portland 5, Ore.

AEC Contracts for Study of Pacific Waste Disposal Sites

The Atomic Energy Commission has signed a contract with Cleveland Pneumatic Industries, Inc., of Cleveland, Ohio, for a year-long study of underwater conditions at two established waste disposal sites off the California coast.

This study is in line with the commission's policy of continuing reappraisal of the safety of its waste disposal measures. An earlier survey of the two areas, in April, 1957, did not disclose any detectable amounts of radioactivity attributable to waste disposal operations even in the immediate vicinity of the older of the two sites.

The new survey will be carried out by the contractor's Advanced Systems Development Division, of El Segundo, Calif., and again will seek to measure the radioactivity, if any, resulting from the disposal of low-level packaged radioactive wastes at the two locations. The company will have associated with it in advisory capacity members of the staff of the Scripps Institution of Oceanography at La Jolla, Calif.

Older of the two waste disposal areas is centered at approximately 37 degrees, 39 minutes north latitude, 123 degrees, 19 minutes west longitude—a point in the Pacific Ocean about 52 statute miles west of San Francisco. Disposal activities have been carried out there since 1946. Approximately 21,000 concrete-encased steel drums and 300 concrete boxes containing some 14,000 curies of radioactivity at the time of disposal have been deposited at the site.

A second site is in the Santa Cruz Basin, the center of which is approximately 33 degrees, 39 minutes north latitude and 119 degrees, 28 minutes west longitude, a point some 53 statute miles south of Santa Barbara. Since 1953, 2950 drums containing 60 curies of radioactivity have been placed at this location.

1,000 Fathoms Depth

All disposals of radioactive waste at these sites have been made in depths of 1,000 fathoms or greater, or more than a mile deep.



In the new study, the Advanced Systems Development Division of Cleveland Pneumatic Industries will conduct two oceanographic field surveys at each disposal area at six-month intervals. The first cruise is scheduled to begin March 8. Estimated total cost of the study is nearly $60,000.

Samples of marine life will be taken from the ocean floor by means of dredging and from the water above the disposal sites by midwater trawl operations. Bottom samples will also be used for mineral analysis of rock and clay from the sea floor, and gravity core samples will be used to measure rates of sedimentation and the possible uptake of radioactive materials by the deposits. A "profile" of water samples will be taken from top to bottom.

Water current measurements will include a check of surface currents, dispersion and bottom current velocity and direction. Laboratory work will include an analysis for radioactivity of all samples of seawater, sediments and marine life.

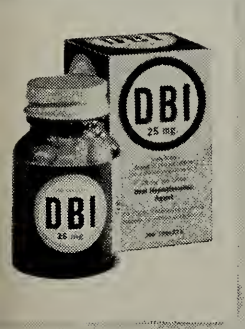
An unique feature of the survey will be a photographic exploration of a sizable portion of the ocean floor at each site in an effort to obtain pictures both of marine life and of the condition of drums containing the disposed radioactive material. Knowledge of the types of marine life at the sites is important in the study of the relation of radioactivity in the waters, if any, to the food chain.

Underwater Photos

The company will traverse each area by means of the survey ship Decatur, a converted minesweeper. Photographic equipment will be suspended from the vessel to a point about 10 feet above the bottom and pictures will be taken every 12 seconds at a towing speed of one knot. About 600 pictures are expected to be produced during each two-hour lowering of the underwater camera.

During the survey operations, each of the two sites is to be permanently marked by buoys attached to deep-water mooring apparatus developed by the company. A special feature of the apparatus is the anchoring system which includes a pair of imbedment anchors that will be

effective in and simplifies
the management of
stable adult diabetes



"In our experience the action of DBI on the adult stable type of diabetes is impressive... 88% were well controlled by DBI."[2]

"Most mild diabetic patients were well controlled on a biguanide compound [DBI]... regardless of age, duration of diabetes, or response to tolbutamide."[3]

"DBI has been able to replace insulin or other hypoglycemic agents with desirable regulation of the diabetes when it is used in conjunction with diet in the management of adult and otherwise stable diabetes."[4]

well tolerated — On a "start-low, go-slow" dosage pattern DBI is relatively well tolerated. DBI enables a maximum number of diabetics to enjoy the convenience and comfort of oral therapy in the satisfactory regulation of...

stable adult diabetes • sulfonylurea failures
unstable (brittle) diabetes • juvenile diabetes

DBI (N^1-β-phenethylbiguanide HCl) is available as white, scored tablets of 25 mg. each, bottles of 100. Send for brochure giving complete information.

an original development from the research laboratories of

u. s. vitamin & pharmaceutical corporation
Arlington-Funk Labs., division • 250 E. 43rd St., New York 17, N. Y.

1. Pomeranze, J. et al.: J.A.M.A. 171:252, Sept. 19, 1959. 2. Walker, R. S.: Brit. M J. 2:405, 1959. 3. Odell, W. D., et al.: A.M.A. Arch. Int. Med. 102:520, 1958. 4. Pearlman, W.: Phenformin Symposium, Houston, Feb. 1959. 5. Lambert, T. H.: ibid. 6. Skillman, T. G., et al.: Diabetes 8:274, 1959. 7. Sugar, S. J. N., et al.: Med. Ann. Dist. Columbia 28:426, 1959.

DBI
Trademark, brand of Phenformin HCl

AEC Contracts

Continued

fired by self-contained explosive charges into the ocean floor. The mooring system will provide fixed reference points for the sites.

The State of California has been invited by the Commission, and has accepted the invitation, to observe the conduct of the ocean survey and the subsequent laboratory operations.

Upon completion of the study, the results will be made available to the public.

AMA Meeting Golfers to Vie In 44th Annual Tourney at Miami

Golf-minded physicians planning to attend the AMA meeting in Miami Beach will be offered an opportunity to play one of the finest 18-hole championship courses in the country, according to John A. Growdon, M.D., president of the American Medical Golf Association.

Their 44th Annual Tournament will be held at the Diplomat Country Club in Hollywood, Fla., Monday, June 13. The outstanding facilities of the Diplomat Country Club are located on a 400-acre site fronting on the Atlantic Ocean.

The AMGA Tournament, long a favorite of AMA members attending the annual meeting, will be held in a setting of tropical splendor on a course that will long be remembered by those members of the AMGA who participate in this year's event.

Cary Middlecoff, former U.S. Open Champion, is the pro of the course and is assisted by five rising professional golfers in keeping the course up to championship playing standards.

Tee off has been scheduled for 8 a.m. through 2 p. m. Monday, June 13. This will give participants the opportunity to start early and finish by lunch time, to play the first nine before lunch and finish after the noon meal, or for completing the entire 18 holes after lunch.

In the late afternoon, professional exhibitions will be scheduled to give pointers and help to AMGA members after they complete their play. The cocktail hour will be from 6 to 7 p.m. and will be followed by the annual banquet and meeting. Prizes for tournament play will be awarded after the banquet.

Members of the American Medical Association who do not hold membership in the American Medical Golf Association should contact Dr. John A. Growdon, 1324 Professional Bldg., Kansas City, Mo., to secure an application form.

AMGA features a lifetime membership to AMA members upon the payment of a membership fee of $3.00. There are no annual dues to the association but members pay tournament fees for those annual events that they participate in.

Complete information about the 44th Annual Tournament will be mailed to all members in early April and reservations may be made at that time.

A limited number of rooms are available at the Diplomat Hotel for those members desiring to stay at the tournament site for the duration of the AMA meeting. Reservation cards will be sent along with the tournament information.

Members staying at other hotels for the AMA meeting will be able to come to the Diplomat by taxi or by automobile. It is only a short ride from Miami Beach, just to the north.

COOK COUNTY GRADUATE SCHOOL OF MEDICINE

INTENSIVE POSTGRADUATE COURSES
STARTING DATES—SPRING-SUMMER, 1960

General Practice Review, Two Weeks, July 11
Surgical Technic, Two Weeks, June 6
Advanced Electrocardiography, One Week, June 20
Surgery of Colon and Rectum, One Week, June 20
General Surgery, One Week, May 23
Gall Bladder Surgery, Three Days, June 20
Surgery of Hernia, Three Days, June 23
Board of Surgery Review, Part II, Two Weeks, August 8
Gynecology, Office and Operative, Two Weeks, June 20

Numerous other courses will be offered by the Divisions of Internal Medicine, Surgery, Gynecology, Obstetrics, Urology, Radiology and Dermatology. Circulars available upon request.

TEACHING FACULTY—ATTENDING STAFF OF COOK COUNTY HOSPITAL

Address: Registrar, 707 South Wood Street, Chicago 12, Illinois

Polyunsaturated Fatty Acids Can Reduce Cholesterol

AMA release, Chicago—The substitution of fats or oils containing polyunsaturated fatty acids for saturated fats or oils is the best way to reduce cholesterol in the blood system on the basis of present information, a New York University physician said recently.

Dr. Herbert Pollack, assistant professor of clinical medicine, Postgraduate Medical School, discussed cholesterol in a signed editorial directed to fellow physicians in the March 12 *Journal* of the American Medical Association.

Cholesterol has been incriminated as a factor in hardening of the arteries and heart trouble.

The terms saturated, polyunsaturated and monounsaturated are used to describe the chemical structure of fats and oils. A saturated fat is one containing all the hydrogen atoms it can hold. A polyunsaturated fat is so named because it has more than one unsaturated bond in its chemical makeup. A monounsaturated fat has only one unsaturated bond in its chemical linkage.

"It is accepted generally that specific alteration in the diet will decrease the concentration of cholesterol in the blood," Dr. Pollack said. "The most effective results to date have been achieved by increasing consumption of polyunsaturated fatty acids, particularly linoleic acid."

At one time, he said, a "low fat, low cholesterol" type of diet was sometimes advocated as a means of lowering the cholesterol level. But he said it is now generally believed that dietary cholesterol, within the limits of the average mixed diet, plays little part in raising the cholesterol concentration in the blood.

Processors Advertising Confusing

Dr. Pollack said confusion has been created because "some of the largest vegetable oil processors in the United States have implied in advertisements that the cholesterol level can be lowered by adding polyunsaturated fatty acids to the diet."

However, he said, a person would benefit little by consuming more polyunsaturated fatty acids if he did not at the same time reduce his intake of other fats. In other words, he said, the polyunsaturated fatty acids "must replace, rather than supplement, some of the saturated fats and oils already in the diet."

Claims for various hydrogenated vegetable oils must be assessed with the knowledge that a product loses most or all of its polyunsaturated qualities when it is hydrogenated, Dr. Pollack said. Products are hydrogenated so they can be stored for longer periods without spoiling.

"Some manufacturers cite the 'iodine number' of a fat or oil as evidence of the unsaturated fatty acid content of their product," he continued.

"This number is not a reliable indicator of therapeutic value because it measures monounsaturated and polyunsaturated fatty-acid content at the same time. A monounsaturated acid . . . does not affect the cholesterol concentration of the blood.

"Contrary to statements sometimes made, not all animal fats are low in the polyunsaturated fatty acid content nor are all vegetable oils high in this quality. The depot fat of chicken is an excellent source of linoleic acid.

"Many vegetable fats and oils contain appreciable amounts of the polyunsaturated fatty acids and if used properly will lower the blood cholesterol level."

Yes Doctor

I am happy, thankful and glad you sent me and my family to Heid's for correct shoes—this eliminates one of our handicaps.



HEID'S 50th Year

Shoes for Men, Women, Children

411 N. Illinois, Indianapolis

Phone MElrose 5-4247 Drive-In Parking

Ob-Gyn Board Exams Open

Applications for certification in the American Board of Obstetrics and Gynecology, new and reopened, Part 1, and requests for re-examination in Part 11 are now being accepted. All candidates are urged to make such application at the earliest possible date. Deadline for receipt of applications is Aug. 1, 1960. No applications can be accepted after that date.

Candidates are requested to write to the office of the secretary for a current *Bulletin* if they have not done so in order that they might be well informed as to the present requirements. Application fee ($35.00), photographs and lists of hospital admissions must accompany all applications.

As announced in the current *Bulletin,* "after July 1, 1962, this board will require a minimum of three (3) years of approved progressive residency training to fulfill the requirements for admission to examination. After the above date, training by preceptorship will no longer be acceptable. Therefore the initiation of preceptorships will not be approved after July 1, 1960."

For information write Robert L. Faulkner, M.D., 2105 Adelbert Rd., Cleveland 6, Ohio.

The New

STATE PROFESSIONAL BUILDING

2828 East State Blvd.

Fort Wayne, Indiana

Leasing now, this new medical & dental building with adequate ground floor space, suites designed to your specifications. Presently under construction.

- Air conditioned throughout
- Ample free parking at the door
- Fastest growing area of quality homes
- Four blocks from our newest hospital Parkview Memorial
- New medical supply house being built nearby

INQUIRIES FROM DOCTORS OF MEDICINE INVITED

Write to: State Medical Clinic, Inc.

2220 Kentucky Avenue

Fort Wayne, Indiana

I.U. School of Medicine Ranks Fifth

Of 83 medical schools in the U.S., I.U. School of Medicine has been ranked fifth by an AMA survey for total enrollment, number of students admitted and number of 1959 students graduated.

The only school in Indiana training physicians, the I.U. medical school was ranked 16th in number of practicing physicians enrolled in postgraduate and refresher courses.

The jump from 10th to 5th place in the past few years, Dean John D. VanNuys pointed out, has been made possible by State Legislature in providing funds for the new Medical Science Building and additional faculty members.

Physicians' Art to be Exhibited at Miami

The 23rd annual exhibition of art works by American physicians will be held June 13-18, 1960, at the Miami Beach Exhibition Hall and Auditorium, it was announced today by Lewis M. Johnson, M.D., President of the American Physicians Art Association.

Held in conjunction with the annual convention of the American Medical Association, the show will include over 300 works of art in oil, water color, sculpture, crafts, photography and lithography.

Participants and prospective exhibitors may obtain further information from Dr. Kurt F. Falkson, 7 East 78th Street, New York City, secretary of the American Physicians Art Association.

1960 Man of the Year

N. H. Gladstone, M.D., Fort Wayne, was named "Man of the Year 1960" by the Brotherhood of the Achduth Vesholm Temple.

The award is one of four given in the 20 years of the organization's existence. It is given for being a leading participant in religious, civic and cultural endeavors within the community.

Dr. Gladstone is a past president of the Temple.

Stephen L. Johnson, M.D., of Evansville, has been named to the governing body of the American Society of Internal Medicine. He and E. Paul Tischer, M.D., of Indianapolis were scheduled to attend the society's annual meeting at San Francisco in April as delegates of the Indiana Society of Internal Medicine. ◄

Add 1

Wide Awake for Spring; A Coincidence with Orchids; Journals for the Cold War

by corki

This morning I was almost glad I couldn't sleep. As the first rays of dawn's light crept flickering into the room, the sound of happy, happy birds filled the air. I don't know my bird calls well enough to identify them, but they all sounded so cheerful and bright.

It was spring . . . the first real spring morning after an all too long and all too cold winter. Warmth wafted in on the breeze and the light grew steadily; and I had to get up to see the sun slip into a clean blue sky with its warm, pleasant reflections.

The sky was clear as last night's sky had intimated when the moon shown full and bright except for occasional mysterious and exciting clouds scudding in front of it on wings of wind.

Spring finally made the grade and the world is so much better for it!

This World Grows Smaller

There must be some light, breezy apropos remark to cover the following story besides the worn and tattered "small world" bit. But with my overdose of spring fever, I just can't find it on my cloud nine. So to the story without fanfare.

Received a letter from our San Francisco medical artist, Rosebud Lane Preddy, who did that beautiful heart for our February issue. To wit!

"I had not met the new chief of pathologic anatomy (at Letterman Army Hospital), Capt. Stanley J. Bolowski of Indianapolis. I passed his office the other day and stopped in to introduce myself.

"Having heard he was from Indiana I opened an Indiana conversation about the *Journal*. 'Oh, yes,' said he, 'Indiana puts out a most unusual *Journal*—one of the best. I particularly like their covers; not the usual printed sort of uninteresting layout, but a beautiful cover that makes you want to pick it up and read it. Take this latest one for example.'

". . . and he reached over his desk and handed me the February heart issue!"

As Rosebud said, "How's that?" And doesn't that go beyond the realm of coincidence! We received a fine compliment and our artist most assuredly must have received a high mark from a physician who will be using her talents in his position at Letterman.

In a subsequent letter she told us he was surprised and pleased and visited her office to see her work there. And Captain Bolowski again praised the *Journal,* saying he knew some physicians who frame our covers for their offices.

We can think of no greater tribute and thank him for his kind words. For those interested, Dr. Bolowski was associated with Dr. William Pierce of Indianapolis and with Methodist Hospital in Nap Town.

Journals for the Cold War

The idea of sending medical journals physicians no longer need to overseas physicians has grown, it seems.

Last month we ran an AMA release about Dr. Charles B. Daugherty of Jeannette, Pa., who began a project to send discarded medical

Add 1

Continued

literature to physicians in foreign lands as an aid in deterring communism.

Now we receive a letter from William Stockdale McCabe II of Greensburg, Pa., who is working on the same idea, according to his explanation, and is associated with Magazines For Friendship, Inc., a non-profit corporation at Occidental College, Los Angeles 41.

The basic idea of the whole thing is that in many less educated countries, where communism has grown due to that very lack of education, the physician ofttimes is the dispenser of information as well as of medication and he greatly influences local opinions of the world in general.

If he receives American medical journals, then he will improve his medical skill through the information he gleans from them and spread the good word for the U.S.

I think that's a mighty fine idea and one worth mulling over. Of course, we'd like to think that our reader members clutch each succeeding issue to their file cabinets for future reference; but for those who do not, utilizing them in this manner would certainly be helping in the cold war.

Dr. Daugherty's story may be found in the Feb. 27 issue of the *AMA Journal*. Mr. McCabe II may be reached at 612 Mount Pleasant St., Greensburg, Pa., for information.



"May I point out the business man's luncheon, sir? It's a tranquilizing pill on a cracker."

Company for Fido

I've heard a lot of husbands remarking about being in their wives' proverbial dog house, but I somehow can't think any of them are as well acquainted with Fido as the poor speaker of Britain's House of Commons is about to become.

Per an AP release printed in the *Indianapolis Star*, a little round of politics and his wife's ability to talk has put him in the position of perhaps ruling that his wife stands accused of breach of parliamentary privilege. His wife is the Honorable Audrey Hylton-Foster, who made some untimely remarks about women in politics.

If so accused, her spouse may call her before the assembled House of Commons for a severe dressing down and require her to apologize.

Make mine a ham bone! ◄

It should be a matter of great concern to us that our values are so confused that we pay television and movie actors more than we pay our school teachers, and we hardly notice the absurdity.—Brock Chisholm, *Chicago Schools Journal*.

The Norbury Sanatorium

Established 1901 — Incorporated
Licensed — Jacksonville, Illinois

FRANK GARM NORBURY, A.M., M.D., Medical Director
HENRY A. DOLLEAR, M.D., Superintendent
FRANK B. NORBURY, M.D., Physician

Operating

Maplecrest—

Restful, congenial homelike surroundings are combined with the most modern diagnostic and therapeutic equipment.

Maplewood—

Most comfortable hospital facilities for individuals requiring rest, scientific diagnosis and treatment. Fireproof construction.

Deaths . . .

Robert S. Ball, M.D.

Dr. Robert S. Ball, Lebanon physician since 1927, died in Indianapolis March 4 at the age of 60.

A graduate of Northwestern University, Dr. Ball was a World War I and II veteran and a former president of the Boone County Medical Society.

Clancy Bassett, M.D.

Dr. Clancy Bassett, who practiced in Thorntown for 53 years, died March 17 at his office at the age of 80. He had received his 50-year ISMA pin in 1957.

Dr. Bassett, a Boone County coroner for 17 years, was a graduate of Danville Central Normal College and Indiana Medical College. He belonged to Scottish Rite, Knights of Pythias and the Masonic Lodge.

Rose J. Buttz, M.D.

Dr. Rose J. Buttz, Indianapolis physician for 59 years and a pioneer worker in the problems of alcoholism, died Feb. 28 at the age of 86.

Dr. Buttz was a staff physician at the Indiana Girls School for several years, and later at the Indiana Women's Prison, Norways Sanitarium and Fletcher Sanitarium. She is said to have been one of the earliest students of combating alcoholism from a medical rather than a moral viewpoint.

B. J. Wyland, M.D.

Dr. B. J. Wyland, 76, Mishawaka physician since 1914, passed away Feb. 17.

A graduate of Purdue and Indiana Universities, Dr. Wyland had been secretary of the Mishawaka Board of Health since 1926, with exception of two years interruption due to his appointment as deputy coroner.

He served as vice-president of the St. Joseph County Medical Society and had been president of the St. Joseph Hospital staff for two years.

District, County Society News



Chinese Ambassador to Speak Before First District Members

The Chinese Ambassador to the United States, Dr. George Kung-chao Yeh, will be feature speaker at the June 23 meeting of the First Councilor District.

Dr. Yeh has held many diplomatic offices for his country, including chairing the Chinese delegations to the 7th, 9th, 10th and 11th regular sessions of the U.N. General Assembly and to the Commemorative Session of the 10th Anniversary of the U.N. in San Francisco in 1955.

His list of decorations reads like a U.N. roster, with awards from China, Thailand, Spain, Venezuela, Cuba, Chile, Ecuador, Peru, Guatemala, Greece, Iran, Jordan, Iraq, Lebanon, Dominican Republic, etc.

He has taught English at several Chinese universities, winning the research fellowship in literature by the China Foundation in 1937-39.

His publications include "Social Forces in English Literature;" an introduction to China;

County, District

Continued

"The Concept of Jen," and "Cultural Life in Ancient China" (for which he was awarded the 1943 medal of the Royal Society of Arts, London).

He authored a paper on Ancient Chinese Poetry and numerous articles in Chinese on English and American literature.

The First District meeting will be held at the Farm Bureau Picnic Grounds, Mt. Vernon, at 3 p. m. Dinner will be at 6.

Allen

Mr. Layman L. Hay, Chicago bank and trust executive, spoke on "Wills, Women and Woe" at the March 1 meeting of the Allen County Medical Society. Fifty-seven couples attended.

At the society's April 5 meeting, Dr. Sam T. Gibson, Director of the National Blood Program, American Red Cross, Washington, D.C., spoke on "Problems Related to Blood Procurement and Transfusion." Fifty-two were present.

Carroll

Dr. James McLaughlin, Flora, reviewed diagnosis and treatment of coronary artery heart disease at the March 16 meeting of the Carroll County Medical Society. Eight doctors and eight guests attended.

Cass

Two Indianapolis physicians were recent speakers at the Cass County Medical Society meetings. Dr. Glenn Irwin spoke to 20 society members on "Endocrine Problems in General Practice" on March 7.

"Etiology of Pericarditis" was Dr. Pasquale Genovese's subject at the April 4 meeting.

Clark

New officers of the Clark County Medical Society are Drs. Lee Dare, president, Norman Forsee, vice-president, and Edsel S. Reed, secretary-treasurer.

Clay

Eleven members of the Clay County Medical Society met at Brazil on March 15 for a business meeting.

Decatur

Twelve members of the Decatur County Medical Society met at Greensburg March 23 for a general business meeting and a discussion on legislation.

Delaware-Blackford

Thirty-five members of the Delaware-Blackford Medical Society met March 15 for a general business meeting.

Elkhart

Ladies of the Elkhart County Medical Auxiliary presented a skit entitled "Ladies in Lobby" at the county society's March 10 meeting. Dr. Burton Kintner and Mrs. Otis Bowen also took part in the program.

Dr. Vernon K. Pancost has been elected president of the society. Assisting him will be Drs. Forest Kendall, vice-president; Page E. Spray, secretary-treasurer; S. T. Miller and Jack Hannah, delegates; and Floyd Martin and Frederick Bigler, alternate delegates.

Fayette-Franklin

Ten members of the Fayette-Franklin Medical Society met at Connersville on March 8 for a discussion on legislation and a general business meeting.

Floyd

Dr. Ronald McDonald spoke on Glaucoma at the February 11 meeting of the Floyd County Medical Society. Twenty-three members attended.

Fountain-Warren

Doctors of the Fountain-Warren Medical Society met at Attica March 3 for a general business meeting.

Grant

Dr. Joseph Davis is the new president of the Grant County Medical Society. Other new officers include Drs. James P. Powell, vice-president; Eugene S. Rifner, secretary-treasurer; Robert Brown, delegate; and Max Long, alternate delegate.

Harrison-Crawford

Dr. Louis Blessinger is the new president of the Harrison-Crawford Medical Society. Assisting him in 1960 will be Drs. David Dukes, vice-president; Richard Jordan, secretary-treasurer; William Amy and Novy Gobbel, delegates, and Richard Jordan and Jesse Benz, alternate delegates.

Henry

Thirty-eight members of the Henry County Medical Society met at New Castle March 17 for a legislative meeting.

Continued

Huntington

Dr. William Martz of Indianapolis spoke on "Electrolytes and Atherosclerosis" at the Feb. 9 meeting of the Huntington County Medical Society. Seventeen attended.

Knox

"Upper Abdominal Pain" was the subject of Dr. Stanley Battersby's paper at the Knox County Medical Society meeting March 15 at Vincennes. Twenty-six members attended.

Kosciusko

Members of the Kosciusko County Medical Society met with county nurses, medical assistants and practical nurses for a legislative discussion March 21.

Laporte

Dr. Edward W. Custer spoke on "Tuberculosis and the Mantox Test" at the March 15 meeting of the Laporte County Medical Society; 18 members attended.

Lawrence

Twenty-two Lawrence County physicians attended a general business meeting of the county medical society on March 2.

Marshall

Dr. Ernest Norris is the new president of the Marshall County Medical Society. Assisting him are Drs. James Hampton, vice-president; James O. Coursey, Jr., secretary; James Kubley, delegate; and Paul Connell and L. W. Vore, alternate delegates.

Montgomery

Dr. Willis D. Gatch, Indianapolis, spoke on Cancer at the March 17 meeting of the Montgomery County Medical Society. There were 29 present.

Orange

Drs. Ivan Clark and Charles X. McCalla III spoke on "Surgical Considerations of Diseases of the Biliary System" at the April 4 meeting of the Orange County Medical Society.

At the group's March 1 meeting, Dr. Edward Warrick Jr. of Louisville discussed current concepts of emergency treatment of burns.

Owen-Monroe

Twenty-nine members of the Owen-Monroe Medical Society heard a discussion on personal estate planning at their March 31 meeting.

Parke-Vermillion

Dr. William J. Markin, Terre Haute, spoke on "Eye Treatments in General Practice" at the March 16 meeting of the Parke-Vermillion Medical Society.

Porter

Eighteen members of the Porter County Medical Society met for a legislative discussion March 29.

Randolph

Twelve members of the Randolph County Medical Society heard a discussion on liver disease at their March 14 meeting.

Ripley

Dr. Charles Lippoldt spoke and presented a film on "Rescue Breathing" at the March 10 meeting of the Ripley County Medical Society.

Rush

Rush County Medical Society members met at Rushville March 10 for a discussion on current Federal legislative problems.

Sullivan

Dr. Robert O. Bethea is the new president of the Sullivan County Medical Society. Other new officers are Drs. J. H. Crowder, vice-president; J. S. Brown, secretary-treasurer, and Joe E. Dukes, delegate.

Wayne-Union

Dr. Robert W. Wissler, Head of the Department of Pathology at the University of Chicago, spoke on the Relationship between Pathogenesis and Therapy of Atherosclerosis at the March 8 meeting of the Wayne-Union Medical Society. Forty-one physicians attended. ◄



"He's quite a famous baby doctor!"

Association News

EXECUTIVE COMMITTEE

March 10, 1960.

Roll call showed the following present: Don E. Wood, M.D., chairman; Wendell E. Covalt, M.D.; Earl W. Mericle, M.D.; Okla W. Sicks, M.D.

Treasurer's Office

The statement of income and budget balances for February and the treasurer's report were approved by consent.

Membership Report

Number of members as of February 28, 1959	3,618
1960 members as of February 29, 1960:	
Full dues paying	3,258
Interns	17
Residents	152
Council remitted	28
Senior	349
Military	32
Honorary	1
Total 1960 members as of February 29, 1960	3,847
Gain over last year	229
Number of members December 31, 1959	4,256
Number of AMA members as of February 28, 1959	3,590
1960 AMA members: Dues paying	3,136
Exempt, but active	607
Total 1960 AMA members as of February 29, 1960	3,743
Gain over last year	153
Number of AMA members as of December 31, 1959	4,120
Number who have paid state dues but not AMA dues in 1960	107

Legislation

Also discussed was the change in the date of the dinner for the Indiana delegation from May 2 to May 4, which was approved by consent.

Copies of the statement made by Dr. Wood before the Legislative Advisory Committee on March 8, 1960, were distributed for the information of the other members of the committee.

Organization Matters

Billboard advertising. The matter referred to the Executive Committee by the Commission on Voluntary Health Agencies concerning the billboard advertising of the National Foundation was again discussed, and upon motion of Drs. Mericle and Covalt, this matter is to be referred to the Council at its next meeting, with the recommendation that the Executive Committee consider favorably their request, with the idea of questioning their statement in the advertisement, "Guarding America's Health."

National Foundation scholarship program. A letter from the National Foundation, addressed to the president of the Association, again requesting the appointment of three physicians to a Scholarship Committee, was discussed and a report was made of the recommendation of the Commission on Voluntary Health Agencies and the action of the Council at its meeting of January, 1959, was also reviewed, and by consent it was agreed to again refer this matter to the Council at its April meeting.

Southern Indiana Personal Counseling Service. A letter from the Floyd County Medical Society concerning the position of the Association with respect to the Southern Indiana Personal Counseling Service was reviewed and by consent this was referred to the Commission on Special Activities for investigation and report.

New Business

Dr. Mericle read a letter which he had received from the Board of Trustees of Indiana University, and after a thorough discussion Dr. Mericle recommended that he and the secretary make a personal call upon the writer and the county medical society involved. In the meantime the secretary is instructed to write a letter to the Board of Trustees of Indiana University thanking the Board for calling this matter to the attention of the Association and stating that an investigation will be made and a report supplied following the investigation. This was approved by consent.

An invitation to the president to attend a Board meeting of the Medical Assistants Association on March 20 in Indianapolis was read and Dr. Mericle said it would be impossible for him to attend and it was suggested that Dr. Ralph Everly be requested to represent Dr. Mericle.

Future Meetings

Attention was called to the State Chamber of Commerce Board of Directors meeting at French Lick, April 22, 23 and 24, the AMA meeting on Aging, April 22 and 23, in Chicago, and the United States Chamber of Commerce meeting at Washington May 1 through May 4.

AMA National Congress on Prepaid Health Insurance, Chicago, May 13 and 14. It was recommended that Dr. Owsley and the secretary attend and either Dr. John Langohr or Dr. E. T. Edwards.

There being no further business the committee adjourned to meet again at 6:00 p.m. on Saturday, April 9, 1960. ◄

Lighter Vein . . .

Anyone who thinks by the inch and talks by the yard, ought to be moved by the foot.—Campbell *Brevities.*

———

A rich man is one who isn't afraid to ask the clerk to show him something cheaper.—Campbell *Brevities.*

———

Hardening of the heart ages people more quickly than hardening of the arteries.—Campbell *Brevities.*

———

You can do a lot with an old house these days if you're handy with money.—Campbell *Brevities.*

———

A woman motorist was being examined for a driver's license.

Examiner: "And what is the white line in the middle of the road for?"

Woman: "Bicycles."—Campbell *Brevities.*

———



"I take it your backache isn't the only thing that's nagging you!"

A supermarket is a place where you can find anything you want except the kids when you're ready to leave.—F. G. Kernan.

———

Everyone believes in the golden rule: Give unto others the advice you can't use yourself.—*Personnel Administration.*

———

If the cost of a college education continues to snowball for many more years, a person can make a profit by remaining ignorant.—*Grit.*

———

"A father," as defined by George Hall, "is an ambitious man who diligently works his son's way through college."—Burton Hillis, *Better Homes and Gardens.*



"Hello, Bixby. You must have grown another foot since I've last seen you!"

Every noble deed springs from a character that has been trained in small things.—"Little Things," *Megiddo Message.*

———

Some of today's movies should be pitied rather than censored.—Anna Herbert.

———

A thoughtful man is one who gives his wife a birthday present without mentioning her birthday past.—Frank G. McInnis.

———



"Then one day I noticed my wife was deliberately eating all my favorites in our variety pack of individual cereals!"

NEW MEDICAL SCHOOL FACILITIES

Indiana University recently dedicated its Medical Science Building, a major step in improvement of medical education. Despite these increased facilities and partly due to the depreciating dollar, the medical schools need your financial support. Please help the school of your choice through American Medical Education Foundation.

"Only when people make some kind of financial sacrifice for their schools do they take an active and wholesome interest in education."

Mail your AMEF Contribution to

AMEF—Indiana State Medical Association

1021 Hume Mansur Bldg.

Indianapolis, Ind.

LABORATORIES
PATHOLOGISTS

CLINICAL PATHOLOGISTS IN INDIANA

SOLICIT THE COOPERATION OF THE PHYSICIANS OF INDIANA IN UPHOLDING AND MAINTAINING THE HIGH ETHICAL STANDARDS OF CLINICAL PATHOLOGY IN INDIANA. THE ASSOCIATION URGES THAT PHYSICIANS BECOME ACQUAINTED WITH THE PATHOLOGISTS IN THEIR VICINITY.

David L. Buckles, M.D., Anderson
Wemple Dodds, M.D., Crawfordsville
A. P. Bennett, M.D., Evansville
Fred E. Mills, M.D., Evansville
Francis W. Porro, M.D., Evansville
A. W. Ratcliffe, M.D., Evansville
K. R. Schlademan, M.D., Fort Wayne
W. P. Loh, M.D., Gary
Jean Pilot, M.D., Hammond
Lee N. Foster, M.D., Indianapolis
J. L. Haymond, M.D., Indianapolis
Lester H. Hoyt, M.D., Indianapolis
Harold C. Thornton, M.D., Indianapolis
Wm. E. Bayley, M.D., Lafayette
James M. McFadden, M.D., Lafayette
L. G. Montgomery, M.D., Muncie
L. L. Blum, M.D., Terre Haute
Jack G. Weinbaum, M.D., Terre Haute

SPECIMEN CONTAINERS WILL BE SENT ON REQUEST

COMMERCIAL ANNOUNCEMENTS

RESIDENCY AVAILABLE. 3-year approved residency in Physical Medicine and Rehabilitation in 1300-bed Veterans Administration Hospital with Baylor University College Medicine affiliation. Regular residency $3,250-$4,165; career residency $6,505-$9,890 (stipend dependent upon qualifications). U.S. citizenship required. Physicians qualified in specialty of PM&R are in great demand within the VA, private institutions of rehabilitation, private hospitals and private practice. Write Manager, VA Hospital, Houston, Texas.

FOR SALE: BEAUTIFUL HOUSE AND OFFICE in rapidly growing west suburb of Chicago, equipped for x-ray diagnosis and/or general practice. Financing optional. Owner retiring. Write Box 114, ISMA Journal, 1019 Hume Mansur Bldg., Indianapolis 4.

FOR SALE OR LEASE: Doctor's office in rapidly growing community with unusual cultural and recreational advantages. Located ½ block from St. Joseph Hospital, Mishawaka, Ind. Write R. C. Vance, Realtor, 410 West Third St., Mishawaka, for details.

MEDICAL OFFICE: Ideal for G.P. or specialist. Three treatment rooms and lab. Heat, light and water furnished. Ground floor; parking lot. All paneled; lease available. Rent $100.00 per mo. Can be inspected at 1060 Virginia Ave., Indianapolis.

PHYSICIAN NEEDED. Covington, Ind., a growing community, is in need of another doctor. Office space available, 2 large hospitals in Danville, Ill., 14 miles. Contact The Business and Professional Woman's Club, 411 Third St., Covington.

GP RENT OR BUY. Boonville, Ind. (pop. 5500), 15 min. fm. Evansville. Active practice with equipment, records, bldg., etc. Rent 10% of gross not to exceed $250 mo. First pmt. due end first month. Apply rent to purchase if desired. Call collect. K. J. Rudolph, M.D., 1827 Norfolk, Ind'pls. 24 (Speedway), phone CH. 1-8720; or Scales Pharmacy, Boonville, Ind., phone 75.

OPHTHALMOLOGIST OR ENT SPECIALIST NEEDED to share beautiful 4-rm. office adjacent to 75-bed hosp. in Huntingburg, Ind. Other physicians located nearby. No such specialist in county; opportunities are excellent. Receptionist, bookkeeper, sec'y., R.N., aide available. Contact H. K. Stork, M.D., 530 Fourth St., Huntingburg.

PHYSICIAN'S OFFICE. Available Jan. 1, 1960, for internist or GP office space in air conditioned office bldg. Sharing overhead expense w/pediatrician, anesthetist, general surgeon. Contact Paul H. Wilson, M.D., 422 North St., Logansport.

PEDIATRICIAN: board certified, age 37, looking for partnership or group practice in Indiana. Write P. O. Box 277, Cambridge, Md.

NOTICE

Commercial announcements are carried in the Journal as a special service to ISMA members. Only advertisements considered to be of advantage to members by the Journal editorial board will be accepted. Those of a truly commercial nature (i.e., firms selling brand products, services, etc.) will be considered for display type advertising.

Charges for commercial announcements are:

First four lines: $3.00
each additional line: 50¢

ISMA members may repeat an ad in the following issue without charge. This is limited to one free ad per year.

Advertiser will be billed at the end of the designated period of insertion(s), or at the end of each three-month period, whichever is shorter.

DEADLINE: Fifth day of month PRECEDING month of issue. (The Journal is in press approximately one month.)

ADVERTISERS IN THIS ISSUE

Volume 53 May 1960 No. 5

Akron Surgical House Inc. 978
Ames Company, Inc. ..... 3rd Cover
Ayerst Laboratories 1003
Baker Brothers 1004
Blue Cross-Blue Shield 971
Blue Shield 1011
Bristol Laboratories 974-75
Breon, George A. 981
Burroughs Wellcome & Company 866
Central Pharmacal Company 821
Ciba Pharmaceutical Products Co., Inc. 838, 1015, 1047
Claypool Hotel 972
Cook County Graduate School of Medicine 1056
Curtis & French 1049
Desitin Chemical Company 999
Durst, S. F. & Co., Inc. 822
Endo Products, Inc. 983
Geigy Pharmaceuticals 835, 969
General Electric 1001
Glenbrook Laboratories 843
Hanger, J. E., Inc. 1004
Harding Sanitarium 1019
Heid's Shoe Store 1057
Home Lawn Mineral Springs Company 1005
Hume Mansur Building 1007
Indianapolis Artificial Limb Corp. 984
Jaguar Midwest Distributors Inc. 980
Keeley Institute 972
Lederle Laboratories 809, 818-19, 837, 844, 856-57
Lilly, Eli, & Company 850
Lorillard, P., Co. 839
Maney, Paul, Laboratories, Inc. 836
Medical Protective Company 1022
Merck, Sharp & Dohme, Inc. 805, 833, 848
Milwaukee Sanitarium Foundation 834
Norbury Sanatorium Co. 1060
North, Emerson A., Hospital 993
Original Contour Chair-Lounge 1045
Ortho Pharmaceutical 989
Parke, Davis & Co. ..... 2nd Cover & 803
Pepsi-Cola 992
Physicians Casualty Association 988
Public Service Company of Indiana 973
Robins, A. H., Company 967
Roerig, J. B., & Company, Inc. 823, 840, 845
St. Paul Western Insurance Companies 982
Sardeau, Inc. 842
Schering Corporation 814-15, 841, 849, 988
Searle, G. D., & Company 865
Shirley Brothers Mortuaries 1039
Smith-Dorsey 806-07, 987
Smith, Kline & French Laboratories ..... 4th Cover
Squibb, E. R., & Sons 813, 991
State Professional Building 1058
Storck Pharmaceuticals, Inc. 977
Telex Hearing Center 964
Testagar Company, Inc. 811
Tutag, S. J., Co. 1051
U. S. Vitamin Corporation 1054-55
Wabash Valley Sanitarium 990
Wallace Laboratories 830-31, 979, 995-97
Wesson Oil & Snowdrift Sales Co. 846-47
White-Haines Optical Company 982
Winthrop Laboratories 817, 985

when air-borne tree pollens attack...

BENADRYL®

antihistaminic-antispasmodic

gives prompt, comprehensive relief

In sensitivity to tree pollens, BENADRYL provides simultaneous, dual control of allergic symptoms. Nasal congestion, lacrimation, sneezing, and related histamine reactions are effectively relieved by the *antihistaminic action* of BENADRYL. At the same time, its *antispasmodic effect* aids in alleviating bronchial and gastrointestinal spasms. This duality of action makes BENADRYL valuable throughout a wide range of allergic disorders.

BENADRYL Hydrochloride (diphenhydramine hydrochloride, Parke-Davis) is available in a variety of forms including: Kapseals,® 50 mg.; Kapseals, 50 mg. with ephedrine sulfate, 25 mg.; Capsules, 25 mg.; Elixir, 10 mg. per 4 cc.; and, for delayed action, Emplets,® 50 mg. For parenteral therapy, BENADRYL Hydrochloride Steri-Vials,® 10 mg. per cc.; and Ampoules, 50 mg. per cc.

25960

PARKE-DAVIS

PARKE, DAVIS & COMPANY • DETROIT 32, MICHIGAN



The Journal

June 1960

of the INDIANA STATE MEDICAL ASSOCIATION

Office of Publication:
1019 Hume Mansur Building, Indianapolis, Indiana

$1.00 per copy
except Yearbook
$5.00 per copy

Contents

SCIENTIFIC

Hyperfunctioning Adrenal Lesions, James T. Priestley, M.D., Rochester, Minn. 1109
Treatment of Imperforate Anus, Arthur DeBoer, M.D., Chicago, Ill..... 1116
Griseofulvin—An Advance in the Treatment of Tinea Capitis, Paul V. Chivington, Jr., M.D., Howard R. Gray, M.D., Robert L. Wolf, M.D., John Eric Dalton, M.D., Indianapolis..... 1120
Problems of Ovarian Cysts, J. Donald Woodruff, M.D., Baltimore, Md. 1124
The Challenge of Triacetyloleandomycin in Pediatric Infections, C. K. Newsome, M.D., Evansville..... 1131
Duration of Convalescence Following Surgery, N. Henry Moss, M.D., Philadelphia, Pa. 1134
The Case of the Cement Boot, Arnold Lieberman, M.D., New York, N. Y. 1137
Pathfinder: Commission on Forensic Sciences..... 1143
Condensed Cardiology: Diagnosis of Chronic Pericardial Effusion, Edward F. Steinmetz, M.D., Indianapolis..... 1146

EDITORIALS

Retirement—Activity or Apathy?..... 1154
Americans More "Health Conscious"..... 1155
"Progressive" Care Experiment..... 1155
Watch Out! (From Virginia) 1156

SPECIAL FEATURES

Proposal Submitted by the Treasury in Lieu of HR 10, 86th Congress 1158
Eisenhower Administration's Plan for Aged (from AMA) 1105
Lightning Does Strike!, A. L. Marshall Jr., M.D., Indianapolis..... 1164
Report to the Nation, Austin Smith, M.D., President, Pharmaceutical Manufacturers Association 1166
RE: "The Forand Bill and the Record of AMA"
Text of Letter From Dr. Louis M. Orr to Mr. George Meany..... 1194
In Refutation (an answer to each allegation) 1195
In Answer to Mr. Meany's Response..... 1204
Hawaii—Rich in Lore of Medicinal Herbs, Miki Wilson, San Francisco 1206
Group Clearance Eliminated in Quarantine Procedures..... 1216
Inaugural Address, Mrs. Ina Rigley, South Bend..... 1226

REGULAR FEATURES

Month in Washington..... 1092
Fourth Estate 1098
President's Page 1161
Woman's Auxiliary Reports to ISMA..... 1162
"Preferred Sales" in Relation to Income (Blue Cross-Blue Shield Series) 1220
Wanted: Physicians, Locations..... 1224
News Notes
Three I.U. Students Winners in SAMA Competition..... 1231
Indiana Diet Manual Available..... 1232
Hoosiers Participate in AMA Meeting at Miami..... 1234
Board of Health Report 1235
Add 1 1236
Deaths 1238
AMEF 1243
1960 Annual Convention..... 1239
Advertisers Index 1254

BUSINESS

County and District News..... 1238
Association News: Executive Committee, April 9, 1960..... 1244

EDITORIAL AND ADVERTISING INFORMATION

All articles must be typewritten, double-spaced with margins of one inch.

Photographs should be printed on glossy paper. Negatives cannot be used.

Illustrations are desirable. Selection of illustrations submitted at discretion of editor and editorial board members. Cost of color illustrations must be shared by the author.

Contributors are responsible for all statements made in their articles. The editors and editorial board members may not be in agreement with all views expressed by authors, but it is desired to give all authors as great latitude as possible. However, the right is reserved to reduce in length or reject any article.

Articles are accepted for publication with the understanding that they are submitted for exclusive publication in THE JOURNAL of the Indiana State Medical Association.

Communications dealing with editorial matter should be sent to Frank B. Ramsey, M.D., Editor, 1802 North Illinois Street, Indianapolis 2, Indiana. All other communications should be sent to THE JOURNAL of the Indiana State Medical Association, 1019 Hume Mansur Building, Indianapolis 4, Indiana.

Advertising rates will be furnished on request. Copy must be received by the 5th of the month preceding month of issue. (Scientific manuscripts must be received at least two weeks earlier if geared for a specific issue.)

Entered as second class matter January 25, 1933, at the Postoffice at Indianapolis, Indiana. Copyright, 1960, by the Indiana State Medical Association. Published monthly at 1019 Hume Mansur Bldg., Indianapolis 4, Indiana.

-pain due to or associated with -spasm of skeletal muscle

a new muscle relaxant-analgesic

Robaxisal®

ROBAXIN® WITH ASPIRIN

Many conditions, painful in themselves, often give rise to spasm of skeletal muscles. ROBAXISAL, the new dual-acting muscle relaxant-analgesic, treats both the pain and the spasm with marked success: In clinical studies on 311 patients, 12 investigators[1] reported satisfactory results in 86.5%. Each ROBAXISAL Tablet contains:

- A relaxant component — Robaxin* — widely recognized for its prompt, long-lasting relief of painful skeletal muscle spasm, with unusual freedom from undesired side effects ..... 400 mg.

  *Methocarbamol Robins U.S. Pat. No. 2770649

- An analgesic component — aspirin — whose pain relieving effect is markedly enhanced by Robaxin, and which has added value as an anti-inflammatory and anti-rheumatic agent. . . (5 gr.) 325 mg.

INDICATIONS: ROBAXISAL is indicated when analgesic as well as relaxant action is desired in the treatment of skeletal muscle spasm and severe concurrent pain. Typical conditions are disorders of the back, whiplash and other traumatic injuries, myositis, and pain and spasm associated with arthritis.

SUPPLY: ROBAXISAL Tablets (pink-and-white, laminated) in bottles of 100 and 500.

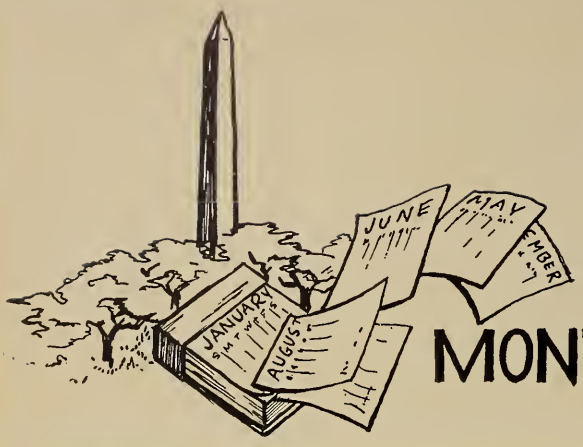
Also available— ROBAXIN Injectable, 1.0 Gm. in 10-cc. ampul. ROBAXIN Tablets, 0.5 Gm. (white, scored) in bottles of 50 and 500.

[1]Clinical reports in files of A. H. Robins Co., Inc., from J. Allen, Madison, Wisc., B. Billow, New York, N. Y., B. Decker, Richmond, Va., C. Freeman, Jr., Augusta, Ga., R. B. Gordon, New York, N. Y., J. F. Holmblad, Schenectady, N. Y., L. Levy, New York, N. Y., N. LoBue, Chicago Heights, Ill., H. Nachman, Richmond, Va., A. Poindexter, Los Angeles, Cal., E. Rogers, Brooklyn, N. Y., K. H. Strong, Fairfield, Ia.

Additional information available upon request.

A. H. ROBINS CO., INC., Richmond 20, Virginia

Making today's medicines with integrity . . . seeking tomorrow's with persistence



This summary of what is happening in Washington is prepared by A.M.A.'s Capital office and airmailed to *The Journal* on the ninth of each month preceding month of issue.

MONTH IN WASHINGTON

WASHINGTON, D.C.--Politics now overshadows all other factors in the issue of health care for the aged.

It appears certain to be a major issue in this year's campaigning for the White House and Congress, regardless of what Congress does in the field before adjourning this summer.

Both the Democrats and the Republicans are supporting costly, sweeping plans which differ on the basic approach. The major Democratic plans call for use of the Social Security system. The Republican proposals would have the Federal government and the states put up hundreds of millions of dollars to help the aged buy health insurance on a voluntary basis.

The medical profession and allied groups oppose these political solutions because, among many other important reasons, they actually would not meet the problems of many aged who need help in financing the cost of illness.

Meanwhile, a key Democrat--Rep. Burr Harrison of Virginia--warned Congress against acting on such legislation in this year of a national election. He predicted that if any such legislation should be approved this year, it "would be certain to be a monstrosity."

Noting that various solutions had been proposed, Harrison said:

"The only features which these proposals have in common are that they are all tremendously expensive; they all propose revolutionary change, and they are all complicated, uncertainly-based and little-understood by the prospective beneficiaries."

URGES CONGRESS TO DEFER ACTION

Harrison, who is a member of the House Ways and Means Committee which handles such legislation, urged that Congress defer action until next year. He recommended that, in the meantime, the Ways and Means Committee "conduct an exhaustive study of the various proposals."

In early May, the Eisenhower Administration unveiled a Federal-state $1.2 billion-a-year plan to help the aged with limited incomes buy broad medical and hospital insurance coverage. Under the plan, an aged person--if able financially--would bear part of the cost of both the insurance and of the medical care and hospitalization.

Arthur S. Flemming, Secretary of Health, Education and Welfare, and Vice President Richard M. Nixon stressed that participation by the aged in the Administration program would be on a voluntary basis.

Continued



6-10 HOURS
SUSTAINED THERAPY

ONE *and only* ONE
Timed AMO*dex* CAPSULE
PER DAY *will economically*

control appetite in weight reduction or relieve the nervous symptoms of anxiety and the underlying depression.

Timed AMO*dex CAPSULES* (Testagar) furnish a controlled uniform action. The medications provide prolonged, continuous therapeutic effect from active ingredients over a period of 6 to 10 hours.

Following ingestion of one *Timed* AMO*dex CAPSULE*, small amounts of the medication are released immediately.

Each *Timed* AMO*dex CAPSULE* contains a daily therapeutic dose of:

Dextro-amphetamine hydrochloride	15 mg.,
Amobarbital	60 mg.

AMO*dex* ADVANTAGES

- HIGH-LEVEL ANOREXIGENIC ACTIVITY WITHOUT NERVOUS EXCITATION
- SMOOTH, UNIFORM ACTION
- THERAPEUTIC EFFECT LASTING 6 TO 10 HOURS
- ONLY ONE DOSE DAILY
- CLINICALLY ECONOMICAL TO THE PATIENT

PROTRACTED THERAPEUTIC EFFECT

Before the development of *Timed* AMO*dex* (Testagar) the usual dose of Dextro-amphetamine hydrochloride, for the control of appetite, was one 5 mg. tablet two or three times a day. The usual dose of Amobarbital ranged from 20 to 40 mg., two or three times a day. On such a dosage regimen the absorption of the drugs, after ingestion, takes place quite rapidly. The therapeutic activity occurs within one-half to one hour. When the therapeutic peak is reached, a gradual decline takes place. At this point, the patient should receive another dose of medication . . . the cycle is then repeated.

Patients frequently fail to follow the physician's instructions. They take medication at irregular intervals. When this occurs with drugs such as dextro-amphetamine sulfate, phosphate or hydrochloride, excitation may result. A balanced combination of Dextro-amphetamine hydrochloride, **the preferred salt,** plus a balanced daily dose of Amobarbital will give the expected therapeutic results *without* excitation.

Timed AMO*dex*, after ingestion, releases Dextro-amphetamine Hydrochloride and Amobarbital steadily and uniformly over a period of 6 to 10 hours. Therefore, the physician may dispense with the usual dosage schedule thereby *attaining better control of therapy*. The patient will receive the benefits of even and sustained therapeutic effects. Side reactions such as anxiety and excitation are greatly minimized.

ACTION AND USES

Timed AMO*dex CAPSULES* (Testagar) supply the antidepressant and mood-elevating effects of Dextro-amphetamine hydrochloride and the calming action of Amobarbital. *Timed* AMO*dex* elevates the mood, relieves nervous tension, restores emotional stability and the capacity for mental and physical effort.

Timed AMO*dex CAPSULES* are manufactured under these patent numbers:
2,736,682 — 2,809,916
2,809,917 — 2,809,918
Which provide prolonged, continuous therapeutic effect over a period of 6-10 hours

INDICATIONS

Timed AMO*dex* is the preferred treatment in anxiety states and in the management of obesity. *Timed* AMO*dex* may also be used in the treatment of Depressive states, Alcoholism, Nausea and Vomiting of Pregnancy.

DOSAGE The Daily Dose of *Timed* AMO*dex* (Testagar) IS ONE CAPSULE ON ARISING OR AT BREAKFAST.

SUPPLIED Bottles of 100 and 1000 capsules, available at all pharmacies. Also supplied in half strength as *Timed* AMO*dex*, Jr.

SAMPLES AND LITERATURE UPON REQUEST

Testagar & co., inc. 1354 W. Lafayette Blvd. Detroit 26, Michigan

The Administration's plan immediately ran into widespread opposition. Dr. Louis M. Orr, Orlando, Fla., President of the American Medical Association, said it was based "on the false premise that almost all persons over 65 need health care and cannot afford it."

"This is not a fact," Dr. Orr said. "The truth is that a majority of our older people are capable of continuing a happy, healthy, and, in many cases, productive life. Of the more than 15 million persons in the nation over 65 years of age, only 15% are on old-age assistance."

Dr. Orr said neither the Administration's proposal nor the Forand-type Social Security approach is tailored to meet the problems of the undetermined number of older persons who, "although able to finance other costs, find it difficult to withstand the additional burden of the cost of illness."

Dr. Orr advocated the AMA's positive eight-point program for the health care of the aged as a "sensible, economical" plan that would preserve freedom as well as promote security. If both these objectives are to be realized, Dr. Orr said, health care programs for the aged "must necessarily be limited to support for the needy aged and leave to voluntary, competitive, private enterprise, those activities needed to improve the health care of the rest."

AMA PROGRAM OUTLINED

In brief, the AMA program comprises: 1) improved preventive medical care for the aged; 2) a state-administered program of Federal grants-in-aid to states for liberalization of existing old-age assistance programs so that the near-needy could be given health care without having to meet the present rigid requirements for indigency; 3) better nursing home facilities for the long-term care of aged persons, especially those over age 75; 4) rapid development of health insurance and prepayment policies to provide long-term nursing home care;

5) Expansion of home nursing care services; 6) elimination of compulsory retirement and a basic change in the attitude that a person who reaches 65 has suddenly become non-productive and senescent; 7) health education to instill a "will to live" in older persons and to make them aware of the need for continuing healthful nutrition; and 8) anti-inflationary curbs to maintain the purchasing power of fixed pension and annuity benefits.

A Republican lawmaker, Sen. Barry Goldwater of Arizona, denounced the Administration's plan as "socialized medicine" and a "dime store new deal." The outspoken conservative predicted its ultimate cost would be "staggering." He said the Administration could have done better by pro-



for the acute asthmatic attack elixir synophylate®

(Theophylline Sodium Glycinate)

RAPID ORAL CONTROL WITHOUT G.I. IRRITATION

ELIXIR SYNOPHYLATE relieves wheezing and dyspnea in 5 to 10 minutes after a single dose. Significant blood levels are achieved in 15 minutes, persisting for at least 4 hours.

Because of its built-in buffer, theophylline sodium glycinate [SYNOPHYLATE] is "tolerated in larger doses than are possible with other theophylline preparations,"[1] including aminophylline.[1-3]

the most potent theophylline elixir available . . . may avoid need for I.V. injection

1. A.M.A. Council on Drugs: New and Nonofficial Drugs 1959, Philadelphia, Lippincott, 1959, p. 389. 2. United States Dispensatory (Osol-Farrar), ed. 25, Philadelphia, Lippincott, 1955, p. 1412. 3. Grollman, A.: Pharmacology and Therapeutics, ed. 3, Philadelphia, Lea & Febiger, 1958, p. 208.

Each tablespoonful (15 ml.) contains 0.33 Gm. (5 gr.) equivalent to 0.16 Gm. (2½ gr.) Theophylline U.S.P. Supplied: Bottles of 1 pint and 1 gallon.

Literature on request.

. . . particularly useful for children

Products Born of Continuous Research

THE CENTRAL PHARMACAL COMPANY Seymour, Indiana

posing "full deductions for taxes for any amount spent for medical care of anyone" and for full costs of health plans by either an individual or corporation.

In endorsing the Administration's plan, Vice President Nixon charged the Forand-type proposals backed widely by Democrats would "open the door for socialized medicine." He said:

"The Forand bill and similar plans would set up a great state program which inevitably would head in the direction of herding the ill and elderly into institutions whether they desired this or not. Such a state program would threaten the high standards of American medicine."

Sen. Pat McNamara (D., Mich.), Chairman of the Senate Subcommittee on Problems of the Aged, headed a group of 16 Senate Democrats who sponsored legislation that would provide hospitalization and medical care for virtually all the nation's older persons.

The co-sponsors included three avowed candidates for the Democratic nomination for president--Sens. Hubert H. Humphrey (Minn.), John F. Kennedy (Mass.) and Stuart Symington (Mo.).

Cost of the McNamara legislation was estimated at $1,578,000,000 a year. This would be financed by a one-quarter per cent increase in the Social Security tax and 370 million dollars from general tax money. ◄

THE HARDING SANITARIUM

WORTHINGTON
OHIO

For the Diagnosis and Treatment of Psychiatric Disorders
and with
Limited Facilities for the Aging

GEORGE T. HARDING, M.D.
HARRISON S. EVANS, M.D.
Medical Directors

CHARLES W. HARDING, M.D.
Clinical Director

GEORGE T. HARDING, Jr., M.D.
HERNDON P. HARDING, M.D.
ARNOLD L. NIELSEN, M.D.
ROBERT L. SMITHWOOD, M.D.
W. W. WINSLOW, M.D.

GRACE M. COLLET, Ph.D.
VERNON W. SHAFER, Ph.D.
Clinical Psychologists

MARY JANE McCONAUGHEY, M.S.W.
BENJAMIN E. WHEATLEY, M.S.W.
Psychiatric Social Workers

PAULINE L. TOOILL, R.R.L.
Medical Record Librarian

JAMES L. HAGLE, M.B.A.
Administrator

ESTHER L. SIMPSON, R.N.
Director of Nurses

Phone: Columbus TUXEDO 5-5381

sulfa therapy suited to young tastes and tempers...



Employs the N^1 acetyl form of KYNEX to impart high palatability yet retain single-daily-dose effectiveness and rapid, high sustained action against sulfa-susceptible infections. **Dosage:** first day, 1 tsp. (250 mg) for each 20 lbs.; thereafter, ½ tsp. daily for each 20 lbs. For 80 lbs., use adult dosage of 4 tsp. (1.0 Gm.) initially; and 2 tsp. (0.5 Gm.) thereafter. Taken once a day—preferably after a meal. **Supplied:** Each tsp. (5 cc.) contains 250 mg. sulfamethoxypyridazine activity. Bottles of 4 and 16 fl. oz.

CHERRY LIQUID AND 1-DOSE-DAILY

KYNEX®

N^1 Acetyl Sulfamethoxypyridazine

ACETYL PEDIATRIC SUSPENSION

Lederle LEDERLE LABORATORIES, a Division of AMERICAN CYANAMID COMPANY, Pearl River, New York



LOOKS AT MEDICINE

This section of THE JOURNAL is devoted to the presentation of opinions which appear on the editorial pages of the public press, and which are of interest to the medical profession. Its function is to review comments which may be favorable or unfavorable to medicine. Members are invited to submit editorial clippings for this column.

Lawyers Blasted Over Suits For 'Malpractice'

A blast at lawyers in general for bringing doctors to court in so called malpractice cases with so called malpractice cases without having substantial grounds for bringing their suits was made by Judge Felix Forte in Superior civil court Thusday afternoon as he directed a jury to return verdicts for Dr. John T. Batal of Andover, Dr. J. Leroy Wood of Lawrence and Dr. Julius Kay of North Andover, defendants in three separate suits brought by Albert Erban, 54, 5 Hemlock street.

The suits were brought to recover damages for the alleged conscious suffering and death of the plaintiff's wife, Marie W. Erban, who died June 21, 1957, a day after an operation at the Lawrence General hospital. The plaintiff had sought damages of $50,000 in each case, alleging unskillfulness and negligence by the defendants.

In ordering a dismissal of the suits against the three doctors Judge Forte stated there was no evidence of neglect or unskillfulness by the doctors in their handling of the case of Mrs. Erban.

In making his comments to the jury Judge Forte said: "If every time an operation goes wrong a doctor is going to be sued and goes through the trouble and expense these doctors have gone through how many doctors are going to be willing to take those chances?"

The verdicts were ordered by Judge Forte after Dr. Kay and Dr. Wood had completed their testimony.

Did Everything They Could

Judge Forte said he had no brief for a surgeon who operates on a patient's stomach and leaves an instrument there or for a doctor who amputates the wrong leg. He said it was the responsibility of counsel to have something substantial to stand on when they bring a doctor to court.

Referring to Dr. Batal Judge Forte said the doctor had done everything any practicing surgeon would have done and that there was no evidence that he had failed in any manner to perform his duties.

Judge Forte also stated there was no evidence of unskillfulness or neglect by Dr. Wood and Dr. Kay.

Dr. Kay testified he arrived in the operating room at 12:15 and about 15 or 20 minutes previous to that had examined the oxygen machine. He said he knew the bag was missing from the machine then and that it had been placed on the machine right after Dr. Wood came into the operating room.

Dr. Kay testified he had observed the sudden stopping of Mrs. Erban's pulse and told Dr. Batal. The doctor stated all humanly possible had been done and that all equipment needed was available. He said a cardiac arrest is something which occurs suddenly. He said Dr. Wood had used a tube in administering oxygen to Mrs. Erban and the bag on the oxygen machine was there when its use was needed.

When the trial resumed Thursday morning, Atty. Arthur J. McLaughlin of Concord, counsel for the plaintiffs asked Judge Forte to allow his associate, Atty. Robert Athas to question the witness. Atty. McLaughlin's voice had been affected because of an illness.

Continued on page 1102

as it calms anxiety!

Smooth, balanced action lifts depression as it calms anxiety... rapidly and safely

Balances the mood — no "seesaw" effect of amphetamine-barbiturates and energizers. While amphetamines and energizers may stimulate the patient *—they often aggravate anxiety and tension.*

And although amphetamine-barbiturate combinations may counteract excessive stimulation—*they often deepen depression.*

In contrast to such "seesaw" effects, Deprol's smooth, *balanced* action lifts depression as it calms anxiety—both at the same time.

Acts swiftly — the patient often feels better, sleeps better, within a few days. Unlike the delayed action of most other antidepressant drugs, which may take two to six weeks to bring results, Deprol relieves the patient quickly — often within a few days. Thus, the expense to the patient of long-term drug therapy can be avoided.

Acts safely — no danger of liver damage. Deprol does not produce liver damage, hypotension, psychotic reactions or changes in sexual function—frequently reported with other antidepressant drugs.

Bibliography *(13 clinical studies, 858 patients)*: **1.** Alexander, L. (35 patients): Chemotherapy of depression – Use of meprobamate combined with benactyzine (2-diethylaminoethyl benzilate) hydrochloride. J.A.M.A. 166:1019, March 1, 1958. **2.** Bateman, J. C. and Carlton, H. N. (50 patients): Meprobamate ond benactyzine hydrochloride (Deprol) as adjunctive therapy for patients with advanced cancer. Antibiotic Med. & Clin. Therapy 6:648, Nov. 1959. **3.** Beerman, H. M. (44 patients): The treatment of depression with meprobomate and benactyzine hydrochloride. Western Med. 1:10, March 1960. **4.** Bell, J. L., Tauber, H., Santy, A. ond Pulito, F. (77 patients): Treotment of depressive states in office practice. Dis. Nerv. System 20:263, June 1959. **5.** Breitner, C. (31 patients): On mental depressions. Dis. Nerv. System 20:142, (Section Two), May 1959. **6.** Gordon, P. E. (50 patients): Deprol in the treatment of depression. Dis. Nerv. System 21:215, April 1960. **7.** Landman, M. E. (50 patients): Clinical trial of a new antidepressive ogent. J. M. Soc. New Jersey. In press, 1960. **8.** McClure, C. W., Papos, P. N., Speare, G. S., Palmer, E., Slattery, J. J., Konefal, S. H., Henken, B. S., Wood, C. A. and Ceresia, G. B. (128 patients): Treatment of depression – New technics and therapy. Am. Pract. & Digest Treat. 10:1525, Sept. 1959. **9.** Pennington, V. M. (135 patients): Meprobamate-benactyzine (Deprol) in the treatment of chronic brain syndrome, schizophrenia ond senility. J. Am. Geriatrics Soc. 7:656, Aug. 1959. **10.** Rickels, K. and Ewing, J. H. (35 patients): Deprol in depressive conditions. Dis. Nerv. System 20:364, (Section One), Aug. 1959. **11.** Ruchwarger, A. (87 patients): Use of Deprol (meprobamate combined with benactyzine hydrochloride) in the office treatment of depression. M. Ann. District of Columbia 28:438, Aug. 1959. **12.** Settel, E. (52 patients): Treatment of depression in the elderly with a meprobamate-benactyzine hydrochloride combination. Antibiotic Med. & Clin. Therapy 7:28, Jan. 1960. **13.** Splitter, S. R. (84 patients): Treatment of the onxious potient in general practice. J. Clin. & Exper. Psychopoth. In press, April-June 1960.

Dosage: Usual starting dose is 1 tablet q.i.d. When necessary, this dose may be gradually increased up to 3 tablets q.i.d.

Composition: 1 mg. 2-diethylaminoethyl benzilate hydrochloride (benactyzine HCl) and 400 mg. meprobamate.
Supplied: Bottles of 50 light-pink, scored tablets. Write for literature and samples.

Deprol®

WALLACE LABORATORIES/*New Brunswick, N. J.*

CD-2128

Quotes AMA Journal

Atty. Athas then read to the jury articles which appeared in the *Journal of the American Medical Association* dealing with the following subjects: "Cardiac During Anaesthesia and Surgery." "Cardiac Arrest" and "Prevention and Treatment of Cardiac Arrest."

Called as the first witness Thusday, Dr. J. Leroy Wood testified he was in charge of the anaesthesia service at the Lawrence General hospital. He stated that Dr. Kay was one of his associates in anaesthetic work.

Dr. Wood testified he was not present when the operation was started on Mrs. Erban. He stated that the preparation for anaesthesia and the equipment to be used in surgery and anaesthesia was set up by nurses.

Dr. Wood testified the usual procedure was to make a general survey of the equipment but not particularly to look for the bag on the oxygen machine, that the use of the bag was not necessary in all cases.

He said that when the bag is used it inflates and deflates for the admission of oxygen. He said the bag could be manipulated by hand.

Dr. Wood testified that where a patient's condition is diagnosed as cardiac arrest it is essential that oxygen be administered to the patient without delay. The doctor testified he arrived in the operating room about 1:05 p.m. and was immediately aware of a cardiac arrest. He testified he administered oxygen to Mrs. Erban by inserting a tube in her mouth.

Dr. Wood said that when he entered the operating room he observed the bag was missing from the oxygen machine and asked a nurse to bring in a bag and that it was brought in and applied to the machine.

Dr. Wood testified Mrs. Erban's pulse had been restored within a period of two minutes.

Dr. Wood demonstrated to the jury the use of the oxygen machine showing that the machine could function without the use of the bag.

Dr. Wood testified that before Mrs. Erban was taken from the operating room she was breathing under her own power.

Judge Blasts Lawyers

During his remarks to the jury when he ordered verdicts for the defendants Judge Forte stated that the fact that a man brings an action to court doesn't mean that he is in the right any more than it means that a man who is arrested is guilty of the charge against him. It was then that he directed his attack on lawyers who bring doctors to court in cases without having any real basis for their suits. He said he was not directing his remarks personally against counsel in this case but against lawyers generally who bring such suits.

Atty. Walter F. Henneberry of Boston appeared for Dr. Kay; Atty. G. Joseph Tauro of Lynn appeared for Dr. Batal and Atty. Harry N. Steinberg represented Dr. Wood.

Trial of the case started Wednesday morning. Judge Forte noted exceptions of the plaintiff's counsel to his rulings.

Lawrence Eagle-Tribune
Lawrence, Mass.
Mar. 18, 1960

How About Those Lights?

Many states now require regular inspection of motor vehicles to insure their safety. This is highly commendable, and ought to be universally adopted.

Still, it isn't enough to rule the obvious wrecks off the road through periodic check-ups, or even to bring millions of other cars briefly up to snuff. We need ways of enforcing car safety 365 days a year. For example:

In a certain large eastern state, the semiannual inspection is particularly rigid as to the condition of an automobile's headlights.

Yet any day of the week you can drive on the open road in that state and pass half a dozen cars operating with a single headlamp.

This is always dangerous, since a motorist approaching a "one-eyed George" can't always tell quickly whether the right or left lamp is out. Collision is a real threat.

A motorist whose car has a disabled headlight should take it to the nearest gas station for immediate repairs. There should be no excuses and no exceptions. Failure to act instantly should bring automatic arrest.

It's a little silly to worry over headlight angles at inspection time, when two days later the driver may be barreling along with the light not functioning at all.

Kokomo Tribune
Mar. 20, 1960

Continued



no irritating crystals[1] · uniform concentration in each drop[2]

STERILE OPHTHALMIC SOLUTION

NEO-HYDELTRASOL®

PREDNISOLONE 21-PHOSPHATE-NEOMYCIN SULFATE

2,000 TIMES MORE SOLUBLE THAN PREDNISOLONE OR HYDROCORTISONE

"The solution of prednisolone has the advantage over the suspension in that no crystalline residue is left in the patient's cul-de-sac or in his lashes . . . . The other advantage is that the patient does not have to shake the drops and is therefore sure of receiving a consistent dosage in each drop."[2]

1. Lippmann, O.: Arch. Ophth. **57**:339, March 1957.
2. Gordon, D.M.: Am. J. Ophth. **46**:740, November 1958.

supplied: 0.5% Sterile Ophthalmic Solution NEO-HYDELTRASOL (with neomycin sulfate) and 0.5% Sterile Ophthalmic Solution HYDELTRASOL®. In 5 cc. and 2.5 cc dropper vials. Also available as 0.25% Ophthalmic Ointment NEO-HYDELTRASOL (with neomycin sulfate) and 0.25% Ophthalmic Ointment HYDELTRASOL. In 3.5 Gm. tubes.

HYDELTRASOL and NEO-HYDELTRASOL are trademarks of Merck & Co., Inc.

MSD MERCK SHARP & DOHME Division of Merck & Co., Inc., Philadelphia 1, Pa.

Most Hoosiers Have Health Insurance

More than 75% of all Indiana residents are covered by health and hospitalization insurance, a General Assembly committee on insurance problems was told yesterday.

The statement was offered by the Indiana Association of Legal Reserve Life Insurance Companies at a public hearing on the insurance problems of "senior citizens," or persons more than 65 years old.

In its statement the association noted that 43% of those persons covered by government old age benefits also are covered by health and hospital policies.

Health and hospital business has increased 30 times in the last 25 years, the committee was told, and most companies offering such policies now extend them to persons more than 65 years old.

An Indiana Medical Association statement urged reconsideration of the usefulness of persons more than 65 and provision for their continued activity. Retirement rules and limits on earnings should be reexamined, the association stated.

In another statement the committee, headed by State Senator J. Russell Townsend Jr. (R-Indianapolis), was told that more hospital and health coverage is not the answer to Indianapolis' medical care problem.

These policies make for easy admission to hospitals and contribute to overcrowding, the committee was told, and a plan for diagnosis and treatment of policy holders at clinics or elsewhere should be considered.

Before the hearing, the committee received a proposal to investigate the need for a small claims court to handle traffic accident claims usually uncollectable because of their minor nature.

A bill for such a court has been prepared for every session of the Legislature in recent years. The committee said it would study the proposal.

The Indianapolis Star
Mar. 9, 1960

Indiana and the Aged

Indiana Governor Harold Handley, who thinks states and local communities should solve most of their own problems and not go running to the federal government for rescue every time they face a problem, has turned down a federal planning grant for the White House Conference on Aging and Aged next January.

Now, this does not mean that the Governor is opposed to planning for better care of the aging and aged. It does not mean—as Democratic Congressman John Fogarty of Rhode Island attempted to imply—that Indiana's program for the aged is deficient.

It simply means, as Governor Handley explained, that Indiana has enough money in its treasury to pay its own way in planning for the conference. Indiana is going to take part in the conference and is going to do its share of planning for the parley. It just doesn't need a federal grant to meet the cost of its planning.

The federal government wanted to hand out a chunk of cash to Indiana to spend on planning, but Indiana didn't need it. If more states were as self-reliant as Indiana, we might not see federal spending and federal taxes increasing as much.

The Governor said he has also rejected federal aid for the White House Conference on Youth and similar programs. "I have done this," he said, "because of programs we already have in existence, supported by state aid, in our various university extension centers and in the public schools. Until a sovereign state will exercise some selectivity in accepting or rejecting federal programs, the people of this country will see more of their hard-earned dollars suffering further deflation and federal tax confiscation."

One of our troubles in this country is that so many of us are willing to accept handouts whether we need them or not, and regardless of what effect it has on national taxes, national debt and decline of the dollar's value.

It is well that the Governor has set the record straight.

Kokomo Tribune
Mar. 17, 1960 ◄

From AMA

EISENHOWER ADMINISTRATION'S PLAN FOR AGED



Dr. Louis M. Orr, Orlando, Fla., President of the American Medical Association, issued the following statement May 6 on the Eisenhower Administration's Medical Care Plan for the aged which was announced in Washington May 5. Dr. Orr's complete statement in behalf of AMA follows:

THE ADMINISTRATION proposal is based on the false premise that almost all persons over 65 need health care and cannot afford it. This is not a fact. The truth is that a majority of our older people are capable of continuing a happy, healthy, and in many cases productive life. Of the more than 15 million persons in the nation over 65 years of age, only 15% are on old age assistance. An undetermined number, although able to finance other costs, find it difficult to withstand the additional burden of the cost of illness.

It is for these people that something should be done. Neither the Forand advocates nor the administration proposal are tailored to meet these problems.

Here is AMA's positive eight-point program for the health care of the aged:

(1) The needy aged. These aged now receive health care through OAA programs. Here the need is for better organized medical care programs, including improved preventive medical care.

(2) The near-needy. This is the group whose size is indeterminate, who can meet ordinary costs of living but cannot pay for health care costs. The AMA supports a state-administered program of federal grants-in-aid to the states for the liberalization of existing OAA program so that the near-needy could be given health care without having to meet the present rigid requirements for indigency. A liberalized definition as determined locally would permit an expanded program and encompass the near-needy group:

(3) Facilities. Better nursing home facilities for the long-term care of the aged person, especially those over the age of 75, are the most urgent health care need before the nation today. The average age of nursing home patients is 80, and their average duration of stay is two years. It is here that major improvement can be brought about. AMA supports federal programs for the provision of grants through the Hill-Burton mechanism to provide for new nursing home additions to existing hospitals. For proprietary nursing homes the AMA supported the recently enacted amendment to the Federal Housing Act providing for government guaranteed mortgage loans to proprietary nursing homes. AMA is also cooperating with the American Nursing Home Association and the American Hospital Association in an effort to bring about a rapid improvement in medical care provided in nursing homes;

(4) Voluntary Health Insurance. Health insurance and prepayment policies tailored to meet the need of the aged for long-term nursing home care must be developed as rapidly as possible.

Continued

Eisenhower Plan

Continued

Health insurers and the Blue Cross and Blue Shield plans across the nation are already experimenting in this new area of coverage;

(5) Home Nursing Care. Care of the aged patient at home is psychologically, medically and financially desirable. Many programs to promote home nursing care are being developed.

Homemaker's services also provide opportunities for children caring for aged mothers or fathers to continue gainful occupation. They need to be expanded;

(6) Attitude toward aged. A basic change in attitude toward the aged person must be brought about. The person who reaches 65 has not suddenly become non-productive and senescent. On the contrary, most persons over 65 are reasonably well and able to work. Increased productivity by eliminating compulsory retirement and permitting voluntary change of work is an essential part of the answer to the present problem;

(7) Health Education. Many older persons are unaware of the need for continuing healthful nutrition and other practices that contribute to good health. Above all the "will to live" is essential to continuing health. Preventive medical measures instituted long before the age of 65 also can contribute materially to the promotion of good health after age 65;

(8) The purchasing power of the dollar. One of the principal economic problems of the aged person in the last 20 years has been the constant and continuing erosion of the purchasing power of his pension benefits. Any government program to help the aged must be anti-inflationary and maintain the purchasing power of fixed pension and annuity benefits.

Sensible, economical health care programs for the aged that preserve freedom at the same time that they promote security must necessarily be limited to support for the needy aged and leave to voluntary, competitive, private enterprise, those activities needed to improve the health care of the rest. ◄

Tested . . . and proved . . .

ORAL therapy in diaper rash!



Convenient . . . simply open a capsule and add the contents to the baby's daily formula, or to fruit juice or water. No lotions . . . no rinses . . . no ointments . . . just oral therapy.

Send for samples and literature.

S. F. DURST & CO., INC.
Philadelphia 20, Pa.

Effective therapy! Thousands of pediatricians and general practitioners prescribe Pedameth for ammonia dermatitis—and they continue to prescribe it. Clinical tests have proved its effectiveness. Pedameth is safe because it contains only dl-methionine (0.2 Gm.) one of the essential amino acids. When Pedameth is administered, the pH of the urine is lowered and an as-yet-unknown antibacterial agent appears in the urine. Pedameth works . . . it's the safe, effective, convenient answer to ammoniacal diaper rash.

Prescribe

PEDAMETH®

(dl-methionine DURST)

The Journal of the INDIANA STATE MEDICAL ASSOCIATION

Supervised by THE COUNCIL

Volume 53 — June 1960 — Number 6

Adrenal tumors present complicated syndromes—Advances in knowledge have made possible curative surgical treatment, especially in non-malignant states.

Hyperfunctioning Adrenal Lesions

*JAMES T. PRIESTLEY, M.D.**

Rochester, Minnesota

I AM HAPPY to have the opportunity to review with you some of the clinical experiences that my colleagues and I have had in the management of patients with hyperfunctioning lesions of the adrenal glands. I shall not discuss hypofunction of these glands since it does not involve the surgeon so much. I would merely point out that anyone who operates on patients with hyperfunctioning adrenal lesions must be aware of the methods of prevention and treatment of hypofunction, as the latter condition may result from adrenal operations.

In considering the clinical syndromes that may result from hyperfunction of the adrenals it is helpful to recall the embryologic development of these structures. The cortex of the adrenal arises from the mesoderm near the primitive sex structures that produce a number of compounds, some of which no doubt have not as yet been recognized. Most of them are steroids, including androgens and estrogens and the hormones that have to do with metabolism of all the major foodstuffs and the retention of sodium and water. Thus it is clear that the clinical picture resulting from hyperfunction of the adrenal cortex may vary widely, depending upon the amount and type of product excreted.

The adrenal medulla, on the other hand, arises from the mesoderm near the neural crest, the site of origin of the sympathetic ganglion cells. At least two main products of physiologic significance, namely norepinephrine and epinephrine, are produced by the medulla.

* From the Section of Surgery, Mayo Clinic and Mayo Foundation, Rochester, Minn.

Read at the Annual Convention of the Indiana State Medical Association, Oct. 6 to 9, 1959, Indianapolis, Ind.

Adrenocortical Tumors

On the basis of their clinical manifestations adrenocortical tumors may be classified as follows (Kenyon): (1) Cushing's syndrome, (2) adrenogenital syndrome, (3) mixed picture of 1 and 2, (4) single endocrine manifestation, (5) feminization, (6) primary hyperaldosteronism, and (7) no endocrine manifestation. The only addition to Kenyon's original classification is hyperaldosteronism, which had not been described at the time he presented his classification.

Incidence of the various types of adrenocortical tumor from the standpoint of clinical manifestations is reflected in a review my colleagues and I made several years ago of the cases encountered over a 10-year period. We found that 23 of 39 patients presented the clinical picture of Cushing's syndrome. Seventeen of these 23 patients had a benign tumor. In contrast, adrenocortical tumors that do not cause Cushing's syndrome are more apt to be malignant than benign. The next most common type of tumor from the point of view of clinical manifestations was the nonfunctioning tumor, and then came tumors causing adrenogenital syndrome, single endocrine manifestation and feminizing syndrome in order of decreasing frequency.

Here I shall limit my discussion to Cushing's syndrome, adrenogenital syndrome and hyperaldosteronism.

Cushing's Syndrome.—In an article published in 1932 Harvey Cushing described the "polyglandular syndrome" which since has borne his name. He at first directed attention to the pituitary as the primary source of this disorder, although he early recognized that a dominant role might be played by the adrenals. Although it cannot be said with certainty where the primary etiologic factor lies in Cushing's syndrome, it is well established that the clinical manifestations arise through hyperfunction of the adrenal cortex, so that treatment of the condition is directed toward the adrenals. This syndrome is the most common result of adrenocortical hyperfunction that we encounter.

Clinical Features.—Patients with Cushing's syndrome present certain characteristic physical features that lead one to suspect its presence. Thus they have an obesity of the face, the so-called moon face, and this obesity extends to the neck and the trunk. Also they often have a deposition of fat in the cervicodorsal region, which has been termed "buffalo hump," and the extremities may appear wasted. They have changes in the skin which generally are very prominent, particularly since most of the patients are women, in whom the changes are more noticeable than in men. Hirsutism is often prominent, characterized usually in the male distribution of the beard and also of the hair in the axilla or in the pubic area.

Often acne is evident in the same areas and also over the anterior and posterior parts of the thorax. Cutaneous striae which are rather wide and purplish are seen over the abdomen, and sometimes over the thighs and around the axillary areas in addition. Ecchymotic areas are almost always evident in the lower half of the legs below the knees; furthermore, these patients notice that they bruise easily in other parts of the body as well, and nearly all of them have a florid complexion.

Majority Have Hypertension

At least four-fifths of these patients have hypertension which, owing to alterations in the cardiovascular system, may result in some of the most serious changes that occur. In fact, in some patients death may be due to the secondary effects of the hypertension.

These patients have osteoporosis to a greater or lesser degree depending upon the duration and severity of the disease. Perhaps half the women have amenorrhea, and somewhat less than half the men are impotent. Not uncommonly Cushing's syndrome develops initially in association with pregnancy. Some psychic change is observed in perhaps one out of five patients; often these changes are very mild and consist perhaps of a little irritability or confusion, but sometimes they are much more pronounced. As the disease progresses, muscular weakness invariably supervenes and patients generally have to give up their usual occupation. Fractures occur spontaneously in proportion to the degree of osteoporosis and commonly affect the vertebrae and ribs.

Laboratory examination may disclose normal or increased values for the 17-ketosteroids in the urine. Usually the urinary corticosteroids are increased. The usual decrease in plasma steroids that occurs in the afternoon does not occur in these patients. Lymphopenia is common, while hyperglycemia is not so common. As a rule,



FIGURE 1

CUSHING'S SYNDROME caused by hyperplasia of adrenals. a. Prior to operation. b. Four years after total right and subtotal left adrenalectomy. (Reproduced with permission from: Priestley, J. T.: Hyperfunctioning Lesions of the Adrenal Glands. *Maryland State M. J.* 8:413-419 [Sept.] 1959.)

there is no disturbance of the electrolytes, but if there is, it consists of so-called hypokalemic, hypochloremic alkalosis.

Typical Symptoms

Cushing's syndrome has been caused by hyperplasia rather than by tumor in about 80% of the patients that my associates and I have seen, and also about 80% of the patients have been women. A typical patient with Cushing's syndrome caused by adrenal hyperplasia is shown in Figure 1. Her rounded facial appearance is characteristic. Oftentimes the face gets so round that one cannot see the ears when standing right in front of the patient. Also, patients frequently have puffiness around the eyes and puckering up of the mouth to give the appearance that has been termed "fish mouth."

Treatment.—Today the treatment of choice for Cushing's syndrome is generally agreed to be surgical. One usually does not know prior to operation whether the condition is due to hyperplasia or tumor, but fortunately this point can be determined without too much difficulty at the time of operation. If the syndrome is caused by a functioning cortical adenoma in one adrenal, the opposite gland is always atrophic, being paler, thinner and smaller than normal. If the condition is caused by hyperplasia or hyperfunction, the adrenal glands are similar in size; they are usually enlarged, but not always. Therefore, at the time of operation, if a tumor is found in the first adrenal gland exposed it is taken out and nothing else need be done.

If the first gland exposed appears atrophic, a biopsy specimen is taken from it and then the opposite adrenal is exposed with the expectation of finding a tumor, which is removed. If, on the other hand, the first gland exposed is enlarged, as indicated not only by an increase in size but also by a little deeper color, irregularity of its surface, more vascularity and greater thickness of the gland, then about 90% of this adrenal is removed, with provision for an adequate blood supply to the remnant, and all of the opposite adrenal is removed.



FIGURE 2

SURGICAL SPECIMEN of sub-totally resected hyperplastic adrenal gland removed in treatment of patient with Cushing's syndrome. (Reproduced with permission from: Priestley, J. T.: Hyperfunctioning Lesions of the Adrenal Glands. *Maryland State M. J.* 8:413-419 [Sept.] 1959.)

Some have suggested that bilateral total adrenalectomy should be performed when hyperplastic adrenals are found as the cause for Cushing's syndrome. However, this procedure seems to be unnecessarily radical when all factors are considered, and personally I would not recommend it.

Preoperative Preparation

Patients who are to undergo surgical removal of adrenal tissue should have adequate preoperative preparation because of the possibility that at least a temporary adrenal insufficiency may follow operation. We still use a plan of preoperative preparation which my colleague, Dr. Randall Sprague, and his associates recommended some years ago, namely the intramuscular administration of 200 mg of cortisone acetate 48 hours before operation, 24 hours before operation and again the day of operation. Cortisone is given also in the postoperative period, the duration and amount of treatment depending upon what was found at operation, what was done, and the patient's progress. Some patients, of course, have a delayed postoperative reaction, which can be treated satisfactorily with cortisone.

A number of surgical approaches have been suggested for operation on the adrenal glands. Patients with Cushing's syndrome are usually fat. I have tried the anterior approach as suggested by some, but it is difficult and is not satisfactory in my opinion. Some advise an approach through the thorax. I have found an approach just underneath the last rib satisfactory. That rib can be resected if more exposure is needed. I operate on one side and then turn the patient and operate on the other side at the same operation.

A specimen of hypertrophic or hyperplastic adrenal gland that has been subtotally removed is shown in Figure 2. The broken line indicates the portion of the gland that was thought to have been left. Atrophy of adrenal tissue that is associated with a functioning cortical adenoma causing Cushing's syndrome is illustrated in Figure 3. The little tail of tissue at the bottom of the adenoma is the atrophic remnant of uninvolved adrenal gland. Figure 4 illustrates a case of adenoma in an adrenal that is not atrophic. The surgeon should be careful to recognize this situation because such a gland is hyperplastic and requires that the patient be treated just as if the adenoma were not present and the condition were caused by hyperplasia alone in the absence of an associated adenoma.

Cortisone Decreases Mortality

Operations on patients with Cushing's syndrome have been greatly affected by the introduction of cortisone. The mortality rate for operation on such patients before the advent of cortisone was about 23%, as compared with 4% after its advent. The rate of 4% can probably be lowered still more.

Adrenogenital Syndrome.—Either tumor or hyperplasia of the adrenal cortex may cause the adrenogenital syndrome. The symptoms are dependent largely on excessive secretion of androgen and certain associated metabolic effects. One form of the syndrome, that associated with congenital adrenal hyperplasia in girls, produces the clinical picture of pseudohermaphroditism. Enlargement of the clitoris and other genital changes make for a mixed appearance. As the condition progresses, there is an early appearance of axillary and pubic hair. The epiphyses close early so that by the time of puberty the trunk is relatively long and the arms and legs are short. The voice is deep and menses are impaired. Currently the treatment is primarily medical and consists of the administration of cortisone. Adrenal resection is not recommended, since the adrenals may atrophy as the patient grows older.

Another form of the syndrome, with clinical manifestations similar to those just described, may develop during the postnatal period in girls

and may be due to tumor rather than hyperplasia. The symptoms and findings are identical with those just described except that no genital abnormality is evident at birth. Treatment is similar to that just mentioned, unless a tumor is present, in which event the tumor should be removed.

The adrenogenital syndrome may have its onset in the adolescent or adult female, and under these circumstances masculine changes, evidenced by hirsutism, deep voice, amenorrhea, increase in muscular strength and other similar changes, are noted. When these symptoms occur in adult life, the adrenal glands should be explored with a reasonable expectation of finding a tumor which should be removed.

Young boys with the adrenogenital syndrome have homologous sexual precocity and experience premature puberty. They are treated in the same manner as the girls.

Hyperaldosteronism.—Jerome Conn first described hyperaldosteronism in 1955. He and others indicate that the main clinical features usually encountered are hypertension, muscular weakness, paresthesias, tetany, polydipsia and polyuria. Hypertension is generally a prominent symptom. In the past, many patients with this condition have been treated for hypertension, and doubtless even today some are treated for hypertension. The muscular weakness encountered progresses at times to periodic paralysis.

Certain laboratory tests are quite helpful in establishing the diagnosis if the syndrome is suspected on the basis of the history and physical findings. The potassium content of the blood is low, as a rule, the sodium content is high and there is usually an alkalosis. The urinary excretion of aldosterone is increased, and the urine often is alkaline and its specific gravity is low.

Patients who manifest hyperaldosteronism usually have a benign cortical adrenal tumor and removal of the tumor will result in cessation of the syndrome. Some patients with this condition are found to have hyperplastic adrenal glands, and extensive subtotal adrenalectomy is the treatment of choice under these circumstances.

Tumors of the Adrenal Medulla

The medulla of the adrenal gland gives rise to three general types of tumor: (1) neuroblastoma, a highly malignant tumor seen in children; (2) ganglioneuroma, a less malignant tumor seen in adults; and (3) pheochromocytoma, which can occur wherever there is chromaffin tissue and may be functioning or nonfunctioning. I shall limit my discussion to the functioning type.

Pheochromocytoma.—A state of hypertension is produced by a functioning pheochromocytoma. This hypertension may be persistent or periodic, depending on whether the secretion of excess pressor products from the medulla is constant or intermittent. The paroxysmal type of hypertension caused by a pheochromocytoma is manifested by periodic increases of blood pressure to at least 200 mm of mercury systolic and 100 mm diastolic. The patient has attacks characterized by vasomotor symptoms such as headache, dizziness, anxiety, flushing, pallor, dyspnea, palpitation, pain in the abdomen or thorax and tremor.

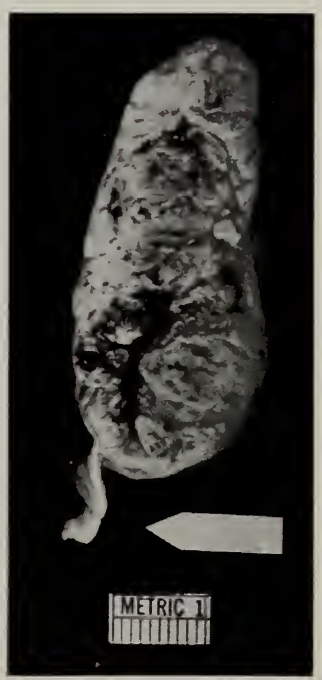


FIGURE 3

ATROPHIC ADRENAL associated with functioning cortical adenoma in presence of Cushing's syndrome. (Reproduced with permission from: Priestley, J. T.: Hyperfunctioning Lesions of the Adrenal Glands. *Maryland State M. J.* 8:413-419 [Sept.] 1959.)



FIGURE 4

ADENOMA IN hyperplastic adrenal gland of patient with Cushing's syndrome. (Reproduced with permission from Priestley, J. T.: Hyperfunctioning Lesions of the Adrenal Glands. *Maryland State M. J.* 8:413-419 [Sept.] 1959.)

These attacks usually last 10 or 15 minutes, although they may continue for a day or longer. They may occur only once in several months, or several times in one day. They usually remain rather constant in character during the progress of the disease, but they may increase in frequency. The basal metabolic rate is often increased somewhat and hyperglycemia also may be manifest.

The picture presented by the persistent type of hypertension resulting from pheochromocytoma may be virtually identical clinically, at least on initial examination, with that of essential hypertension. The patient may also experience paroxysms of increased hypertension. Such patients present a difficult diagnostic problem. As a rule, they are somewhat younger than patients with essential hypertension. They almost invariably have some secondary vascular changes depending upon the duration of the process. Most of them have hypermetabolism and some evidence of diabetes; consequently, one should suspect the possibility of pheochromocytoma in any young patient who has hypertension that is associated with hypermetabolism without concomitant evidence of hyperthyroidism, or that is associated with diabetes.

Clinical recognition of pheochromocytoma is facilitated by certain tests. I believe it was Goldenberg and his associates who did much of the early work on urinary catecholamines. They developed a relatively simple screening test for these products in the urine. If such a test gives positive results, more careful quantitative studies can then be performed. Studies of the pressor amines in the blood also are of diagnostic help if the patient has persistent hypertension due to pheochromocytoma or if the studies are made on a blood sample that is taken during either an induced or a spontaneous episode of paroxysmal hypertension. Manger and others have worked on such tests.

Tests for Pheochromocytoma

My associates, Dr. Grace Roth and Dr. Walter Kvale, have had considerable experience with certain pharmacologic tests for pheochromocytoma. Two of the tests that they use are the histamine test and the phentolamine (regitine) test. The histamine test is used on the patient who has paroxysmal episodes of hypertension, but otherwise normal blood pressure, caused by pheochromocytoma. After an appropriate dose of histamine base given intravenously, a rise in blood pressure that is significantly greater than the rise associated with the cold pressor test constitutes a positive reaction.

The phentolamine test is given to those patients who have persistent hypertension, that is, to patients whose pressure is at least 180/100. An appropriate dose of phentolamine given intravenously causes a precipitous decrease in blood pressure if a pheochromocytoma is present. Neither of these tests is completely reliable; either may give a false positive or a false negative reaction under certain conditions. The patient must not be under the influence of any medication when the test is made.

Although pheochromocytoma usually occurs as a unilateral, single, benign tumor in one adrenal gland, there are exceptions in all these regards, particularly in patients who have persistent hypertension. Thus, multiple tumors may occur on one side, they may occur bilaterally, or one may occur ectopically wherever chromaffin tissue is found.

Most patients with pheochromocytoma are thin, so that an anterior surgical approach is quite feasible. This approach gives an opportunity to explore not only the adrenal regions but also the entire abdomen. Such exploration is important because of the fact that pheochromocytoma may occur in an ectopic location. The right adrenal gland is exposed by first incising the posterior peritoneum in the region of the upper pole of the kidney. The kidney is then retracted downward, the liver upward, and the second portion of the duodenum and the head of the pancreas medially. The left adrenal is exposed by mobilizing the spleen and the tail of the pancreas and elevating them from the left upper quadrant.

During operation for pheochromocytoma the patient must be watched carefully, particularly if hypertension was persistent preoperatively. Characteristically the blood pressure rises sharply during the induction of anesthesia. Although this does not always occur, such a rise is so characteristic of pheochromocytoma that if it is observed during induction of anesthesia in a patient who has not even been suspected of having a pheochromocytoma I think the anesthesia should be discontinued and the operation postponed until this possibility has been investigated,

as there have been some deaths on the operating table from unrecognized pheochromocytoma.

Before the operation is started a needle is placed in a vein and some dextrose solution is administered slowly. A syringe containing 5 mg of phentolamine and one containing a pressor agent such as levarterenol (levophed) should be immediately available during operation. The phentolamine is administered if the blood pressure, which characteristically rises when the tumor is palpated, becomes excessive (reaches 250 or 300 mm of mercury or more systolic) and threatens the patient with circulatory collapse. It is evident that the tumor should not be palpated any more than necessary and its blood supply should be clamped off as soon as possible.

As a rule, the blood pressure falls after the tumor has been removed, and usually at this time a pressor agent such as levarterenol must be given to support the blood pressure. In fact, failure of the blood pressure to fall significantly after removal of a tumor leads one to suspect the existence of a second tumor. Continued use of such a drug in decreasing amounts may be necessary for 24 or 48 hours postoperatively, particularly if persistent hypertension was evident preoperatively.

Results of Treatment

A complete and lasting remission of Cushing's syndrome due to a benign adenoma may be expected to follow surgical removal of the adenoma. If a malignant tumor is removed the result is about the same as it is with most other malignant tumors. If the syndrome is due to adrenal hyperplasia the operative procedure I mentioned gives a complete remission, but there may be recurrence. No one can say for sure what the ultimate recurrence rate will be. In our experience it has been about 10%. It is increasing slowly as more patients are followed for longer periods, and may reach 20%. If the syndrome recurs, one can remove the hyperplastic remnant of adrenal tissue.

In pheochromocytoma, surgical treatment should give complete relief if the hypertension has been paroxysmal and the tumor is benign. If the hypertension has been persistent, complete relief or at least a favorable result, depending upon the degree of secondary changes in the cardiovascular system, can also be expected when the tumor is benign. If the tumor is malignant, it will recur in a high proportion of patients after removal, but some years may elapse before this happens, and recurrent malignant tumors have been successfully removed at times.

Much has been learned about the adrenal glands in recent decades. However, much more remains to be learned, and I am sure that as we increase our knowledge of these organs we shall be able to obtain increasingly better results in the treatment of patients with adrenal hyperfunction. ◄

Treatment of Imperforate Anus



*ARTHUR DE BOER, M.D.**
Chicago

THE PRIMARY GOAL in treating an infant with an imperforate anus is not the establishment of an egress for stool but to construct an anus which has muscular control. Imperforate anal orifice is an obvious finding but is not the essential feature. Presence of a fistula and its location is the most important abnormality to investigate. Many infants with an imperforate anus have an anal or rectal fistula which may communicate with the perineum, vagina, urethra, bladder or uterus. Presence or absence of a fistula usually determines the surgical procedure required to correct the anomaly. These abnormally placed openings have been referred appropriately as "ectopic ani" by Bill et al.[1]

Diagnosis

Absence of an anal orifice usually is discovered quickly. A roentgenogram of the infant in an inverted position with a marker over the anal skin has long been an associated diagnostic procedure. Information obtained from this film is often negligible and may be misleading. Of much more importance is an attempt to determine the presence and location of an associated fistula. If there is no evidence of an opening in the perineum or vagina a sample of urine is obtained and examined for the presence of meconium. Sometimes green flecks of meconium can be seen on the diaper after the baby has voided. If the infant has not voided it may be necessary to catheterize the child.

It has been our experience that if a number eight French catheter cannot be passed into the bladder the chances are fairly great that a rectourethral fistula is present. If the voided urine is clear and colorless a communication between the urinary system and the bowel is quite unlikely. Having determined the presence or absence of a fistula the next step in completing the preoperative diagnostic information is to have an upright film of the abdomen taken. This film is to determine whether there are other anomalies such as diaphragmatic hernia, atresia of the duodenum, ileum or jejunum, hydrocolpos or pneumoperitoneum. To know about one of these possibilities before repair of the imperforate anus can avoid embarrassment later during the postoperative period.

Treatment

Ordinarily the treatment for an imperforate anus is to provide an opening through the anal sphincter and connect the most distal portion of large bowel with this opening. A colostomy seldom is indicated and is avoided if possible. Superficial sphincter muscles are almost always present but are contracted and small. This mus-

* From Northwestern University Medical School.

Presented at the Annual Convention of the Indiana State Medical Association, Indianapolis, Ind., Oct. 8, 1959.

cle will remain so unless it is used by having bowel traverse its central portion. The bowel distal to a colostomy remains small and so will the sphincter. Ideal time for passing the large bowel through the sphincter is at birth. In order not to overstretch the sphincter muscle and thereby destroy its usefulness a small opening is necessary. This opening, if made small, must be dilated slowly and progressively as the baby grows. It requires about 8 to 18 months of dilatations to obtain a normal sized anal opening.

These dilatations can be done relatively easily by the parent when the child is an infant, but it becomes an insurmountable problem to a child, parent and doctor if it must be done later. Rather than doing a colostomy and waiting for the anoplasty to be done when the child is 2-3 years old, an early operation is more desirable. In order to accomplish the best results with less trauma to the child and parent, a definitive therapeutic approach to the imperforate anus at birth is the goal. If there is *no* opening in the perineum, an abdominal perineal pull-through is the usual surgical procedure and is done soon after birth. If there *is* an opening for the gastro-intestinal tract in the perineum or vagina, the tract is usually adequate for 2-3 months and the anoplasty is done at that age. Parents should be advised that the stool be kept soft and the opening kept large enough for stool to pass without too much effort. Occasionally enemas must be resorted to in order to properly empty the large bowel.

Three Treatment Types

The mode of treatment for an imperforate anus is determined by the presence or absence of a fistula and the location of the fistula. The types of imperforate anus can be classified into three major groups according to the treatment required. They are: (1) imperforate anus with no communication; (2) imperforate anus with a recto-vesical or recto-urethral fistula; (3) imperforate anus with a recto-perineal or recto-vaginal fistula.

(1) *If there is no communication demonstrable* the surgical attack is usually begun by the perineal approach but assuming an abdominal incision may be necessary. Therefore, the child is placed on the operating table in a modified lithotomy position so that the abdomen as well as the perineum is exposed. A small sandbag is put under the buttocks to raise the perineum and the legs are taped in an abducted flexed position. Cutdown is done on one of the arms instead of the legs.

The most important part of the operation is to find the superficial sphincter muscle so that the rectum can be pulled through the center of the sphincter muscle. It is true that this muscle is small and underdeveloped, yet it is the primary means of control. Amount of dissection that can be done to attempt to find the blind rectal pouch is gauged by *not* damaging the miniature sphincter muscle that is present. In our experience only a minimal amount of exposure can be obtained through the perineum so that usually an abdominal approach is necessary. The rectum is often attached to the posterior wall of the bladder or urethra at the level of the trigone. The bowel is detached and as short a segment as possible is mobilized to avoid interference with its nerve supply. Often incising the posterior peritoneum on either side of the mesenteric vessels allows adequate length to pull the blind rectal pouch through the perineum. A conservative dissection within the pelvis is likely to disturb the pelvic sympathetic system the least.

After the rectum has been mobilized an opening is made in the perineal floor by blunt dissection. By placing a hemostat through the anal sphincter, which has been identified earlier, and putting the index finger in the pelvis, the hemostat is bluntly forced through the perineum. A posterior direction is more satisfactory than anterior since the levators can then be used as an aid in control.

Once an opening is made in the perineum by gently spreading the tissue, a large enough hole can be obtained to accommodate the bowel which is pulled through the pelvic floor. The same can be accomplished by using increasingly larger catheters as a means of dilating the perineal structures. Too large an opening may permanently destroy the effectiveness of the sphincter and too small an opening may cause obstruction before dilatations can be initiated. An opening that will admit a number 18F catheter with the bowel pulled through is about proper for an average sized infant. After the bowel is pulled through the perineum and remains in place *without* tension, the gut is sutured to the anal skin

with interrupted 5-0 silk sutures. Usually the pelvis is filled with the large bowel so that reconstruction of the pelvic floor is not necessary.

Treat by Abdominal Approach

(2) *Imperforate anus with a recto-vesical or recto-urethral fistula,* the second group, must be treated by the abdominal approach. It is unwise and harmful to attempt any repair through the perineum. The only way one can correct a recto-vesical or recto-urethral fistula in a newborn is through the abdomen. The infant is prepared just as in group 1; however, in these infants who have a fistula to the urethra or bladder, the only perineal dissection is that of locating the superficial sphincter muscle. The remainder of the dissection is from above. It is extremely helpful to have a catheter in the urethra before the fistula is repaired. A few interrupted sutures are all that is required to close the fistula in the urethra or bladder. It may not be necessary to suture the fistula, but better healing can be expected if the defect is properly approximated rather than to have it fill in with scar tissue. After the fistula has been cut and repaired, the bowel is freed adequately to allow it to be pulled through the perineum without tension. The remainder of the procedure is done as in group 1.

(3) *In the third group, imperforate anus with a perineal or vaginal fistula,* the surgical treatment is no longer one of an urgent nature. Usually the infant is able to pass meconium adequately through the fistula. If not, a few gentle dilatations are all that is necessary. The infant is then allowed to leave the nursery and be taken home for 2-3 months. By this time healing of the infant's tissues is better, and one can expect the wound to heal with less tissue destruction and less scarring. Special precautions must be taken that the child does not become chronically constipated because of too small an opening. If this occurs the bowel becomes hypertrophied and thickened and makes it difficult to pass through the sphincter muscle. The mothers of these infants are advised to keep the stools soft by giving high carbohydrate formulas or by giving the child an enema daily.

At the age of approximately three months, if the child is otherwise doing well and gaining weight, surgery is advised. The surgical approach for the perineal or vaginal fistulae is exclusively perineal. The fistula is always anterior to the sphincter muscle. Infants with perineal fistulae are usually male. The fistula is dissected far enough into the perineum to allow adequate length so that the bowel can be put posteriorly through the sphincter without tension. The sphincter muscle is identified and dilated. If the fistula is just anterior to the sphincter, it may be necessary to cut the muscle. However, usually an attempt is made to have the sphincter muscle intact and anchored to the perineal body. The fistula is then tunnelled posteriorly and brought out through the sphincter.

If there is a recto-vaginal fistula present the dissection is also done from below. A V-shaped incision is made along the posterior fourchette excising the cutaneous portion of the fistula. The fistula then is freed from the posterior wall of the vagina and into the perineum with care. This dissection is bloody and tedious, but if done gently and persistently, can be accomplished. Special effort is made to leave a healthy bridge of skin between the new anal opening and the fistula opening. Again, the perineal body is left intact to add support to the perineum and anal sphincter muscle. The fistula is tunnelled posteriorly through the sphincter and sutured in place without tension.

Postoperative Care

The immediate postoperative care is similar to that of any infant. In order to prevent the perineal wounds from constantly being covered with stool the child is placed in the crib with the leg elevated in a modified type of Bryant's traction. This keeps the buttocks just off the bed. Stool can pass through the anal orifice and promptly drop away from the wound. Fewer secondary infections have taken place since this treatment has been carried out. After the wound is healed dilatations are immediately begun. This part of the treatment is as important as the surgery itself. There are many different ways of dilating the anus. A plastic centrifuge tube serves as an excellent instrument for the mother to use. The tube gradually becomes larger in caliber and if well lubricated can be used easily by the parent. Dilatations are continued until the child has an adequate opening. Until the stools become firm enough and the child forceful enough with passing stool the anal orifice may need constant dilatations.

Conclusions

It must be emphasized that when dealing with the imperforate anus the surgeon who places the *initial* scalpel to the perineum is the one who has the best and probably only opportunity for giving that child a competent sphincter. A perineum that has been invaded several times by the surgeon's knife is scarred, non-elastic and almost always a poorly functioning one. Since the first operation is the all-important one, the perineum of of a newborn with an imperforate anus should be regarded as the only avenue whereby this child can be acceptable by society as we know it today.

BIBLIOGRAPHY

1. Bill, Alexander H. Jr., M.D., Johnson, R. J., M.D., Foster, Ralph A., M.D.: Anteriorly Placed Rectal Openings in the Perineum "Ectopic Anus." *Ann. Surg.* 147: Feb., 1958.
2. Potts, Willis J., M.D., DeBoer, Arthur, M.D.: Imperforate Anus with Recto-Vesical-Urethral-Vaginal and Perineal Fistula. *Ann. Surg.* 140:381-395, Sept., 1954. ◄

How to Use a New Drug

If you do wish to consider the early use of new agents, select one at a time, carefully evaluate all of the available data on it, and reject its use unless there is clear evidence that it represents a real therapeutic advance. Thorough investigation of a few agents will always prove to be more profitable than cursory examination of many. It is desirable to select products for investigation from among those for which the manufacturer has provided relatively complete bibliographies. This simplifies the task, provides some selection on the basis that full information is more apt to be provided for those products in which the manufacturer himself has confidence, and finally, in the long run, such selection may induce manufacturers to provide more adequate information on their products.—Mark Nickerson and John P. Gemmel: Doctors, Drugs and Drug Promotion. *Canadian Medical Assn. Journal,* April 1, 1959, Reprinted in *Armed Forces Medical Journal,* Vol. II, No. 4, April, 1960.

New preparation is useful in superficial fungus infections of scalp. The offending organism should be identified prior to treatment.

Griseofulvin—An Advance in the Treatment of Tinea Capitis

PAUL V. CHIVINGTON, JR., M.D.
HOWARD R. GRAY, M.D.
ROBERT L. WOLF, M.D.
JOHN ERIC DALTON, M.D.
Indianapolis

TINEA CAPITIS has been one of the major medical causes of prolonged school absenteeism in children. The methods of treatment which have been available for tinea capitis have been unsatisfactory. Topical therapy has required prolonged, tedious, and exasperating treatment. X-ray epilation has produced satisfactory treatment results; however, a sizable quantity of x-ray irradiation is required in order to produce satisfactory epilation. Many individuals believe that exposure of a child to this quantity of x-ray irradiation produces a radiation hazard which is unwarranted for this disease. Recent reports of the oral use of the antibiotic griseofulvin for superficial fungus infections indicate that a satisfactory method of treatment for tinea capitis is now available.[1, 2, 3]

In Central Indiana, the major causes of tinea capitis have been the fungi Microsporum audouini, Microsporum canis, Microsporium gypseum, and Trichophyton tonsurans. When the scalp is examined by means of the Wood's lamp, the hairs in an area of Microsporum type tinea capitis ordinarily fluoresce a bright green color. Trichophyton infections, however, do not cause the typical green fluorescence. Diagnosis and follow-up examination is therefore more difficult. When infection is caused by a Trichophyton species, culture and microscopic examination of hairs must be relied upon. There has been an increased incidence of Trichophyton tonsurans infections in Central Indiana.[4]

Griseofulvin is a metabolic product of several Penicillium species. Biochemical studies includ- the post-operative period was uncomplicated. The were reported in 1939.[5] Fungistatic and fungicidal properties were noted in succeeding years.[6, 7, 8] In 1958 Gentles reported successful oral griseofulvin treatment of guinea pigs infected with Microsporum canis and Trichophyton mentagrophytes.[9] This report stimulated the use in humans. Toxic and cytological effects of griseofulvin in laboratory animals have been studied and reported.[10] Griseofulvin has been reported to be effective against Microsporum, Trichophyton, and Epidermophyton species. No effect has been noted against Candida albicans, Malasserzia furfur (tinea versicolor) or the deep fungi including Sporotrichium schenckii.[2]

From The Alembert Winthrop Brayton Skin and Cancer Foundation of Marion County General Hospital, Indianapolis, Indiana, John Eric Dalton, M.D., Chairman.

Clinical Study

The present study involves seven cases of tinea capitis treated with oral Grifulvin (McNeil Laboratories, Inc.)† Tabulation of these cases is shown in Table I. Four of these cases were due to Microsporum audouini and three were due to Trichophyton tonsurans. Duration of the disease in these patients prior to treatment varied from three and one half months to 34 months. Two of the cases had previously been treated with x-ray epilation without success, one two years earlier and one six months earlier.

Study Plan

Previous reports have indicated that a dosage of about 10 mg of Grifulvin (McNeil Laboratories, Inc.) per pound of body weight as a single or divided daily dosage is ideal. Dosage in these cases varied from 7.8 mg per pound to 13.9 mg per pound. This was taken orally as 250 mg tablets once, twice or three times daily. The patients were seen at weekly intervals during this study and were examined under Wood's light at each visit. The non-fluorescent cases (Trichophyton tonsurans) were cultured and KOH examinations were done each week beginning at the third week. Treatment was continued in the Microsporum audouini cases until no fluorescence was seen under the Wood's light. The treatment was continued in the Trichophyton tonsurans cases until two negative cultures were obtained at weekly intervals. Another negative weekly culture was then obtained before they were considered cured.

The Microsporum audouini cases have been followed from four to eight weeks after cessation of therapy and all of these cases have continued to show negative Wood's light examinations. In addition, following the completion of treatment they have each had a negative culture and KOH examination. The duration of therapy in the three cases due to Trichophyton tonsurans varied from 36 to 56 days. The series is not large enough to make significant correlation between the duration of required therapy and the dosage taken, but the case requiring the longest course of treatment (56 days) did receive a dosage slightly below that considered to be ideal. This patient received 7.8 mg per pound of body weight.

† Grifulvin supplied for this study through the courtesy of the Division of Clinical Investigation, McNeil Laboratories, Inc., Philadelphia 32, Pa.

Microsporum audouini cases showed a change in Wood's light fluorescence two or three weeks after therapy was instituted. The fluorescent hairs became dull, and frayed, and frequently the newly formed portion of the hair emerging from the scalp would show no fluorescence while the distal part of the hair would continue to fluoresce. Routine shaving of the scalp was carried out in order to remove the remaining infected fluorescing portion of the individual hairs.

The duration of required therapy and results are similar to those previously reported.[2,3,4] Cases have been reported that have required much longer periods of treatment than those in this group, up to 95 days of therapy in one group. Relapses after having a negative Wood's light examination in this same group were noted requiring treatment to be restarted.[3] No relapses were noted in the group of cases presently reported. In none of the present group of cases was there kerion formation. It has been noted, however, that griseofulvin has caused marked clinical improvement after only one week of therapy in cases with kerion formation.[3]

Toxic Studies

In the present group of cases a complete blood count including a differential and a urinalysis was done on each case before therapy was started and at two-week intervals while the patient was under treatment. Liver function studies consisting of total bilirubin and cephalin cholesterol flocculation were done before starting therapy and after the completion of therapy. None of these tests showed any toxic effects from the griseofulvin. There were no side effects noted clinically in this group of cases.

In other series of cases, Kirk and Ajello reported two cases of angioneurotic edema[3] and Blank and Roth noted one case of urticaria.[2] These subsided after cessation of therapy. No serious side effects have been noted. Two instances of a pruritic diffuse macular eruption were noted in the series of Sternberg.[4] These subsided after therapy was discontinued and did not recur when griseofulvin was restarted. In these series mild abdominal distress, headaches, nausea, malaise, dryness of the mouth, blurring of vision, diarrhea, numbness of toes, polyuria and thirst have been noted but have not been of sufficient severity to necessitate discontinuance of therapy. No cross-sensitivity to penicillin has

Tabulation of Cases Treated with Griseofulvin

CASE	AGE	WT. LB.	CAUSATIVE ORGANISM	DOSAGE	DURATION OF DISEASE	DURATION OF THERAPY	FOLLOW UP AFTER THERAPY	COMMENT
1.	12	86	Microsporum audouini	250 mg t.i.d. 8.7 mg/lb.	15 mo.	21 days	7.5 wks.	X-ray epilation (failure) 5.5 mo. prior
2.	6	45	Microsporum audouini	250 mg b.i.d. 11.1 mg/lb.	34 mo.	21 days	4 wks.	X-ray epilation (failure) 2 years prior
3.	5	38	Microsporum audouini	250 mg b.i.d. 13.1 mg/lb.	10.5 mo.	22 days	7.5 wks.	No sign of Relapse
4.	6	42.5	Microsporum audouini	250 mg b.i.d. 11.7 mg/lb.	8 mo.	26 days	5 wks.	No sign of Relapse
5.	3	32	Trichophyton tonsurans	250 mg one daily 7.8 mg/lb.	11 mo.	56 days	4 wks.	3 Neg. Cultures
6.	5	36	Trichophyton tonsurans	250 mg b.i.d. 13.9 mg/lb.	20 mo.	40 days	5 wks.	4 Neg. Cultures
7.	9	72	Trichophyton tonsurans	250 mg t.i.d. 10.4 mg/lb.	3.5 mo.	36 days	5 wks.	3 Neg. Cultures

TABLE I

been noted when given to patients allergic to penicillin.

Comments

It is essential that the diagnosis be established by means of Wood's light examination, KOH examination and culture before instituting griseofulvin therapy. These patients should be adequately followed both during therapy and following therapy. Relapse and reinfection are possibilities that should be kept in mind.

Since this antibiotic is a new drug and is taken for long periods of time, it is believed advisable to be alert for undesirable side effects. Periodic blood counts are suggested.

Summary

Tinea capitis has been a serious and difficult problem. Treatment for this disease has been unsatisfactory in the past. Recently a new oral antibiotic, griseofulvin, has been found to be effective in superficial fungus infections. Seven cases of tinea capitis were treated with griseofulvin and extensive laboratory studies were done before, during and after therapy. Results of this study are presented.

REFERENCES

1. Black, H., Roth, F. J. Jr.: The Treatment of Dermatomycoses with Orally Administered Griseofulvin. *A.M.A. Arch. Dermat.* 79:259-266, March, 1959.
2. Kirk, J., Ajello, L.: Use of Griseofulvin in the Therapy of Tina Capitis in Children. *A.M.A. Arch. Dermat.* 80:259-267, September, 1959.
3. Sternberg, T. H., Newcomer, V. D., Reisner, R. M., Homer, R. S., Sorensen, L. J.: The Treatment of Superficial Fungus Infections in Man with Orally Administered Griseofulvin. *Current Therapeutic Research* 1:1, September, 1959.
4. Gray, H. R., Dalton, J. E., Starcs, H.: Trichophyton Tonsurans Infection of the Scalp in Central Indiana. *J.I.S.M.A.,* 53:75, Jan., 1960.
5. Oxford, A. E., Raistrick, H., Simonart, P.: XXIX. Studies in the Biochemistry of Microorganisms. LX. Griseofulvin, $C_{17}H_{17}O_6Cl$, A Metabolic Product of Penicillium Griseo-fulvum Dierckx. *Biochem. J.* 33:240-248, 1939.
6. Brian, P. W., Hemming, H. G., McGowan, J. C.: Origin of a Toxicity to Mycorrhiza in Wareham Heath Soil. *Nature,* London 155:637, 1945.
7. Brian, P. W., Wright, J. M., Stubbs, J., Way, A. M.: Uptake of Antibiotic Metabolites of Soil Micro-Organisms by Plants. *Nature,* London 167: 347-349, 1951.
8. Grove, J. F., McGowan, J. C.: Identity of Griseofulvin and "Curling-Factor." *Nature,* London 160: 574, 1947.
9. Gentles, J. C.: Experimental Ringworm in Guinea Pigs: Oral Treatment with Griseofulvin. *Nature,* London 182:476-477, 1958.
10. Paget, G. E., Walpole, A. L.: Some Cytological Effects of Griseofulvin. *Nature,* London 182:1320-1321, 1958. ◄

Medical Prepayment and Our Social Philosophy

"A curious paradox of some contemporary social philosophy is the idea that man should spend what he earns for his pleasures rather than for what he needs. It is appropriate, so this reasoning goes, that he should buy a television set, a vacation in Florida or an outboard motor boat, because these are cardinal rights. But for something that he really needs, such as his life or his health, or the life of his child, someone else should pay. This may be the Government, his employer, his union, his great-aunt or anyone else who can be cajoled or coerced into paying the price for him. If no one else will pay for it, the doctor should serve him for nothing."—Dr. C. Marshall Lee, Jr.

A practical outline of diagnosis and management . . .

Problems of Ovarian Cysts

*J. DONALD WOODRUFF, M.D.**
Baltimore, Md.

PROPER EVALUATION of cystic enlargement of the ovary is one of the most perplexing diagnostic problems. Commonly, the neoplastic lesions are asymptomatic in the early stages of the disease and the first sign of trouble is an abdominal mass, distention due to ascites or rarely bleeding as a result of extention of the tumor to the uterus or vagina. On the other hand, functioning or non-neoplastic cysts are prone to produce menstrual irregularities which usually bring the patient to the doctor immediately. As a result of these incongruities, the patient with the functioning cyst is often explored unnecessarily while the neoplastic tumor grows silently often beyond the possibility of salvage.

This is further evidence of the importance of the routine physical examination and the need for careful evaluation of any palpable abnormalities. Although the cytologic examination is most valuable in detecting microscopic, asymptomatic lesions in the lower genital canal, progress has been made in the use of this method for the diagnosis of ovarian lesions. Consequently, the importance of thorough pelvic examination plus cytologic study cannot be overemphasized if progress is to be made in early diagnosis and salvage improved. Even with the methods available today, about 75% of ovarian cancer is first diagnosed long after curative therapy can be instituted.

* Assoc. Prof. Gynecology, Johns Hopkins Hospital; Chief Gyn. at The Hospital for the Women of Md.

Presented at the Annual Convention of the Indiana State Medical Association, Indianapolis, Ind., Oct. 7, 1959.

To add to the problem of differentiating varieties of ovarian enlargements are the factors which complicate the pelvic examination. Frequently, in the obese patient it is almost impossible to evaluate the pelvic contents because of the panniculus. Added to the external fat are masses often adherent in the pelvis from the omentum, mesentery or the appendices epiploica of the sigmoid. This is particularly true in the patient who has had previous surgery, and many a patient has had repeat exploration for an apparent tumor with only the finding of adipose tissue adherent in the pelvis. The prolapsed, gas-filled caecum often forms an evanescent pelvic mass observed at times by both patient and doctor.

Feces, loculated in the bowel, may present anteriorly, posteriorly or laterally to the uterus and further confuse the picture. Finally, the incompletely emptied bladder or one that has refilled while the nervous patient awaits examination may be easily mistaken for an anterior ovarian enlargement. Consequently, it is of major importance that the patient be as much at ease as possible and that any physiologic impediment to a good examination be eliminated if satisfactory exaluation of even the normal pelvis is to be attained.

Pathologic, Physiologic Abnormalities

Although physiologic problems may offer some difficulties to the physician, pathologic and developmental abnormalities present even greater complications. The anomalous pelvic kidney has been explored by many a surgeon as an adnexal

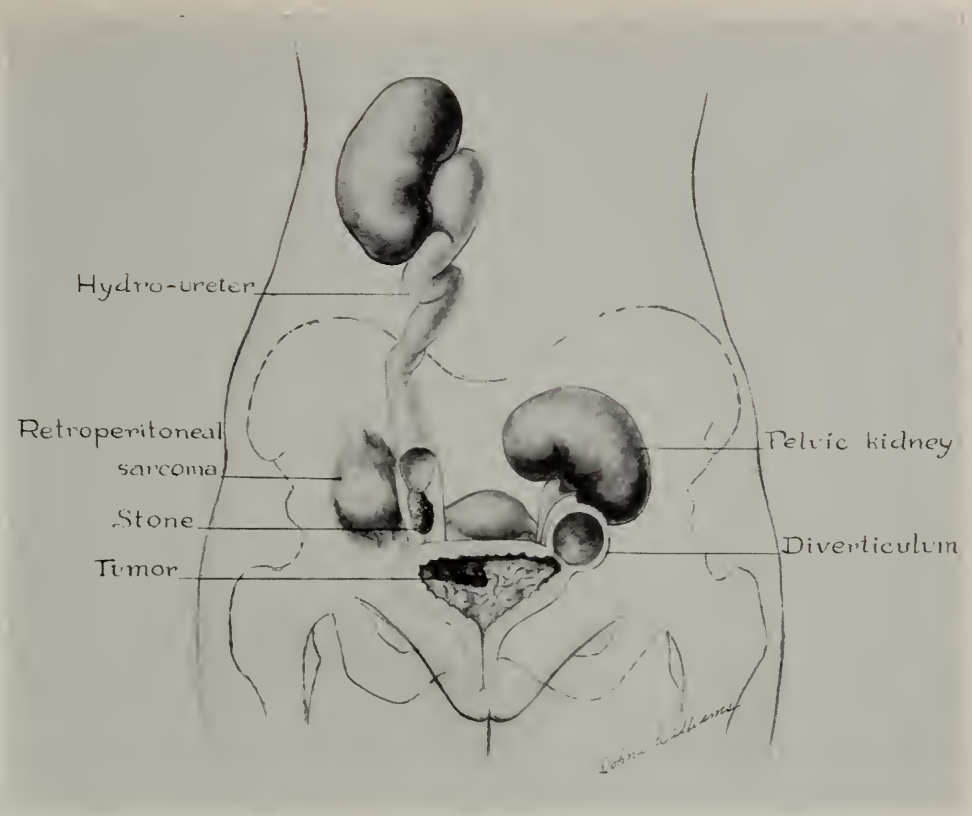


FIGURE 1
URINARY ABNORMALITIES and retroperitoneal sarcoma which may interfere with or cause misinterpretations of the pelvic examination.

mass. Bladder tumors may attain sufficient size to be palpable either anteriorly or laterally to the uterus. Rarely a huge hydroureter has been mistaken for a soft ovarian mass.

Diverticulitis and tumors of the rectosigmoid are most commonly mistaken for ovarian enlargements; however, it is obvious that neoplasms from the other areas in the intestinal tract might be prolapsed into the pelvis. In the right lower quadrant, regional ileitis may form a palpable pelvic mass. Retro-peritoneal tumors, commonly sarcoma or lymphoma, are frequently recognized first by pelvic examination and often interpreted as ovarian in origin. Subserous pedunculated myoma presents the most common problem in differentiation from an ovarian lesion. Too commonly the mistake has been reversed and an ovarian tumor has been observed as representing a benign fibroid while the adnexal tumor was progressing beyond the point of salvage. Even the deeply retroverted fundus filling the *cul-de-sac* of Douglas may become oedematous and resemble a tense ovarian cyst.

These physiologic and pathologic abnormalities demand that the physician make every effort to eliminate as many of them as possible to insure a better evaluation of the pelvic contents. If an apparent tumor is present, repeat examination after a good catharsis is worthwhile. Should incompleted emptying of the bladder be suspected, catheterization may be necessary. Recto-vaginal examination should be a routine part of the pelvic study, but is of even more importance where the question of bowel abnormality exists. Should doubt still exist, further diagnostic studies may be necessary. Certainly it is unfair to the patient to suggest examination if such examination is to be inconclusive.

Ovarian cysts fall into two groups Namely (1) the functioning or non-neoplastic cysts including inflammatory disease, and (2) the true new growths. An intermediate group might be inserted in this classification, namely the endometrial and parovarian cysts, because of the certain clinical and palpatory findings which help differentiate these tumors. It is of major importance that every effort be made to evaluate the enlargement and treat the neoplastic disease early while observing the non-neoplastic tumor. The possible grouping of these cystic enlargements is as follows:

Non-neoplastic cysts:

1. Follicle cyst
2. Stein-Leventhal ovary
3. Lutein cysts
4. Inclusion and tubo-ovarian inflammatory cysts

Neoplastic cysts:

1. Serous a. papillary, b. non-papillary
2. Pseudomucinous cysts
3. Dermoid, including struma ovarii

Intermediate cysts:

1. Endometrial cysts
2. Parovarian cysts

Non-Neoplastic Cysts

Cystic enlargements of the ovary are extremely common. Actually one or more cystic cavities are formed in the ovarian cortex with each cycle. As the follicle develops, the central cavity containing the liquor folliculi produces a small cyst. Frequently, especially in the menarchal and premenopausal years, the follicle fails to rupture and the lining cells continue to function for indefinite periods, thus producing an abnormal cycle, either prolonged bleeding or prolonged interval. These cycles are anovulatory, the bleeding phase relatively painless and the patients obviously are infertile. The cystic enlargement associated with such cycles may be insignificant or may become as large as an orange. With the clinical picture suggesting such a functional abnormality, it is wise to treat the patient conservatively and follow through further cycles. However, despite the frequency with which this picture is associated with a functioning ovarian cyst, repeat examinations are imperative. There is no other method by which a true neoplasm may be eliminated.

Although anovulatory cycles are often isolated episodes, at times these cycles continue well into adult life and the patient has intervals of two or more months regularly and is infertile due to anovulation and occasionally has other clinical findings such as mild hirsutism, acne and slight obesity. The ovaries in these cases are large and firm with a thick white capsule, often called "oyster ovaries," and the section of the ovaries reveals great numbers of small cystic spaces lined with an inner granulosa layer and an outer lutenized theca. There is no evidence of recent ovulation in the form of the corpus luteum.

This "Stein-Leventhal" ovary may also be several times normal size or the palpable findings may be border line in size. It seems quite possible that many girls in the menarche have ovaries of this general variety for several years during the irregular phase after the onset of menses. However, eventually a normal pattern evolves without medical interference. It would seem wise during these formative years to allow the ovarian cycle to right itself since there is no evidence to indicate that the duration of the problem relates adversely to its curability. Further-

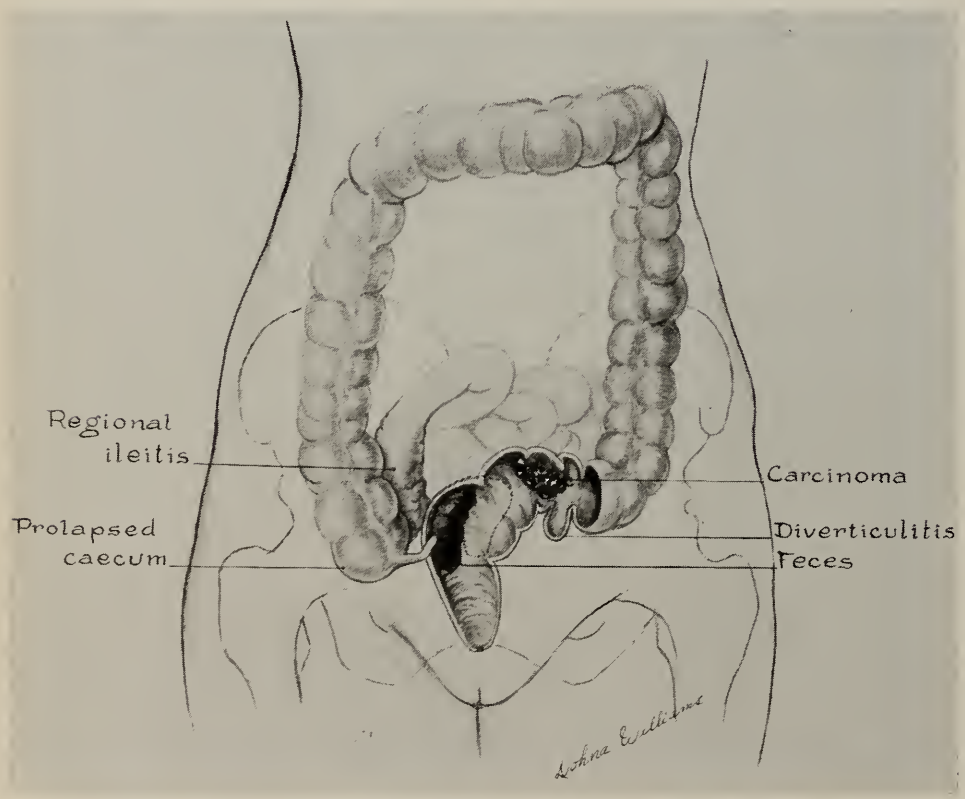


FIGURE 2

GASTRO-INTESTINAL conditions which may interfere with or cause misinterpretations of the pelvic examination.

more, history indicates that the great majority of these patients revert spontaneously to normal rhythm. Wisely, therapy is reserved for the time when infertility is the problem.

The luteal phase of the cycle also has its "functioning cyst." Each corpus luteum goes through stages of development. Shortly after its formation there is striking vascularization and an outpouring of blood into a central cavitation forming the "corpus hemorrhagicum." This process forms a slight physiologic enlargement and on occasions there is rupture with the discharge of a quantity of blood into the abdominal cavity on or about the seventeenth day of the usual monthly cycle. This hemorrhage may be sizeable and in rare cases shock may accompany the pain. The clinical picture is a rather definite one as to time of onset and typical pain with rectal tenesmus which is unproductive of stool. Not too uncommonly the episode follows shortly after coitus and shoulder pain and fainting may follow. These dramatic episodes are uncommon. The corpus luteum usually goes on to form a small cystic central cavity as a result of the extravasation of blood into the core and the resorption of the hemoglobin. Occasionally the cyst may become a palpable entity and the lutein tissue continues to function over its normal life cycle.

"Corpus luteum persistens" produces prolongation of the interval and slight pain in the side due to ovarian distention. This picture simulates tubal pregnancy, both historically and clinically, with pain, overdue period, and an enlarged adnexa. The most common mistake clinically, however, is to interpret the pain as evidence of salpingitis. Not infrequently, the story of recurrent pelvic pain, treated with penicillin, subsiding in four to five days or less and diagnosed as "infected tubes" is reported by the patient. In between episodes there has been one or more pregnancies. Such situations are almost routinely related to ovarian bleeding at time of ovulation or from the corpus luteum. These enlargements, like the follicular cysts, resolve spontaneously, usually with conservative therapy, unless the intra-abdominal bleeding is too severe.

Other lutein cysts are of thecal origin and are produced as a result of stimulation of the thecal cells by the chorionic gonadotrophin hormone either from hydatidiform mole or choriocarcinoma. Treatment of the disease of the trophoblast is the major feature in this situation, the cysts regressing after removal of this abnormal trophoblast. Regression often does not occur for several months, but nevertheless, with satisfactory reduction in the levels of chorionic gonadotrophic, there is no indication for surgical interference. Again, however, warning must be repeated that if the periods return normally and the cysts are persistent, other neoplasia must be considered and exploration should be performed.

These functioning or physiologic cysts are non-neoplastic. There is also no evidence that any of this variety of change can develop into any true neoplasm. Further they are generally associated with obvious cyclic disturbances in the menstrual regularity and with this picture present there is every reason for observation rather than surgical interference except in cases of severe bleeding or pain. However, true neoplastic cysts may be associated with menstrual irregularities so each ovarian enlargement must be carefully observed until either regression occurs or persistence demands further investigation.

Asymptomatic Enlargements

Whereas these functioning cysts are hearalded by rather specific symptomatology, other varieties of cystic enlargements are commonly asymptomatic. Among these are the peritoneal inclusion and tubo-ovarian inflammatory cysts. Although there has usually been some history of precedent pelvic disturbance, this has usually been in the past and the resultant pathology is commonly discovered on routine examination. Both of these situations occur following pelvic irritation, usually infection or surgery. Cystic masses are indefinite and adherent. The bowel often makes up part of the tumor. Repeat examination, especially after the bowel has been emptied, will commonly result in a reduction in the size of the mass or even complete disappearance.

If such repeated exams reveal no change in the size of the cyst, exploration should be carried out, as again true neoplasm cannot be specifically ruled out. On occasions when the physician is very familiar with the details of previous surgery, the cyst may be needled through the *cul-de-sac* and the fluid studied cytologically. The disadvantages of this procedure are obvious. If the cyst is neoplastic, puncture may allow for spread of the anaplastic cells, cytology will not absolutely evaluate the malignant potential of any given cyst, especially the papillary serous variety, and finally the bowel may be needled in the proce-

dure. As a result of these problems needling is not a procedure to be recommended generally.

Intermediate are Potentially Malignant

The intermediate group is inserted because although there is a functioning element to the first member, the endometrial cyst, it does have malignant potential. Furthermore, this cyst is usually symptomatic, although the most confusing feature of endometriosis is the fact that the severity of symptoms is inversely proportionate to the palpable pathology. Often the largest cyst is found on routine examination while the patient with fine nodules in the utero-sacral ligaments commonly complains of marked discomfort. These nodules of course are composed of functioning endometrium which causes pain by producing swelling, edema and local irritation during cyclic variations. The cyst, on the other hand, frequently has lost its functioning tissue as a result of pressure and inflammatory reaction due to the mass of old blood. Malignant change in these "chocolate cysts" and endometrial implants in the ovary are rare, possibly occurring in 0.25 to 0.5%. However, it must be remembered as a potentiality.

The second member of the intermediate group is the parovarian cyst. Although not truly ovarian in origin, it commonly lies in the immediate vicinity and is difficult to differentiate from a true tumor of the ovary. This cyst arises from the mesonephric duct and is therefore related to many of the hydatids and also to solid tumors, the mesonephromas, arising in this region and along the course of the duct. The tumors occurring in the ovarian region are usually simple cysts without adenomatous or papillary developments. Consequently, the malignant potential is almost zero. These tumors are silent as is usual for the neoplastic cysts. Occasionally, careful pelvic examination will fix the position of the cyst outside the limits of the ovary. Culdoscopy is of particular value in this instance.

Benign Neoplastic Cysts

The benign neoplastic cysts are made up of three primary varieties, namely the serous, mucinous and dermoid cysts. All of these are commonly asymptomatic. Discovery of tumor is most often the result of routine pelvic examination. Obviously twisting of the cyst will produce acute symptoms of pain and peritoneal reaction. On occasions the tumors form a mass which can be easily recognized by patient and physician. It is most fortunate where symptoms or mass do appear prior to the development of malignant change in the cyst; however, such situations are all too infrequent. There are a few clinical findings which may help to differentiate these cysts pre-operatively. This differentiation is generally of academic interest since even though the incidence of malignant transformation differs from one to the other, no opportunity should be afforded for such change to take place. Furthermore, conservative therapy is more feasible when the benign tumor has not replaced the entire ovary.

Dermoid is bilateral in 15-20% of the cases; it occurs frequently in young girls, occasionally even before puberty, and is rarely malignant. It is not uncommon to find calcification in the form of bone or teeth in these cysts. X-rays of the pelvic may assist in making a differential diagnosis. However, again this is of more or less academic interest since, although the malignant potential of these tumors is only about 1 to 1.5% nevertheless destruction of the ovary may occur due to frequent rapid benign growth, and exploration is indicated. This variety of neoplasm often lies anterior to the broad ligament where its weight, due to the sebaceous material, tends to hold it after motion of the tumor has helped it to attain this position.

The dermoid cyst is a variety of teratoma, and usually the ectodermal elements predominate; hence, the name dermoid. However, in about 90% of the cases elements from other embryonic layers are found, and occasionally, one of these becomes prominent. Such is the case in the struma ovarii, a teratoma made up largely or completely of thyroid tissue. In about five percent of the cases the tissue is active and produces symptoms of hyperthyroidism. In the occasional case mistakes have been made by removing the thyroid in the neck when the functioning tissue was actually in the ovary. Accurate diagnosis can be arrived at by radioactive iodine uptake studies which will demonstrate the presence of thyroid tissue in the pelvis. Recognition of such a condition allows for better preparation of the patient prior to operation.

Since dermoid cysts are frequently bilateral and occur in young girls, it is important to study both ovaries thoroughly and to be conservative in surgery. The latter type of therapy is relatively

easily carried out in the young patient with dermoid cysts and resection should be carried out even if only a small fragment of ovary can be salvaged. These fragments are largely cortex containing the functioning elements of ovary and a "little bit goes a long way."

Pseudomucinous are Largest

The pseudomucinous cysts are the largest tumors which occur in the human body, making up the majority of the so-called "giant cysts" weighing over 50 lbs. The term pseudomucinous has been fairly well proven by recent studies to be a misnomer in that the secretion from the cells of the tumor is a muco polysaccharide similar to that of the intestinal tract and therefore mucinous cyst is a more correct term. The tumors, usually a variety of teratoma in which all elements except those of endodermal origin have been eliminated, occur commonly in young people in the third decade of life. Generally, there are no specific symptoms, most of the tumors being recognized first by their size. Diagnosis may be established by needling the cyst and recognizing the mucoid character of the fluid. This, however, is not an advisable procedure, because of the possibility of spread of the mucous secreting tissue and the development of pseudomyxoma peritoneii.

Again, pre-operative diagnosis is more or less of academic importance since operative therapy is necessary. Conservative surgery is indicated in the young patient since these tumors are unilateral in 95% and malignancy occurs in 10-12% of the cases. Furthermore, the malignant tumors are usually obviously anaplastic as evidenced by gross local extension and/or metastatic disease. In the older patient, complete surgery is advisable irregardless of the gross benign appearance.

The most complicated and difficult cystic tumor to evaluate is the serous cyst. This is probably the most common of the neoplastic cysts and arises from invaginations of the normal serous covering of the ovary (so called germinal epithelium). Many of these invaginations are in the general area of the main cyst, form an adenomatous arrangement and with the common papillomata on the surface involved in the cystic tumor. The final result is the papillary serous cystadenoma. The tumors occur largely in the fourth and fifth decades of life but are not infrequent in the younger years. In the simple form of the cyst, there is little if any malignant potential. By the same token, the malignant variant of the tumor, a papillary serous cysadenocarcinoma, is quite obvious. The intermediate form is the semi-malignant or implanting papillary tumor. This tumor often seeds its fine papillomata throughout the peritoneal cavity and thereby produces extreme ascites suggesting malignant change in the tumor. Fortunately in many of these cases, the removal of the parent tumor, with the omentum, will produce permanent cure. Even in the obvious malignant variant, the removal of the pelvic tumor followed by x-ray therapy will effect excellent relief for many months and even long-term salvage in seemingly hopeless situations.

As a result of these peculiarities, it is worthwhile to treat every ovarian tumor with all the methods available—that is, surgery with x-ray therapy in the form of external irradiation or intraperitoneal isotopes. Lately, chemotherapy has been effective in producing symptomatic improvement. The most effective of the chemotherapeutic compounds are the alkylating agents which affect the actual metabolism in the nucleus. Chlorambucil and thio-TEPA have effected reduction in the size of metastatic or local masses and relief of symptoms temporarily. It must be recognized, however, that at present no long-term cures have been reported by use of these compounds. There are few side effects, but the blood picture must be carefully watched, as reduction in white count occurs not uncommonly. Intraperitoneal nitrogen mustards have reportedly effected reduction in ascites; however, the results are not uniform and side reactions are sometimes severe.

Proper Evaluation Problem

The problem of proper evaluation of the ovarian enlargement probably demands more thorough study than any other in gynecology today. Whereas great advances have been cytologically in early diagnosis of lesions of the cervix and fundus with significant increases in salvage therapy, such is not the case with ovarian tumors. Nevertheless the use of all diagnostic methods on the patient with ovarian neoplasm and early therapy in the patient with persistent enlargement are the only methods available and must be used to the fullest extent if progress is to be made. Too frequently the old adage that a cyst should be explored if it is over 10 cms is quoted as a reason

for observation. Nothing could be more damaging to the fight against ovarian cancer!! Everyone has seen an almost normal sized ovary simply riddled with carcinoma.

Certain diagnostic aids, although not perfect, may be helpful in the patient with a minor but persistent ovary enlargement. Vaginal cytology has revealed that in the post-menopausal patient with ovarian tumors, there is often a high maturation index in the vaginal epithelium. Such a report should make the physician suspicious and demand further study. Culdocentesis for cytologic study has been attempted on several occasions, but our results, like others, have been of little value diagnostically. It would seem, however, that some such method may be devised for early recognition of anaplastic cells in the ovarian cyst. Examination under anesthesia and culdoscopy have been valuable aids in establishing the presence of an ovarian tumor; on occasions the type of enlargement may be established by visualization. For the most part, however, abdominal exploration is necessary to properly evaluate and treat this silent, lethal disease. ◄

Rate of Admission to General Hospitals Soars

The rate of admission to general hospitals in this country has increased by almost 80% in the last 20 years, from 56 to 99 admissions per 1,000 population. As a result, says Health Information Foundation, these hospitals "have become increasingly important in the total health picture."

The average patient in a general hospital today spends 8.6 days there—a decline of about one-third from the 12.5 average of 20 years ago.

Despite sharp drops in the incidence of venereal disease since the development of antibiotics, an estimated 60,000 cases of syphilis and 1,000,000 of gonorrhea are still acquired each year. "Complete elimination of these diseases," says Health Information Foundation, "is at this point far from achieved."

The Challenge of Triacetyloleandomycin* In Pediatric Infections

C. K. NEWSOME, M.D.

Evansville

EVOLUTION OF STREPTOCOCCI and staphylococci that are highly resistant to antibiotic agents currently available is a growing health problem. Of particular importance is the effect of these resistant organisms on the course of microbial infections in infants and children.

Culture and sensitivity studies are, although invaluable, not always practical to obtain. Particularly with acute infections in very young children is it necessary to provide prompt antibiotic and/or other medication. The practitioner is, more often than not, obliged to prescribe early treatment based upon his clinical evaluation and judgment.

Development of derivatives and analogues of some of the older antibiotics, and the judicious use of antimicrobial-drug combinations appear to be the "first line of defense" in control of resistant organisms. One of the most challenging of these newer drugs is triacetyloleandomycin, the completely acetylated ester of oleandomycin. Bacterial resistance to this drug has increased very little, if any, during the past two years, possibly due to its degradation, systemically, to at least six analogues.

It was believed that triacetyloleandomycin, a medium-spectrum antibiotic, would be effective in many of the common acute infections, especially those resistant to penicillin and broad-spectrum antibiotics. Also, by using this medium-spectrum antibiotic, there was the objective of avoiding superinfection and overgrowth of secondary invaders often seen with the broad-spectrum compounds.

* TAO, J. B. Roerig and Company, Division, Chas. Pfizer & Co., Inc.

Materials and Methods

One hundred and fourteen pediatric patients, ranging in age from newborn infants to five-year olds, were studied. Those patients selected were in most instances seriously ill with one or more of the following or related infections: bronchial pneumonia, acute pharyngitis, acute bronchitis, tonsillitis, otitis media and acute pyodermias. These conditions were in many instances complicated by vomiting and/or diarrhea.

One of two medications containing triacetyloleandomycin was used. In one series (Group A) of 88 patients, an oral suspension, containing in each 5 cc teaspoonful tricaetyloleandomycin equivalent to 125 mg of oleandomycin with 125 mg of glucosamine,† was given. In another series (Group B) of 26 patients, an oral suspension containing in each 5 cc teaspoonful triacetyloleandomycin equivalent to 125 mg of each of three sulfonamides—sulfadiazine, sulfamerazine and sulfamethazine**—was used.

With both drugs, the usual daily dosage was one-half to one teaspoonful four times a day. The aim throughout this study was to prescribe only the minimal effective dosage. This antibiotic therapy was given, usually for five days, but this included two days beyond the time evidence of infection had disappeared. Therapy with other medium-spectrum antibiotics or with penicillin had been tried and had failed in some of these patients. Measures to control diarrhea and/or emesis were taken concomitantly where these were needed.

† TAO Oral Suspension—J. B. Roerig and Company, Division, Chas. Pfizer & Co., Inc.

** TAOMID Oral Suspension—J. B. Roerig and Company, Division, Chas. Pfizer & Co., Inc.

Laboratory facilities were not available nor did time permit sensitivity testing in this study.

Results

Of the 88 patients in Group A, excellent results occurred in 49 (56%); good results in 33 (37%); and fair six (77%). Complete failure of therapy did not occur. (Table I)

Of the 26 patients in Group B, results were as follows: excellent, 13 patients (50%); good, 10 (38%); fair, two (8%). Failure occurred in one patient. (Table II)

"Excellent" means complete and prompt control of the infection on minimal dosages of medication, usually after three days (72 hours). "Good" means complete control of the infection after dosages of the antibiotic were increased and therapy prolonged, usually to a total of five days (120 hours). "Fair" means equivocal results in controlling the infection even after five days of total therapy, including two days on higher dosages.

Triacetyloleandomycin was, of course, the antibiotic substance given to both Groups A and B. A total view shows that excellent to good therapeutic results were obtained in 105 of the 114 patients (92%), while fair or no results occurred in nine (8%).

The only side reactions observed throughout the study were stomach upset manifested by emesis in three children, all of whom presented acute bronchial infections. Results of therapy in each of these three patients were excellent, good, and fair, respectively.

Commentary

Acute infections in all age groups call for active and prompt control. Pediatric infections especially may prove most threatening. Clearly, however, no one medication and certainly no one antibiotic may be looked to as an easy cure-all. A convincing rationale may nonetheless be advanced for first using an effective, safe, medium-spectrum antibiotic such as triacetyloleandomycin in many of these commonly encountered pediatric infections.

In antibiotic therapy, the pediatric practitioner must constantly consider the need for minimal dosages, the avoidance of resistant strains and the possibility of side reactions. Also, palatable and adjustable antibiotic dosage forms are particularly needed in practice with children. Triacetyloleandomycin has satisfactorily proved itself in these cases.

The combination of triacetyloleandomycin with triple sulfas in one dosage form (TAOMID) does provide a broader spectrum than triacetyloleandomycin alone. This combination product might best be reserved for acute infections in which the invading pathogen is suspected to be of a Gram-negative variety. Triacetyloleandomycin alone (TAO) has shown itself chiefly valuable in infections most frequently due to Gram-positive bacteria. In the absence of sensitivity testing facilities, having two preparations containing triacetyloleandomycin available to use according to individual judgment and patient needs is helpful.

Results of Treatment with Triacetyloleandomycin* in Pediatric Infections (Group A)

DIAGNOSIS	Results				
	Excellent	Good	Fair	Failure	Total
Bronchitis	21	18	3	0	42
Otitis Media	3	1	0	0	4
Acute Scalp Infection	4	0	0	0	4
Pneumonia	1	0	0	0	1
Acute Upper Respiratory Infection	8	11	1	0	20
Diarrhea and Upper Respiratory Infection	2	1	1	0	4
Toe Infection	1	0	0	0	1
Pyoderma	4	1	1	0	6
Laryngeal Croup	0	1	0	0	1
Tonsillitis	3	0	0	0	3
Furunculosis	1	0	0	0	1
Blepharitis	1	0	0	0	1
					88

* TAO

TABLE I

Results of Treatment with Combined Triacetyloleandomycin and Triple Sulfas* in Pediatric Infections (Group B)

DIAGNOSIS	Excellent	Good	Fair	Failure	Total
Purilent Otitis Media	5	0	1	0	6
Acute Upper Respiratory Infection	1	6	0	0	7
Tonsillitis	0	1	0	1	2
Bronchitis	7	3	0	0	10
Croup	0	0	1	0	1
					—
					26

* TAOMID

TABLE II

Conclusions

A. The two oral suspensions containing triacetyloleandomycin have proved palatable and acceptable to the pediatric patients studied.

B. Triacetyloleandomycin has been found to be a dependable and safe antibiotic, effective clinically even when given in minimal dosages to pediatric patients.

C. Triacetyloleandomycin alone is an ideal medium-spectrum antibiotic to meet the challenge of resistant pathogens; use of triacetyloleandomycin in combination with triple sulfas (TAOMID) is recommended for a broader-spectrum and reduced likelihood of resistant strains.

D. Triacetyloleandomycin has demonstrated exceeding safety along with a demonstrated medium-spectrum therapeutic index. ◄

Carver Community Center Clinic
705 Lincoln Ave.
Evansville, Ind.

Today's Children Need Less Hospital Care

Children nowadays need hospital care less often than they did 20 years ago, largely because the rates for two common operations, tonsillectomies and appendectomies, have declined by about half. At the same time, Health Information Foundation reports, improved surgical technics have increased admission rates for most other operations, especially complicated heart surgery.

May surgical recovery time be reduced with benefit to patient?

Duration of Convalescence Following Surgery

*N. HENRY MOSS, M.D.**
Philadelphia, Pa.

THERE IS CONSIDERABLE evidence to indicate that the average duration of uncomplicated surgical convalescence in current civilian practice is unduly prolonged. Furthermore, such uncomplicated convalescence may be considerably reduced with safety to the patient. Studies[1,2,3] conducted during the past four years have demonstrated that the major factor in determining the duration of post-surgical convalescence is the opinion of the responsible surgeon or physician. And since there are no adequate objective criteria that have been established in the past to define the logical periods of surgical convalescence, management of surgical patients in the latter phases of their convalescence has been based upon impressions and vague concepts rather than objective evidence. We can support this statement after a thorough search of the literature, by informed discussion with many physicians and surgeons and following the results of a survey questionnaire, in which a wide diversity of opinion was expressed by many physicians and surgeons in answer to the same hypothetical case examples.[1]

This questionnaire survey requested the opinion of surgeons, gynecologists, industrial physicians and general practitioners throughout the United States regarding the proper time for an individual to return to work following certain selected operations of limited magnitude. In each case, it was assumed that the hypothetical patient enjoyed good health except for the disability that necessitated the operation and that the post-operative period was uncomplicated. The answers for both light and heavy work were requested.

Results of the survey demonstrated a wide range of opinion for all physician groups polled. For that same patient, the recommended time interval between appendectomy and return to light work ranged from one to four weeks; to heavy work from one to ten weeks. For hemorrhoidectomy, cholecystectomy, hysterectomy and inguinal herniorrhaphy, the same wide range of opinion as to the length of the convalescent period in these hypothetical uncomplicated cases was apparent. This indicates the lack of adequate criteria for determining the optimum duration of surgical convalescence.

Comparison of the results of the questionnaire survey for inguinal herniorrhaphy to the statistics of the Travelers Insurance Company shows a close correlation. This would suggest that the opinion of the responsible surgeon is one of the major factors in determining the duration of convalescence following surgery.

What are the possible factors that may be considered? They are:

1. Physiological
2. Psychological
3. Socio-Economic
4. Doctor's opinion

A separate study is being conducted on the psychological and socio-economic aspects of this problem. Suffice it to say that most patients lose money when they stay away from their jobs for

* Attending Surgeon, Director of Tumor Clinic, Director of Medical Education, Albert Einstein Medical Center of Philadelphia; Department of Surgery, School of Medicine, University of Penn.

Presented at the Indiana State Medical Association Annual Convention, Indianapolis, Ind., Oct. 8, 1959.

prolonged periods of time. Even with the benefits of health and accident disability insurance, statistics have demonstrated a significant dollar loss to the average family income. We believe that malingering and "gold bricking" plays a minor role in this problem and that most people do not stay out merely to collect their disability checks.

With regard to the physiological factors concerned with convalescence, we should consider the metabolic and neuroendocrine responses to surgery, wound healing and the influence of early ambulation.

Metabolic and Neuroendocrine Response

Dr. Francis Moore and his associates[4] at the Peter Bent Brigham Hospital have made numerous studies of the metabolic response during the convalescent period after surgery. It has been demonstrated that, after even a major surgical procedure such as gastric resection or resection of the large bowel, adrenal cortical function has returned to normal in approximately eight to 10 days and that nitrogen balance is normal in approximately three weeks. Studies by Hardy and Ravdin,[5] and Hardy, Richardson and Dohan[6] have shown the same pattern of response. It appears that there are no measurable metabolic abnormalities which can explain the long periods of convalescence thought necessary by many surgeons and physicians.

Certainly from the studies of Taylor and Keys[2] we know that it is not nitrogen loss that can justify the prolonged periods of convalescence which we see following many surgical procedures.

Experimental evidence from the classic work of Howes and Harvey[7] clearly indicates that maximum wound strength is obtained in two to three weeks. Clinical observation by numerous authorities would support this thesis in uncomplicated cases. Thus in an uncomplicated case in an otherwise healthy individual, fear of disruption of the wound after the third week is usually ill-founded.

If early ambulation has proven beneficial in the early post-operative period, there is much reason to believe that an extension of this concept into the latter phases of convalescence is indicated. Many of you remember the change in thinking that took place following the national conference on the abuse of bedrest and the publications of Dr. Leithauser and others with regard to ambulation.

Numerous studies have indicated that it is safe to return patients to their pre-operative activities at much shorter intervals than has been current civilian practice in the uncomplicated case. We certainly know this is true for animals. Alam and Martin[2] have demonstrated that racing dogs and horses are back on the track following hysterectomy at a far earlier date post-operatively than would be expected from current clinical experiences in man.

Static Convalescence Tradition

Even though the period of hospitalization has been reduced for a number of surgical procedures to one third or less of what it used to be two decades ago, examination of statistics for the total convalescent period during the past 40 years shows very little change. There has been a static tradition of prolonged total convalescence during the past 40 years for appendectomy and inguinal herniorrhaphy.

In the light of these physiological considerations and of increasing clinical experience, particularly from the military, there is mounting support for the concept that earlier return to preoperative activity is not only safe, but may provide increased physiological, psychological and economic benefits.

Experience with a group of Navy boot trainees demonstrates that shorter periods of convalescence than has been civilian practice are safe. Spoont[8] studied 69 trainees who had an inguinal herniorrhaphy. These individuals returned to the vigorous activity of boot training nine to 32 days after operation with an average of 22 days. There were no significant complications or recurrences during a three-month follow-up period.

The experience of the Air Force as reported by Col. Wenger[9] in 1956 and Col. Gold[2] in 1958, the latter at the Symposium on Surgical Convalescence of the New York Academy of Sciences, shows striking contrast to civilian practice. Gold's data indicates that the convalescence times after appendectomy, hemorrhoidectomy and inguinal herniorrhaphy are approximately *one-third* those of current civilian practice, age for age, as judged by insurance statistics and those of Fleming[2] who reported the experience of a very large industrial corporation. Thus for appendectomy, Gold reported an average convalescence of 12.3 days with 50% of the patients being returned to duty in nine days, and 90% by 21 days. For herniorrhaphy, the mean was 13

days with 50% discharged in 10 days and 90% by 22 days. For hemorrhoidectomy, 50% of the patients were back to duty in eight days, and for cholecystectomy 50% were returned in 14 days.

Contrast such convalescent periods with actual experience in civilian practice as indicated by Travelers Insurance Company data as reported by Saffeir.[2] One notes that for young men between ages 20 to 30, the duration is two to three times that of Navy and Air Force experience. There are striking differences between the Air Force experience and that reported by a number of interested observers for herniorrhaphy patients returning to varying types of activity.

We might further illustrate this striking contrast. Experience in a series of appendectomy cases operated upon in a number of hospitals and by a number of surgeons in and near Philadelphia, clearly distinguishes the three-fold difference for patients in approximately the same age group. And for inguinal herniorrhaphy, the opinions expressed in the opinion survey for both light and heavy work as shown earlier again illustrate the striking contrast to Air Force practice.

Savings Important to Manpower

Should the period of convalescence following surgery in civilian practice be reduced just one quarter of what is now customary, Dr. Paul Hawley, Director of the American College of Surgeons,[2] has estimated that the savings to the national economy would be more than one billion dollars a year. Dr. Frank Berry, Asst. Secretary of Defense,[2] has stressed the importance of such a saving on national manpower requirements.

Where does the responsibility really lie? It is our firm belief that the opinion of the attending surgeon is the major factor in determining the total duration of convalescence.

In a special convalescence study which we recently completed, it was found that 64% of the patients returned to their jobs within one week of the day forecasted in writing by the respective surgeon. This forecast time was written from 15 to 64 days (with an average of 34 days) prior to the predicted date of return. Thus the prognosis of duration of convalescence by the surgeon almost five weeks previously was accurate within one week in 64% of the cases. And in 30% of the cases, the patients returned on the exact same day predicted by the surgeon.

For appendectomy, one notes that nearly all patients returned to their pre-operative activities within ± 10% of the prognosis date. And of those who were outside the 10% limits, all but one returned earlier than the surgeon had predicted. The same data are illustrated even more clearly for the convalescence period following inguinal herniorrhaphy. These data lead us to conclude that many individuals are advised to undergo far longer periods of surgical convalescence than is necessary.

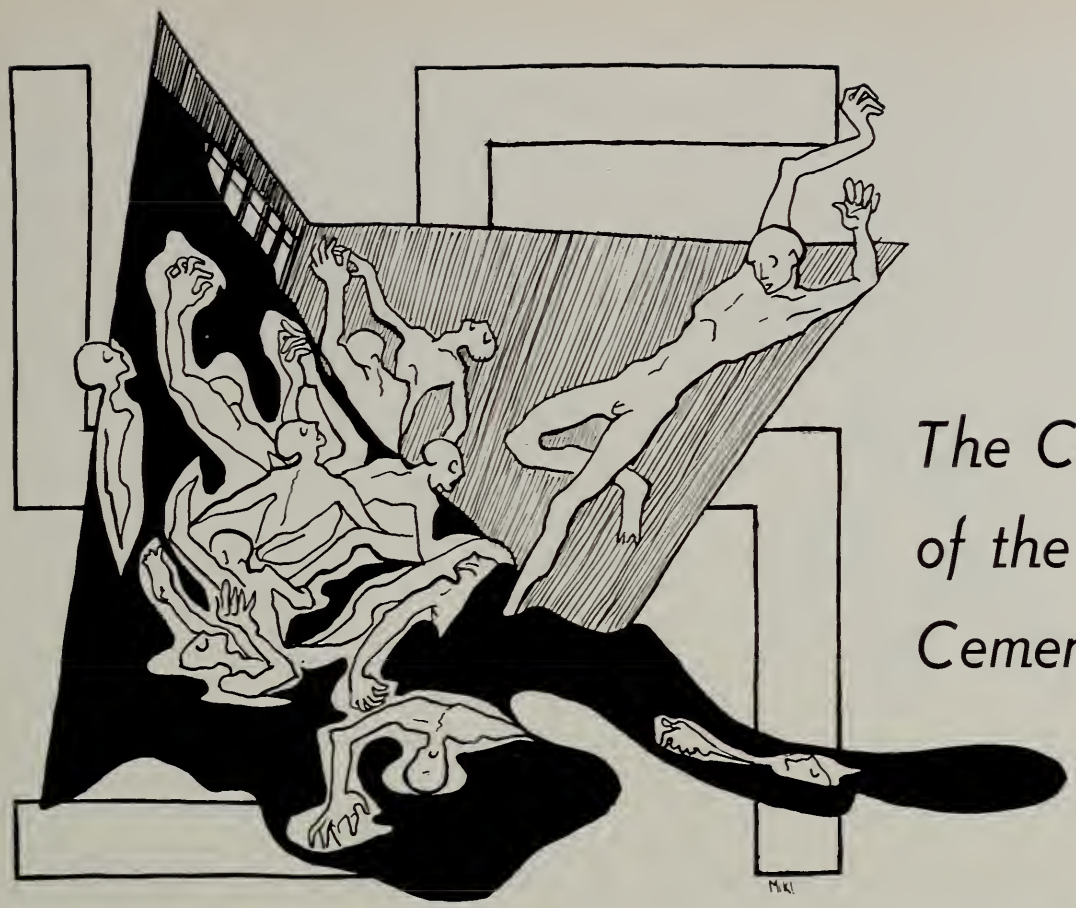
When the patient actually does terminate his convalescence and returns to his job, studies of disability scores reveal that between 50-70% of patients have a zero score, i.e., they have neither symptoms nor positive objective findings. Those returning before the median time show essentially the same distribution of scores as those returning after the median time. We have found that it generally takes at least a week of readjustment for most patients until they are approximately full capacity. This readjustment period exists apparently without relation to the length of the convalescence.

Perhaps these data may be summarized by the experience of Bartels and Johnston who studied the influence of the doctor on convalescent time following inguinal herniorrhaphy. When the time was specifically determined by the responsible surgeon, the duration of convalescence was twice as long as when the patient was told to return when he felt up to it.

In summary, we believe it is physiologically and psychologically appropriate and safe to expect much shorter periods of surgical convalescence than is current civilian practice.

It is up to us as physicians to recognize the importance of shorter periods of surgical convalescence and to incorporate it into our daily practices. ◄

A listing of references will be included in the reprints of this article.



The Case of the Cement Boot

*ARNOLD LIEBERMAN, M.D.**
New York, New York

IT HAD SNOWED in New York that night; window ledges were sheathed with ice; Wasyl Pastiukh (being a window washer) had nothing to grip when his safety belt broke. He fell five floors, but a fortuitous canopy broke the fall; he was somewhat shaken and only bruised slightly. He was taken to St. Clare's Hospital, examined and then sent to our office.

Our orthopod was out to lunch and that is how the patient came directly to me. After the usual preliminaries, he was ushered into my office. He walked in limping slightly. He was short, rather squat and an exaggerated mesomorph of tremendous muscular development. The fresh folder stated that he was a Ukrainian, age 44, widower, married a second time, two teen-aged children, never seriously ill or operated and that he was a member of his union in good standing.

The height was 65″, weight 190, temp. 98.2 F, pulse 72, and B.P. 120/80. The man looked completely calm and unruffled by his harrowing experience. The scalp was clean shaven in the common Slavic fashion popularized by Yul Brynner: the cheek-bones were high Mongoloid; the wide blue eyes were serious and gave intelligence to the face; the mustache was small and trim in the Chaplin fashion and the mouth was straight and firm above a stubborn, out-jutting jaw.

The tale of the accident was confirmed; x-rays of the entire spine, pelvis, and all extremities had already been taken and read as being entirely devoid of fractures; and now the usual routine physical examination was started in a rather perfunctory manner. Wasyl had landed, cat fashion, on his hands and knees; except for trifling bruises and a broken fingernail, he appeared intact. The pupils were equal and regular, reacting to light and accommodation; all teeth were unchipped even if tobacco stained and all arm and hand movements were normal through their entire ranges of motion.

On his left forearm I noticed a tattoo of a row of numbers—that location and type of script I

---

* The fourth of an intermittent series of case reports. Dr. Lieberman formerly practiced in Lake County, Ind. Art by Miki Wilson, San Francisco.



". . . fell five floors . . ."

had seen before. Abruptly I changed from English to Ukrainian and asked, "Did you get this memento in Mathausen?" He looked startled and replied, "Da! Kak Vy znaly—Yes! How did you know?"

We exchanged a few words but he seemed reluctant to bring up ghosts of the past and so I went on with the examination. The heart was ticking away serene and clear; the lungs expanded well and there were no rales or rhonchi; the abdomen was muscled magnificently, there were no masses and there was no undue tenderness. The thighs were thewed as mightily as were his shoulders. In the right groin there was a small hard lump that at first seemed to be a small, incarcerated hernia. However, it was fixed and there was no impulse on coughing; pressure on it made him wince just a little. During the examination, he had kept his socks on. There had been no signs of any limitation of leg movements even if he had seemed to drag his foot a trifle as he had made his first entrance.

Almost Mummified

Wasyl Pastiukh had no qualms about removing his socks when so requested. Down to the ankle the tissues of the right extremity appeared just as did the skin elsewhere; at the malleoli there was a cuff-like border entirely circling the foot. Below this demarcation, the skin was blanched, rumpled tissue-thin; the ankle could be flexed and extended somewhat but there was no motion in the toes; the underlying structures appeared shriveled and shrunken—almost mummified. That really described what I saw; my mind traveled almost automatically to the memory of a mummy I had seen uncovered in the dry sands of Arizona. That, however, was the body of a man long dead; this was a curious attachment to a man very much alive. Just below the outer malleolus, the scar was abraded and oozing slightly.

This was a chronic lesion obviously unconnected with the trauma of that morning. It felt gristle hard and the edge had just the least suggestion of a roll to it; almost automatically I reached for a slide and took some of the serum from the ulcer's surface for a Papanicolau smear. My eyes went from the foot to Wasyl's face; he read the query and uttered, "Auschwitz!" The monosyllable did not encourage further exploration.

X-rays of the chest were taken; the usual routine blood chemistries, c.b.c., urinalysis, etc. were ordered and Wasyl Pastiukh was requested to return the next week for a follow-through when the orthopod would give him clearance. The chest film had some old calcific tbc in both upper lobes, there was also a small pea-sized density that the radiologist wanted to call a coin lesion. He became quite insistent on that when the Papanicolau smear revealed a grade one, borderline grade two, malignancy on the ankle, possibly basal cell but a straight squamous cell affair did not appear to be ruled out.

However, it was that mummified foot that intrigued me especially. Just what had been done to this man? How was I to get the story from him? A couple days later, while mulling over the case, my eye roamed over an article in the N. Y. *Post* of that day. It was over the byline of Seymour Freidin and called "A Name on a List." It dealt with Adolf Eichmann, the grisly Nazi sadist who had supervised the extermination camps, had escaped Allied justice, and was now alive and well, living in the oil-rich Arab country of Kuwait. As my memory was being refreshed, a plan of action re Wasyl Pastiukh began to take form in my mind.

When the patient came in the following week, attached to his folder were both the article on Eichmann and also an item about Krupp having

set aside a couple million dollars as a token restitution to the slave laborers who had toiled in his plants while these were furnishing the sinews of strength to Hitler's juggernaut. First, I congratulated Wasyl on his miraculous escape; then, the several dubious findings were mentioned; lastly, he was stripped completely and subjected to a really searching examination.

That mummified foot intrigued me no end; I asked both the orthopod and our dermatologist to examine it. It was a really surprising appendage; the more it was looked at, the more astonishing it got. That skin was blanched and puckered like an old scar over an ancient burn; the underlying muscles and tendons felt desiccated to ancient leather; the tiny oozing ulcer could have been easily overlooked had we not known the results of the smear—it *did* have that indolent look of a basal cell lesion. We were unanimous in suggesting biopsy excision of this plus more of same for that lymph-node in the groin. The chest film was reviewed; tomographic studies were undertaken right then and there; the "coin" lesion seemed less and less innocent the more we looked. The trifling accident had brought to our office a really formidable problem.

After Wasyl had dressed, he was channeled back to my consultation room; we sat down and he asked permission to smoke. As he relaxed, I made the newspaper clipping re Eichmann appear most conspicuous. "Have you ever heard of this S. O. B.?" I asked Wasyl as I extended the item to him. He took it from me and started reading the story. I could see his face purple as intense anger, hatred and loathing penetrated the chinks in the icy armor of his self-possession. As if not observing his reaction, I passed on the other item anent Krupp with the casual, inane sarcasm, "I suppose that this $1,100 per survivor will salve everyone's conscience, n'est ce pas?"

Flood Gates Burst Open

Suddenly, the flood-gates of Pastiukh's reserve burst open. He leaned forward and pointed a monitoring finger at me. "You Jews have had a sympathetic world press and have made everyone think that Hitler was exterminating Jews only!" He switched to Ukrainian and had said *Vy Zhydy* (you, sheenies, literally) but he meant no offense—his colloquial dialect had no other term. "Let me tell you something!" He did.

"Let us skip my hungry childhood, the peasant scrounging for a living and all that sort of thing. In 1939 I was eking out a living of a sort in a little Polish hamlet far southeast of Warsaw; my wife and I were living next door to my parents; across the muddy ruts was the hut inhabited by my married sister who already had two children. When the Germans invaded Poland, we were all mobilized; all the men were mustered into a cavalry regiment; we were given a lance apiece plus a carbine we did not know how to use. Four days later a column of Panzers caught up with us; of course, you know what happened! We were cut to ribbons; the officers were mostly killed; the men were made prisoners. A few managed to gallop away, I among them. How come? Don't ask me. In the general confusion, I guess I was overlooked. Anyways, I took a week in finding my way home. I found a nondescript German uniform to wear and I rode mostly by night, hiding by day.

"When I approached my own little village I was lucky enough to see that there were a lot of Germans about; I skulked in and so was able to see without being seen. A German line regiment had gotten there just that afternoon. The soliders were just 'relaxing' with the women, children and old folk.

"Now, mind you, doctor! There wasn't a Jew in that village! We were all God-fearing Catholics! And what did those blank blank whoring, bloody bastards do? They sabered the priest; they raped and they killed! Yes! I saw—and could do nothing about it! I *saw* my wife impaled on a pike, her belly ripped open and the baby inside her fed to the hogs! And she still breathing! I *saw* my sister's two little children swung by their feet and their brains bashed out against the gate posts of their yard! These were not S. S. Einsitz Polizei! These were just line troopers practicing their Aryan strength on the sub-human Slavs!" There was concentrated venom, fury and anguish in Wasyl Pastiukh's figure and voice as he gathered his breath to go on.

"So I got away that night! I wore that cursed German uniform and walked and scrounged my way to France—never mind the details! So I got into the French Foreign Legion and found my way to Africa. I started to read and study so I could better myself and so be able to take better revenge on the Germans. Oh, yes! I was going to be another Edmond Dantes; you see, I had read *The Count of Monte Cristo!*

Permitted to Survive

"And along came Rommel and the Afrika Korps. The old story repeated itself; we got caught in a booby trap; our column got strafed by Stukas and sprayed by Panzers. By some miracle, my dead horse and two dead Legionnaires sheltered me from the deadly rain of lead. The Germans pulled me out unconscious from concussion but unhurt; I woke up a prisoner on my way to Mathausen. Being a Pole, I was put to work on the squads making the extermination chambers. That made me one of the aristocrats at Mathausen—one of those permitted to survive and so fed adequately; the others were worked and starved until they faded to skeletons and dropped; then we had to shovel them into the furnaces."

Wasyl Pastiukh was reaching a peak of almost livid ferocity as he poured out in clipped sentences his terrible memories—long contained and now bursting forth in volcanic vehemence. He shook under my nose the article about Adolph Eichmann. "You know how I first met this here monster the first time? He was 'inspecting' Mathausen. Well, there was a young girl still not too wasted by hunger; Eichmann looked at our squad and pointed at the man next to me, 'You, there! strip and mount her!' "

Wasyl lapsed into German at this point giving the harsh gutturals of the barked command; then he went back into his Ukrainian, "Both poor creatures were naked; somehow the poor wretch attempted a fumble at it. Eichmann leaned over, leering sadistically—and then he brought down his saber, thus chopping the member off! Of course, the girl was gashed in the process; Eichmann watched them both bleed to death. Then, Eichmann turned to the Kommandant and cursed coarsely, closing with 'You feed these mongrels too well! They still can breed.' "

Wasyl paused and collected himself a bit. In a more matter of fact tone, he went on, "The rest of our squad was shipped to Auschwitz and we were put on the gas chamber crew. They constructed them like theater stages: conveyor belt efficiency. The victims were made up in platoons of 70, stripped and led into rooms resembling showers, the gas would be turned on, then the side wall would lift and the floor revolve so that the now dead people would be right up against the furnace, the wall would fold back in place, and our squad would have the task of stacking the bodies within the maw of the furnace. First, the Germans made us check the bodies for gold in the teeth and rings on the fingers; an S. S. trooper supervised the job.* Oh, yes! The Nazis were very efficient; they kept the furnaces going around the clock and thus burned many thousands every day. Yes, doctor! I saw this Eichmann around there, too—many times.

Flooded With Fresh Cement

"When the Russians began to approach, these Nazi rats panicked; they knew their turn was coming; they scurried around—as if they could hide their tracks! My entire squad was driven by the guards into the cellar under one of the furnaces; they locked the doors and flooded the place with fresh cement, thus burying the men alive. I happened to be in the far corner; the foul carrion (the Ukrainian was far more vivid and unprintable) did not have quite enough cement to fill the place completely; I leaped up and held on to a pipe in the flue *above* the cellar. However, my right foot had to rest lower and so was lapped by the rising cement and lime mixture.

"I don't know how long I held on and how I survived. The departing Nazis dynamited the furnace; the walls of the flue protected me from the blast even as they were ripped apart unsealing the top of my tomb. When I regained consciousness, it was dark; around me were only the dead and some skeleton inmates soon to drop of starvation but still wandering like wraiths. I still held clutched in my hand the mattock I had been using before being clubbed into that fatal cellar. I hacked away at the cement gripping my foot; it had not had the time to really harden and so I managed to chop out the hunk of concrete encasing that scorched foot of mine. Yes, doctor! That foot there!"

Wasyl pointed at the leg that had puzzled me so sorely, "You might say I acquired a CEMENT BOOT attached to my leg; it hardened rock solid as I crawled away from that abode of horrors. Well! I'll make it brief! I got in with some guerrillas. They had no tools for chipping the cement off without chopping off the leg at the same time and I did not want to bleed to death. Anyways, that boot made a wonderful weapon; there was a metal chunk of the flue

* For the tougher fibered reader I would recommend as further literature—Rudolf Hoess: *Commandant of Auschwitz,* Trans. by Constantine Fitzgibbon. Wared, 285 pp., $4.50.

embedded over the area of the toes and I learned to use it as a spike. How many S.S.'ers faces did I grind it into! And how effective was it when I kicked it into a groin!"

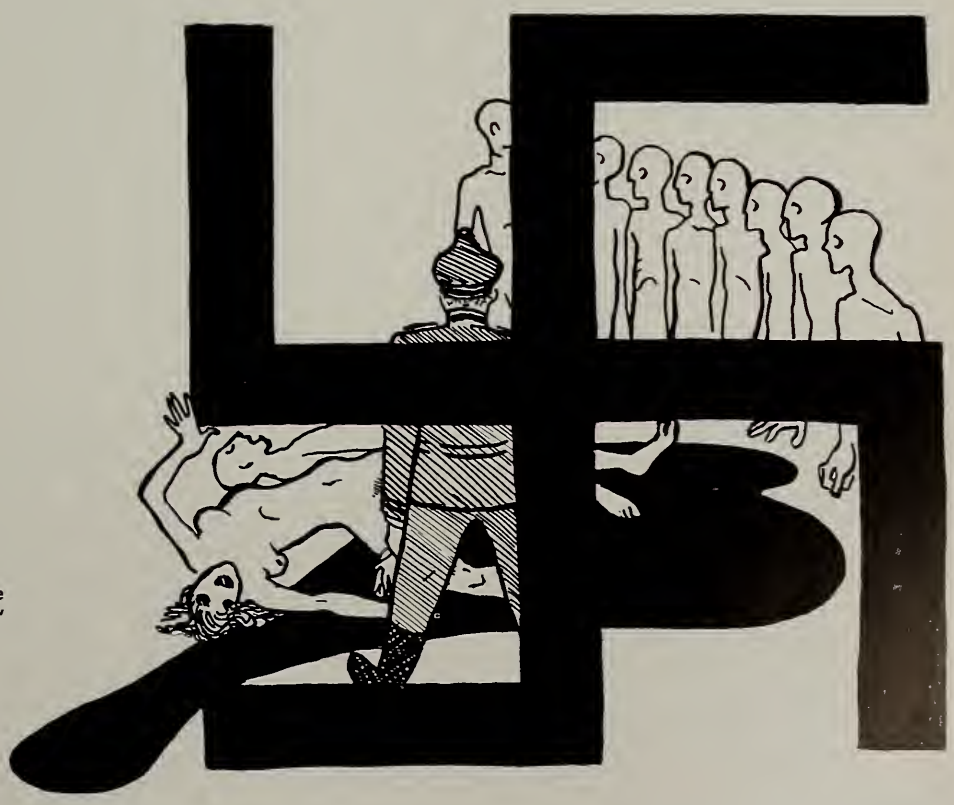
Pastiukh, the quiet farm lad born in a remote Polish hamlet, stopped to think back for a moment. "Yes, every time we caught some of these Nemstis (what venom there was in the hiss of that), I would think of my wife and the unborn babe—and other things! Yes, doctor! It was a pleasure to stuff their own testes down their throats and hang them by their own guts while still conscious!" It was the avenging guerrilla fighter who was clenching mighty fists in that office of mine.

"Why didn't I join the Russians? Well, they weren't such angels either! (Wasyl used the term, tsatskas, an unprintable adjective.) Stalin had decreed that Russians had had no business being taken prisoner of war, so he had ordered mass executions of repatriates and I just had no hankering for being mistaken for a *Russian*-born Ukrainian. That's why!

"Anyway, my guerrilla band drifted westward; one late afternoon, a retreating German division blundered right upon us; we were machine-gunned as we tried to run for cover; they were all killed; I tumbled into a ravine and an overturned ammuntion cart covered me from detection. I laid low and played dead until late at night; the Germans had left and I crawled away unscathed. I drifted to the American zone; I spoke French and told them I was a Legionnaire; this was verified; I got French citizenship; the cement was scraped off the foot; I refused amputation; I emigrated to New York. I make a living; I study so I can forget, but still, at night, I awaken often to—memories. . . . I *hear* those pigs chomping on that unborn babe of mine: I *hear* the screams of that poor lad bleeding to death in Mathausen; AND, doctor! I *hear* this monstrous Eichmann smirking to the Kommandant, 'You feed these mongrels too well! They still can breed!' "

Pleasure to Stoke Fires of Hell

Wasyl Pastiukh had again worked himself into a furor of frenzy as his satanic recollections overwhelmed him. And then the blast shrank—visibly; the emotions shriveled and subsided; almost impassively he handed me back the newspaper clippings. We were back in the English language; the year was 1959; and the place was New York. "Yes, doctor! I'll be glad to enter the hospital for this excision biopsy and the possible chest exploration and all the other things you doctors have been talking about. The outlook is not so very good, is it? Well, it will be a positive *pleasure* to go to hell and wait in the deepest pit there! Just wait for Eichmann and



"you feed these mongrels too well . . ."

Krupp to be tossed in; I'll gladly stoke the fires under them still hotter! I AM a religious man!"

But the hospital examination was not to be; the Lord God of Hosts himself decreed otherwise. Christmas was only a week away; the streets were slippery with sleet and slush. Wasyl Pastiukh was going to the grocery store around the corner from his quiet Bronx home. Just as he stepped off the sidewalk, a car turned the corner a mite too sharply and skidded a trifle. Wasyl was side-swiped and thrown to the ground; his neck was snapped neatly; he never knew what struck him. The usually accurate N. Y. *Times* left off the final "h" in the spelling it gave his name when it carried a three-line obituary notice in the appropriate column of its next day's edition.

Dante's *Inferno* was re-read by me that weekend; I wondered if Wasyl's wish to *wait* down there was being granted. And then the words of the Kaddish—the unbending and yet hopeful ancient Hebraic chant for the dead—came to me clearly. I stood up and recited "Praised and glorified be the name of the *Holy One* though He be above all the praises we can utter . . . May the Father of peace send peace to all who mourn and comfort all the bereaved among us."

Somehow, I knew that Wasyl Pastiukh heard me and understood. . . . ◄

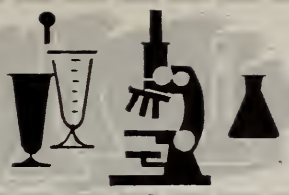
1026 Sixth Ave.
New York, N. Y.

Munchausen's Syndrome

I have only once named a disease and that was Munchausen's syndrome. I discovered nothing about it; I only described something that most doctors knew already and gave it a name. Yet the effect of christening it astounded me: case-reports, articles and correspondence on the subject have continued ever since, both here and abroad; new names are added to make it more confusing, and new explanations offered for its occurrence (in America the allegation has been made that it is only caused by the National Health Service).

Finally, a psychiatrist and a psychologist have been making a special study of it for over four years; they have a flying squad standing by for 24 hours a day ready to collect cases from anywhere in the country. They keep them in for months (to the great benefit of the community) and they ask them what different-shaped ink splotches remind them of (with less definite benefit to the community).—Richard Asher: Making Sense. *The Lancet,* Sept. 19, 1959. Reprinted in *Armed Forces Medical Journal,* Vol II, No. 4, April, 1960.

Path-finder
PUBLISHED UNDER THE AUSPICES OF THE INDIANA ASSOCIATION OF PATHOLOGISTS



An effort to help the public by helping the courts, coroners, police, industry and the doctors.

Commission on Forensic Sciences

THAT WHICH is everybody's business is nobody's business (Izaak Walton). This statement applies to many public problems and is exemplified by the neglect of the sciences as aids to legal decisions.

Although a majority of legal decisions involve medical facts and opinions, most physicians avoid courtrooms, lawyers and public office. The reluctance of physicians to participate in legal matters stems from (a) the inconvenience and publicity attending legal proceedings, (b) the lack of training in forensic problems and (c) the lack of scientific help to detect physical evidence.

Indiana lacks scientific help in many fields for detection and analysis of evidence (except for toxicology, criminalistics and questioned documents). It is estimated that much loss of time and money and numerous incorrect legal decisions are the result of inadequate scientific evidence on which to base proper conclusions. The innocent may be convicted and the criminal may go undetected because of lack of scientific help.

A study of Indiana's services in the "legal sciences" (classification by the American Academy of Forensic Sciences) reveals certain deficiencies as presented here:

	FORENSIC SCIENCES	SERVICES AVAILABLE
I.	Criminalistics (police sciences, photographs, fingerprints, footprints, tire-marks, firearms identification, paint analyses, etc.)	*Greatly variable:* many local policemen have only a vague notion as to how to preserve physical and medical evidence, although some services are excellent. More courses are needed in the School of Police Administration, Indiana University, Bloomington, and at conventions of police, coroners, etc.
II.	Immunology (identification of blood, tissues and secretions)	*No qualified immunologist available.* Blood, tissue and semen identification now forced on the State Police Laboratory and on many others who are not adequately trained.
III.	Jurisprudence	*Lawyers* and prosecutors dealing with personal injury and numerous other types of cases need help in evaluating hypotheses and facts. More claims could be settled out of court if a panel of medical experts were named by the Supreme Court of Indiana (a law is needed).

IV.	Psychiatry	*A forensic phychiatrist* is needed to teach medical students and physicians in the identification of dangerous mental patients and in evaluating accusations made by hysterical or psychotic persons. Time, trouble and lives could be saved.
V.	Pathology (injuries from mechanical, physical or chemical trauma)	*A forensic pathologist* is needed to conduct training courses for pathologists, coroners, prosecutors and others who could use anatomic evidence in legal matters. The forensic pathologist could consult with pathologists in Indiana and give service as needed. Some pathologists now avoid the courtroom because of the inconvenience and the lack of encouragement to participate. Funds are frequently not available. More readily accessible help in tissue analysis (microscopic, toxicologic and immunologic) would permit the pathologist to conduct a thorough investigation for the coroner and others.
VI.	Toxicology (alcohol, drugs and poisons in pure form, mixtures, or in blood and tissues)	*Excellent services now available* (Dr. Robert B. Forney, State Toxicologist, Indiana University School of Medicine). Coroners and others lack funds and incentive to use the services properly.
VII.	Questioned Documents (handwriting, manuscripts, ink, typing, etc.)	*Excellent services available to governmental agencies only* (Captain Schroeder, Indiana State Police. Possibly this service should be under the Commission on Forensic Sciences to make it available to all citizens).
Other fields:	(radiology, dentistry, bacteriology, anatomy, physical anthropology, geology, botany, drugs, poisons, volatile solvents, highway engineers, automotive engineers, aeronautical engineers, electrical engineers, safety experts, veterinarians, etc.)	*There are many* teachers, researchers, manufacturers and other experts in Indiana who could be identified and listed as available for consultation with public officials and private citizens when needed.

The Commission on Forensic Sciences proposes to follow the directive given by the General Assembly to:

(a) determine the needs for forensic sciences in Indiana.

(b) conduct research in areas not otherwise covered by agencies in the state.

(c) teach forensic sciences to public officials, medical students, physicians and interested private citizens.

(d) provide service in scientific areas and in geographic areas not provided with suitable service.

The Commission of Forensic Sciences, Dr. Andrew C. Offutt, secretary, 1300 W. Michigan Street, Indianapolis 7, Ind., is trying to determine ways and means of using sciences and scientists in legal matters. If you have suggestions or any information regarding matters of interest in the field of forensic sciences please send them to the commission.

Created by General Assembly

The Commission on Forensic Sciences was created by the 1959 General Assembly of Indiana through the passage of Senate enrolled act No. 381. The commission is directed to promulgate

the use of forensic sciences in the state and to establish facilities for research, teaching and service in those areas not already available through some other agency.

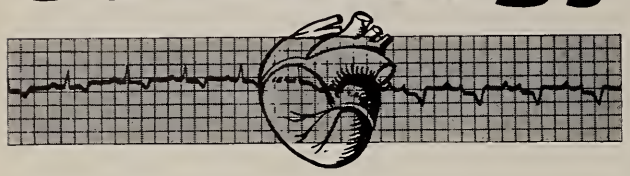
The commission is the result of many years of interest and study by representatives of the bar association, law school, coroners, medical association, medical school, pathologists, sheriffs, state police, traffic safety commission, legislators and numerous private citizens.

The state health commissioner (Doctor Andrew C. Offutt) is the permanent secretary-treasurer of the commission. The other members serve staggered terms of four years and presently are Lt. Charles A. Davis, Chairman, Commission on Forensic Sciences, Director of Laboratories, Indiana State Police, Stout Field; Mr. Lee M. LeMay, Indianapolis attorney, formerly Chief Deputy Attorney General, State of Indiana; Roy B. Storms, M.D., Coroner, Marion County, Indianapolis; Edward B. Smith, M.D., Chairman and Professor of Pathology, Indiana University School of Medicine, Indianapolis. ◄

Stop the Presses

Although I firmly believe that the discipline of research of controlled observation is a vital ingredient in medical education, has not the demand for printed evidence of submission to this discipline got somewhat out of hand? Are not journals cluttered up with indifferent work and does not good work have to wait too long for publication? . . . Perhaps if all journals agreed to stop publication for six months every five years, it might give everyone time for reflection and time to decide whether there is room for both *pointillisme* and polysaccharides, and coproporphyrins as well as Copernicus, and whether Emile Zola's realism and the Zollinger-Ellison syndrome are mutually exclusive Phenomena.—J. F. Stokes: "A British View of an American Hospital." *New England Journal of Medicine,* Jan. 8, 1959. Reprinted in the *Armed Forces Medical Journal,* Vol. 2, No. 3, March, 1960.

Condensed Cardiology



Presented as a regular feature of The JOURNAL, Condensed Cardiology is a series of short talks on cardio-vascular diagnosis and treatment, edited by the staff of the Robert M. Moore Heart Clinic of the Marion County General Hospital, Indianapolis.

Diagnosis of Chronic Pericardial Effusion

*EDWARD F. STEINMETZ, M.D.**

Indianapolis

PERICARDIAL EFFUSION is synonymous to many of us with cardiac tamponade and implies elevated venous pressure, paradoxical pulse, distant heart sounds, enlarged liver with or without pedal edema, water bottle contour of the heart on x-ray, lack of pulsation during fluoroscopy and an electrocardiogram showing low voltage. These prerequisites as passed down through the years have hampered the early diagnosis of effusion and its differentiation from enlarged heart. In many patients simple congestive failure may manifest all the classical signs of pericardial effusion. On the other hand we have seen patients with chronic pericardial effusion without any of the "classical" signs mentioned earlier.

In this brief paper cases with enlarged silhouette suggestive of effusion but without the classical signs will be reported. The etiology of pericardial effusion will not be considered here.

Case Reports

Case 1. A 54-year-old woman was first found to have hypertension and recurrent atrial fibrilation during hospitalization for treatment of "myocardial infarction in 1953." She was readmitted in May 1955 and in December 1956 because of classical signs of acute "left ventricular failure." During the interim, maintenance therapy of digitalis, sodium restriction and occasional injection of a mercurial diuretic was given, despite which the cardiac silhouette continued to enlarge. Repeated fluorocopic examinations failed to demonstrate cardiac pulsation.

The patient was rehospitalized in November 1957 for diagnostic studies because of relative freedom from symptoms in spite of marked cardiomegaly. There was neither venous distention nor paradoxical pulse. Blood pressure varied from 140 to 180 mm of mercury systolic and from 75 to 80 mm diastolic. The apical impulse was easily felt and was, in fact, described as heaving. Heart sounds were of good quality. On fluoroscopic examination, there was marked cardiac enlargement. No visible pulsations were noted, a finding confirmed by kymographic studies. The electrocardiogram showed good voltage of QRS complexes and nonspecific ST-T changes. Angiographic studies showed evidence of pericardial effusion. Diagnosis was confirmed at operation.

Case 2. A 44-year-old man was hospitalized in November 1956 and treated for "coronary thrombosis with myocardial infarction." Subsequently there developed increasing dyspnea, orthopnea, pedal edema, and recurrent chest pain on effort. In November 1957 the patient was again hospitalized, and was in obvious distress with severe dyspnea and orthopnea. Significant findings on physical examination were cyanosis,

* From the Robert M. Moore Heart Clinic, Marion County General Hospital.

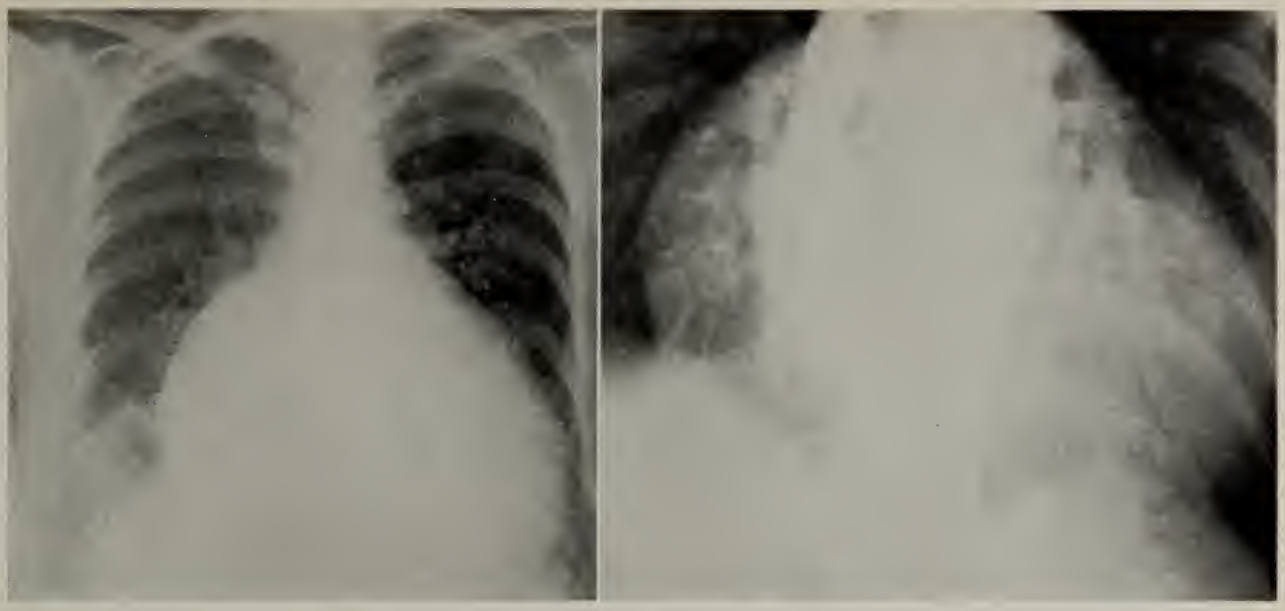


FIGURE 1
CHEST X-RAY and angiocardiogram for Case 1.

venous distention, pulse rate of 90 per minute, absence of paradoxical pulse and blood pressure of 140/120. The point of maximal impulse was easily felt in the anterior axillary line. Heart sounds were distant. There were rales in both bases of the lungs and signs of severe right-sided heart failure.

Radiographic signs included cardiac enlargement and absence of visible pulsation. The electrocardiogram showed normal voltage of QRS and nonspecific ST-T changes. Pericardial paracentesis with use of xiphoid and apical approaches was performed repeatedly, but no fluid was recovered. Angiographic studies, however, disclosed a huge pericardial effusion. The diagnosis was confirmed by aspiration of 5,000 cc of fluid from the pericardium, which was entered in the fourth intercostal space to the right of the sternum.

Case 3. A 44-year-old woman was seen on September 29, 1958. Because of carcinoma of the cervix, radium was implanted. She was readmitted on October 22, 1958 for further treatment with radium. Her blood pressure at that time varied from 132 to 110 systolic and from 68 to 90 diastolic. Chest films taken on August 27, 1958 (prior to admission), on October 30, 1958 and on November 4, 1958 were described as showing "marked cardiac enlargement."

The patient was readmitted on December 1, 1958 and was first seen by the cardiology section on December 12, 1958. Her blood pressure then was 166 systolic and 100 diastolic. There was no abnormal venous distention, and no paradoxical pulse. The PMI was easily felt and the precordium was definitely heaving in character. Heart sounds were of good quality. Chest x-ray on December 4, 1958 revealed a markedly enlarged heart. Fluoroscopy revealed that "pulsations appear fairly active. There is some change in the contour of the heart when the patient is changed from upright to supine position, though this is felt to be within normal limits and no abnormal widening of the base of the heart is demonstrated. Though a pericardial effusion cannot be excluded on the basis of this examination, the findings tend to rule against it." The EKG on November 10, 1958 and on December 3, 1958 when examined independently were normal as to voltage of QRS. However, comparison of the two showed a decided dimunition of the voltage of QRS on December 3, 1958.

Discussion

While present medical teaching supplies a high index of suspicion of pericardial effusion, the diagnosis is not made early enough because of lack of all the previously mentioned signs and symptoms. Too often the diagnosis is discarded because there is no distention of neck veins, the friction rub is too loud, there is no orthopnea, heart sounds are too good, ventricular pulsations are too good on fluoroscopy, etc. While the accumulation of pericardial fluid produces the above findings it doesn't always produce all of these as evidenced by our three cases. There is an increasing number of case reports of chronic idopathic pericardial effusion with few of the

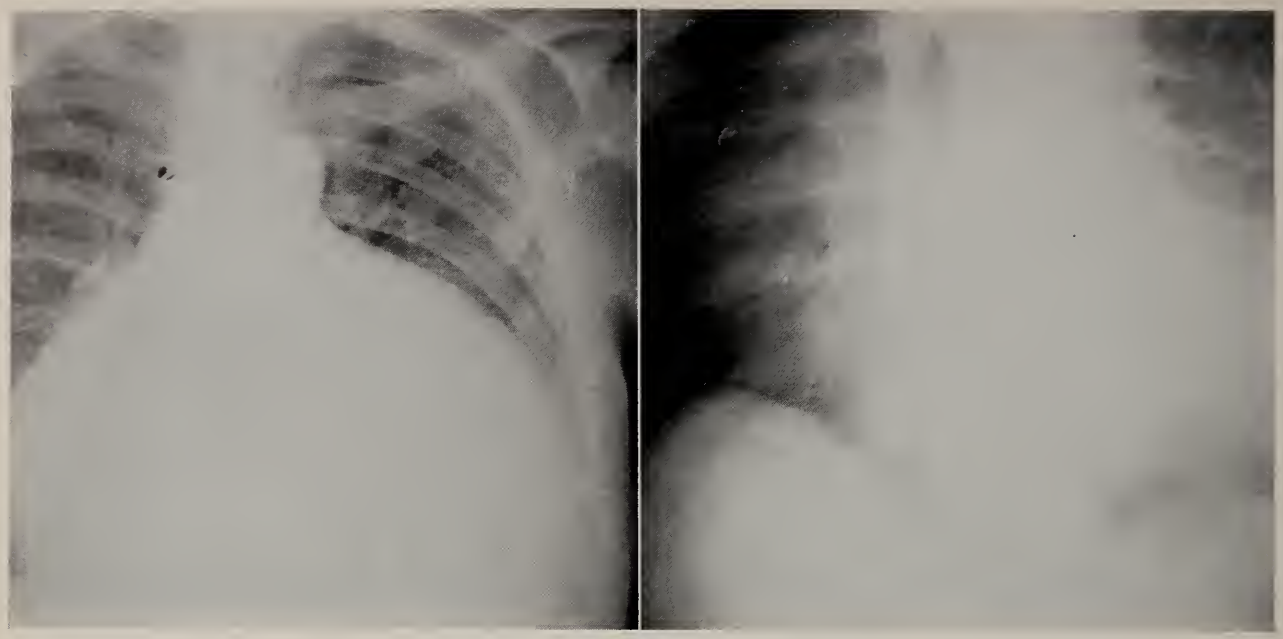


FIGURE 2
CHEST X-RAY and angiocardiogram for Case 2.

"typical" findings of effusion in the early stage of the disease, some of which were followed for eight years.[1, 2, 3]

The evaluation of clinical symptoms and signs may or may not be helpful. None of the patients presented here gave a history of chest pain that would suggest pericardial disease. While typical pericarditis pain may alert the examiner for effusion, slow accumulation of fluid with resultant large volumes may produce no pain. Other complaints such as swelling of the feet, shortness of breath and occasionally orthopnea occur in congestive heart failure due to a variety of heart diseases and are of no help in early diagnosis.

The basic defect in tamponade is impaired diastolic filling due to restriction either by increased pericardial pressure or constriction by scar tissue. The resultant decrease in cardiac output and increase in venous pressure are apparent at the bedside particularly during inspiration when less blood is returned to the left heart producing a paradoxical pulse. This alteration in cardiac output exaggerates a normal physiologic response, i.e. with the patient breathing deeply but

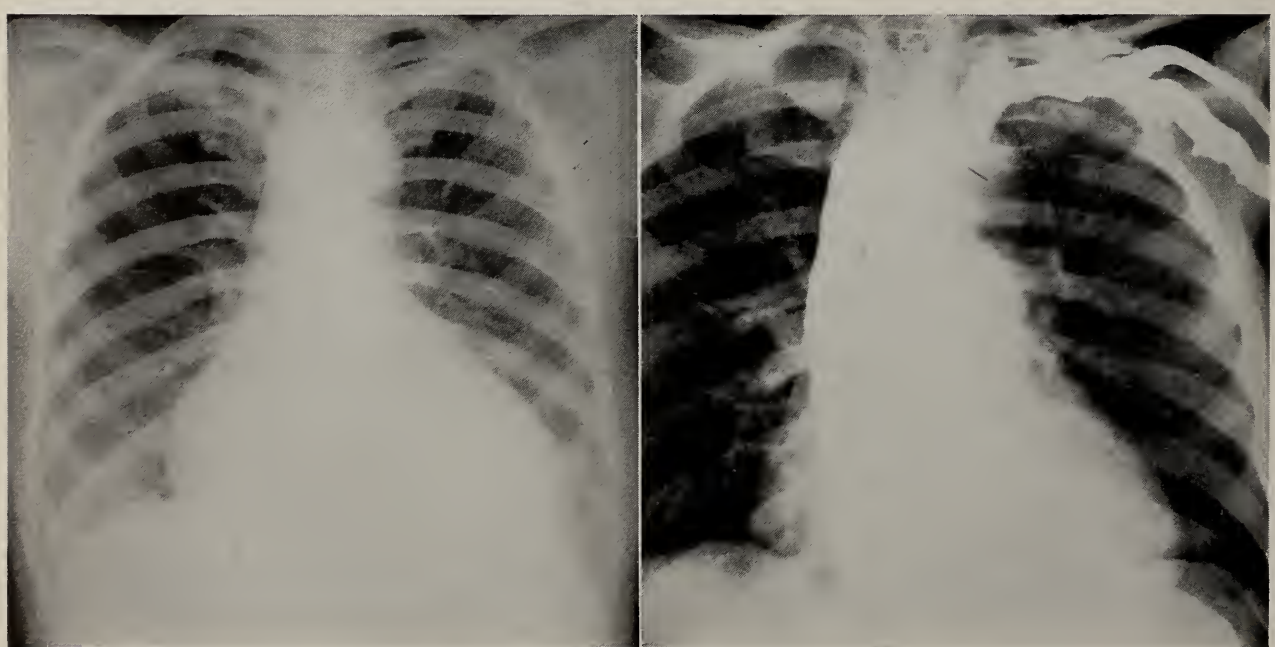


FIGURE 3
CHEST X-RAY and angiocardiogram for Case 3. The faint right heart border has been marked in pencil.

not to full extent of inspiration or expiration, a fall of five mmHg in the systolic blood pressure during inspiration is within normal limits. As tamponade develops the drop becomes more pronounced so that the pulse becomes weaker, the drop in systolic pressure increases with narrowing of the pulse pressure and eventually the radial pulse disappears on inspiration.

In the terminal stages of tamponade, diagnosis may be difficult, as loss of blood pressure, increased venous pressure with venous pooling in viscera and extremities would be indistinguishable from shock due to other causes, particularly myocardial infarction. Williams[4] states that in tamponade the degree of cyanosis in the hands and feet from pooling is out of proportion to cyanosis elsewhere in the body as compared to cyanosis occurring with shock secondary to myocardial infarct. In his review of 17 cases of tamponade, pulsus paradoxus was overlooked in nine of 17 cases. In our cases it was reported present in only one patient.

Diagnosing Pericardial Effusion

Increasing venous pressure with distention of neck veins in the upright position has been passed down through medical literature as pathognomonic of pericardial effusion. This finding may occur normally in recumbent position in overweight persons, in superior vena cava syndrome or with any cause of pulmonary hypertension with tricuspid insufficiency. In Williams'[4] 17 proven cases of effusion not a single case of distended neck veins in upright position was seen. However, pulsating neck veins with the patient sitting upright were seen in all cases. This sign of increased venous pressure is very helpful in aiding the diagnosis of effusion but is aslo present in constrictive pericarditis or disease of the tricuspid valve.

Chest x-ray studies may give the earliest evidence of effusion. The globular appearance is almost pathognomonic. Cardiomegaly may be the earliest finding in the absence of symptoms as in Case 3. Fluoroscopy may help by showing a decrease in pulsations or change in shape with change in position. However, a pericardium tense with fluid may not show the latter change.

In those cases where effusion is suspected but clinical signs and laboratory studies are inconclusive, pericardial tap may establish the diagnosis and at the same time relieve symptoms. Occasionally, as in Case 2, a "dry" tap may occur

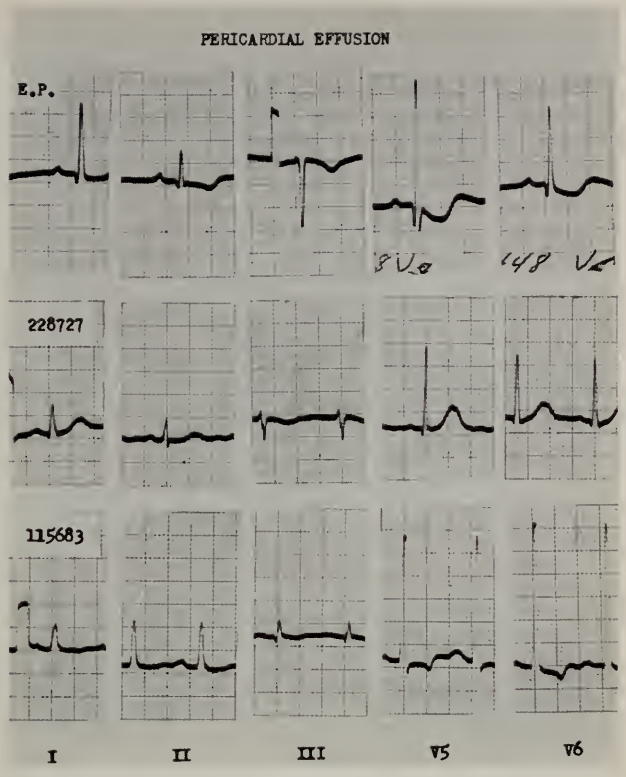


FIGURE 4
ELECTROCARDIOGRAMS from each of the respective cases at the time of diagnosis. The good voltage is another finding against the presence of effusion.

in the presence of fluid. Diagnostic tap may at times become therapeutic in that the procedure may establish a permanent window so that fluid drains into the pleural space. A therapeutic tap may yield dramatic clinical results even though only a few cc's are obtained. Experimental injection of fluid into the dog's pericardium[5] has shown that after injection of 70-80 cc, the next 5-10 cc cause a marked fall in blood pressure and rise in venous pressure. Therefore, obtaining only 5-10 cc may relieve the immediate threat to life until a surgical pericardiotomy may be performed.

Two other procedures are also diagnostic for effusion. Cardiac catheterization may show it by observing the position the catheter assumes in relation to the right heart shadow. This technique does not aid in differentiating effusion from constrictive pericarditis, as both will displace the catheter away from the right heart border. For this reason, angiocardiography has been advocated. Pericardial disease will show a flattened intra-cavitary shadow while effusions show convex intra-cavitary shadow. Case 3 was diagnosed by injecting 40 cc of 90% hyapaque into the left antecubital vein in 10 seconds. The patient experienced no serious side effects from this procedure.

In summary, the early recognition of pericardial effusion is difficult on the basis of the so-called typical findings. It is imperative to establish the diagnosis early because slow accumulation of fluid may be asymptomatic until accumulation of a few extra ml of fluid may so jeopardize cardiac function as to cause a sudden demise. Additional technics that may help establish the diagnosis early are presented.

REFERENCES

1. Cantro, S., De Giuli, G., Ragazzini, F.: Chronic effusive pericarditis. *Cir.* 11:844, 1955.
2. Soloff, L. A., Zatuchni, J.: The definitive diagnosis of effusive or constrictive pericarditis. *Am. J. M. SC.* 234:687, 1959.
3. Connolly, D. C., Dry, T. J., Good, C. A., Clagett, T., Burchell, H. B.: Chronic idiopathic pericardial effusion without tamponade *Cir.* 20:1095, 1959.
4. Williams, G., Soutler, L.: Pericardial tamponade. *Arch. Int. Med.* 94:571, 1954.
5. Evans, J. M., Walter, C. W., Hellums, H. K.: Alterations in the circulation during cardiac tamponade due to pericardial effusion: an experimental study employing cardiac catheterization. *Am. Heart J.* 39:181, Feb., 1950. ◄

The New Neurology

Modern clinical neurology is tending to veer away from the minutiae of the neurological examination in favor of a broader study of the patient. The precise localization of the lesion has given way to an analysis of the disturbance of function in terms of the underlying physiological, biochemical and metabolic disturbance. Accuracy of localization by a careful neurological examination is not to be decried, but lesions in the nervous system, particularly in the case of tumor where localization is so important, can now be sharply delimited by electroencephalography, pneumoencephalography, angiography and myelography.

The surgeons who operate on patients desire information with regard to exact extent, blood supply and the like, which can be obtained from these special tests. They are rarely willing to operate on patients without this valuable additional information. The clinicians who deal with other organic and functional diseases of the nervous system now turn to the physiologist and biochemist for aid in the solution of their problems.—H. Houston Merritt: "The Evolution of Neurology." *Bulletin of the New York Academy of Medicine,* Nov., 1959. Reprinted in the *Armed Forces Medical Journal,* 2:3, Mar., 1960.

...Pathibamate® 400 200

meprobamate with PATHILON® tridihexethyl chloride Lederle

greater flexibility in the control of tension, hypermotility and excessive secretion in gastrointestinal dysfunctions

PATHIBAMATE combines two highly effective and well-tolerated therapeutic agents:

meprobamate (400 mg. or 200 mg.) widely accepted tranquilizer and...

PATHILON (25 mg.)—anticholinergic noted for its peripheral, atropine-like action, with few side effects.

The clinical advantages of PATHIBAMATE have been confirmed by nearly two years' experience in the treatment of duodenal ulcer; gastric ulcer; intestinal colic; spastic and irritable colon; ileitis; esophageal spasm; anxiety neurosis with gastrointestinal symptoms and gastric hypermotility.

Two dosage strengths—PATHIBAMATE-400 and PATHIBAMATE-200 facilitate individualization of treatment in respect to both the degree of tension and associated G.I. sequelae, as well as the response of different patients to the component drugs.

Supplied: **PATHIBAMATE-400**—Each tablet (yellow, 1/2-scored) contains meprobamate, 400 mg.; PATHILON tridihexethyl chloride, 25 mg.

PATHIBAMATE-200—Each tablet (yellow, coated) contains meprobamate, 200 mg.; PATHILON tridihexethyl chloride, 25 mg.

Administration and Dosage: **PATHIBAMATE-400**—1 tablet three times a day at mealtime and 2 tablets at bedtime.

PATHIBAMATE-200—1 or 2 tablets three times a day at mealtime and 2 tablets at bedtime.

Adjust to patient response.

Contraindications: glaucoma; pyloric obstruction, and obstruction of the urinary bladder neck.

Lederle LEDERLE LABORATORIES, A Division of AMERICAN CYANAMID COMPANY, Pearl River, New York

The Journal

of the INDIANA STATE MEDICAL ASSOCIATION

Devoted to the interests of the medical profession of Indiana

Editor: Frank B. Ramsey, M.D., 1802 North Illinois Street, Indianapolis 2, Indiana

Associate Editors: A. W. Cavins, M.D., 221 South Sixth Street, Terre Haute, Indiana; Lall G. Montgomery, M.D., Ball Memorial Hospital, Muncie, Indiana; David A. Bickel, M.D., 515 Odd Fellows Building, South Bend, Indiana; Stephen L. Johnson, M.D., 521 Sycamore Street, Evansville, Indiana.

Editorial Board: Term Expires

George M. Johnson, M.D., Richmond . . Dec. 31, 1960
Irvin W. Wilkens, M.D., Indianapolis . Dec. 31, 1960
Harold D. Lynch, M.D., Evansville . . Dec. 31, 1961
Jene R. Bennett, South Bend . . . . Dec. 31, 1961
Samuel R. Mercer M.D., Fort Wayne . Dec. 31, 1962
Franklin F. Premuda, M.D., Hammond . Dec. 31, 1962

Necrologist: James B. Maple, M.D., 117 West Washington Street, Sullivan, Indiana.

Assistant Editor: Sara M. Snyder

Business Manager: James A. Waggener

1019 Hume Mansur Building, Indianapolis 4, Indiana

Retirement — Activity or Apathy?

RETIREMENT OFTEN FALLS short of expectations. Everyone anticipates the joys of retirement, few achieve complete happiness when it arrives.

While it is a common failing of humans to daydream more into a situation than its actuality warrants, in the case of retirement, much of the disappointment is preventable.

Many of the troubles which develop are due to lack of preparation and planning. Today, more and more hard-working citizens are retiring or are being retired when they are still active, both mentally and physically. It takes quite a bit of doing to make the change and remain content.

Dr. Raymond Harris discusses the situation in the February issue of *Journal of the American Geriatrics Society* in an article entitled "Does the Pension Mean a Ticket to the Human Scrapheap?"

Dr. Harris thinks that most of the ills of the aged are the result of poor adjustment to retirement. He advocates a three-way program:

1. Periodic health checkups, particularly during the two decades from 40 to 60, when "the most critical phase of aging occurs."
2. A flexible retirement program which would permit a healthy employee to continue beyond a fixed retirement age.
3. Advance development of new interests to ward off apathy, the greatest danger to the aged.

Dr. Harris considers the third point the most important. He advises preparation for retirement at least five to 10 years in advance.

Many large corporations with fixed retirement ages conduct regular training programs aimed at conditioning and preparing prospective retirees for this "change of life."

Abandonment of the fixed retirement age, or the elevation of the fixed age to a more realistic level, would be a tremendous help. Today, people at age 65 are as a rule in remarkably good health. Increase in the life span and improvement of the life expectancy for those who approach age

65 should favor the retention of old and experienced employees who are in good physical health.

Certainly if industry and business is to continue a fixed retirement rule, its critical age should advance with the advancing life expectancy.

Best of all would be a retirement rule which took into account the physical and mental capabilities instead of chronological age. There is a lot of work to be done in the world. Skilled and efficient workers should be privileged to continue at it as long as they are capable and wish to work.

Americans More 'Health Conscious'

HEALTH EXPENDITURES in the United States increased considerably in the five-year period from 1953 to 1958. Classification of the total expenditure into what the money was spent for and by whom—as to sex and age—showed significant changes in most categories.

The Health Information Foundation recently published the results of a second survey on family medical costs. The data was collected for a consecutive 12-month period in 1957-58. Comparisons are made with a similar survey conducted during a 12-month period in 1952-53.

The second survey showed an annual family expenditure of $294, an increase of 42% in the five-year period. As would be surmised, the spread from the average was wide: 2.9% of the families reported no expenditure and 0.7% of the families reported expenditures over $2000. The pattern of uneven distribution was the same for both studies, but this was almost the only facet of the two surveys which did not change.

In general, spending on health is higher for women than men and usually increases with the age of the individual. In the period from 1953 to 1958 the sex difference was lessened. Increases by age group were changed in that the largest increase occurred in expenditures for children under six and for people over 65.

The increase was due to two things—price increase and more usage of health services. Overall, the increased usage was responsible for slightly more of the higher expenditures than was increase in prices. In the case of drugs and dentists more of the increase was due to usage. In the case of physicians and hospitals slightly more of the increase was due to price.

The "medical care dollar" was split up differently in 1958 as compared with 1953. Percentages spent for each component of "all personal health service" are expressed as fractions of the hypothetical "dollar." In 1958 the physician's share of the "dollar" was 34 cents, down three cents from 1953. Hospitals absorbed 23 cents, up four cents; drugs 20, up five; dentists 15, down one, and all other goods and services were eight cents, down five.

Such changes are understandable when it is realized that although the total doctor bill increased during the five years by 42%, its proportion to the total health care bill fell slightly due to increased use of hospitals and to the increase in relatively expensive but more effective drugs.

The report as a whole indicates that the American people are becoming more health conscious and are willing to budget more money for this purpose. The increase in expenditures for care of children under six years of age is encouraging since this is the age group in which preventive care will contribute to a lifetime of better health.

It is likewise encouraging to note that expenditures for the population over age 65 is increasing. During the five years the number of persons covered by voluntary insurance rose by 14%; among those over 65 the number with such insurance rose by 40%.

'Progressive' Care Experiment

THE NEWSPAPER, Chicago's *American,* published an interesting hospital story in its Sunday edition on April 24.

Written by Wesley Hartzell, the special feature outlined the experiences of a woman patient in Grant Hospital where she spent 15 days obtaining a diagnostic study, undergoing major surgery and recovering. The interesting part of the story stems from the fact that she was cared for by a "progressive" care plan which is under investigative use at Grant Hospital.

Under the "progressive" care plan the hospital is divided into several zones, each one equipped and staffed to provide a different intensity of patient care. This ranges from the "do-it-yourself" department which has almost no nursing

care up to the super-intensive zones of which the surgical recovery room is an example.

The patients are moved from one zone to another as their conditions and needs for care change. When the plan works ideally no patient is ever in a care zone which provides much more service and attention than is required.

The patient described by Mr. Hartzell was in six different rooms in Grant Hospital during her 15-day stay. She was well satisfied, received excellent care and is quoted as humorously observing that she moved so often she did not understand how the doctors kept track of her location or had her in one place long enough to administer any treatment.

She was admitted for diagnostic tests to the self-care unit which costs $16.50 a day. During the three-day workup she dressed and cared for herself and ate in a self-service cafeteria. The furnishings were of the standard non-hospital type such as a motel would provide. One non-motel advantage was a well-stocked ice box accessible to patients during the night. The entire unit had one registered nurse in the daytime and one practical nurse at night.

After surgery she was cared for in the surgical recovery room. This is the one zone in the Grant Hospital setup which many other hospitals have adopted and found to be highly satisfactory. It was the original result of adapting the hospital environment in equipment and personnel to the patient's expected requirements.

The "Intensive Care Unit" was next. The entire unit consists of three six-bed rooms, each with a specially trained nurse who is always present or is relieved by the supervisor. An intern or resident is always in the unit. The cost is $39.50 per day. Nursing care is so good that private nurses are not needed.

Three days later she was ready for the "Intermediate Care Zone." This consists of two-bed rooms and is staffed in a manner comparable to most hospitals. The daily cost was $22.

Her hospital stay was terminated by a four-day residence in the self-care unit at $16.50 per day.

Total hospital bill was $344. If she had spent the entire time in the $22-a-day accommodations (equivalent to standard hospital care) her bill would have been $330. She did not require any special nurses. If she had had special nurses for one day her bill would have been $54 more. Actually she received special nurse type of care for three days.

Her own doctor selected the time of changing from one zone to another in accordance with her need for care. Grant Hospital officials are quoted as saying that the patients almost always experience a psychologic boost in morale when they graduate to a unit of less magnitude, and that they leave the motel-like rooms with a pleasant recollection of their hospital stay.

The plan is still in the investigational phase. Mr. Hartzell quotes those who have had experience in administering the plan as being reservedly in favor of it. Those outside the hospital who oppose it in varying degrees have not had actual experience with the plan.

Certainly it is a well-thought-out endeavor to surround the patient with all the care that he requires and still not lavish expensive equipment and personnel on those who do not.

From Virginia:

Watch Out!

IT IS QUITE POSSIBLE the powers that be in Washington have more than one reason for complaining about the prices of drugs. Senator Estes Kefauver's drug price investigating subcommittee would have us believe that the government's sole interest is "simply with the price of drugs—a price which must be paid by someone under any system of medical care." I think there is a psychological reason which they hope to keep under cover. This Senate antitrust investigation is just another cunning approach in the attempt to slip socialized medicine in at the back door. It appears to me that Mr. Kefauver almost gave this fact away in his opening

statement when he said: "It is not the purpose of these hearings to question in any way the American system of private medical practice." I react to this statement in the same manner I would if a small boy should rush into my office and exclaim: "Doctor, someone batted a baseball through your back window—and I don't want you to think that I did it."

If these investigators' thoughts were just in the drug field, they should also be concerned about quality as well as price. They certainly have shown a lack of interest in the cost of pharmaceutical research and manufacturing, and without research drugs would soon degrade in both quality and quantity. The Senator's line of reasoning in advocating that druggists be allowed to use generic instead of brand names, would throw the drug business into a tailspin within a short time. If one company spends a million dollars to produce a new drug, and another concern is allowed to copy the formula, pay none of the research cost, and market the product at a low price, the results would be disastrous. The better firms would go broke, initiative to find new drugs would be smothered and we would find ourselves advancing in reverse—back towards the "calomel and castor oil days."

I feel that these governmental probes are motivated, primarily, for publicity. If they can attract enough attention by their investigations of the major drug manufacturing firms, and lead the American people into believing that the prices of drugs are too high, it might be possible to gain a large number of sympathetic listeners.

They hope to stir up enough interest in the drug controversy to swing the spotlight away from the doctors for a while, give us a breathing spell, make us feel complacent and lessen our vigil against legislation like the Forand bill. It is their wish that we don't get wise to their two-fold purpose of these investigations in relation to the Forand bill itself. First, they will attempt to convince the lay public that older people, on social security, will not be able to pay the high drug prices—and that the government should step in to help. Second, if these tactics could get a Forand type of legislation passed without enough medical publicity to stir up strong opposition—they would be in position to widen social security to cover everybody. Then we would have socialized medicine under another name.

People, consciously, or unconsciously, associate drugs and physicians together. An aroused populace against drug prices would not be too friendly towards the medical profession. Such a situation would gain recruits for a more effective battle against the free practice of medicine. While we sit on the side lines, apparently unmolested, and watch the steam roller attempt to crush the drug firms, we must remain alert. We could get caught napping like Hitler did one time during World War II—when the Allied soldiers were issued heavy, long-handled underwear. As soon as the Germans got wind of it, they rushed up to Norway while our troops poured into Africa. It behooves us to watch out for all sorts of misleading tactics, because this drug battle is only a sham attack. The medical profession is their chief objective. They hope to find time to reorganize their forces, turn upon us without warning and launch a surprise attack where and when we might least expect it.

F. Clyde Bedsaul, M.D., *Floyd, Va.*

Reprinted with permission from *Virginia Medical Monthly*, Vol. 87, pp. 175-176, April, 1960.

Journal Offers $5 Each for Anecdotes

A new department of *The Journal* is being organized for the publication of accounts of personal experiences of Indiana physicians. The practice of medicine is interwoven and frequently involved with the drama of life. In a lifetime of practice doctors are in contact with many episodes of amusing, thrilling, ridiculous or dramatic import. Members of the association are invited to submit manuscripts for this purpose. Author's names need not be published, initials may be used. The narrations may be short, but should be limited to 1200 words. *The Journal* will pay $5.00 for each one published.

PROPOSAL SUBMITTED BY THE TREASURY IN LIEU OF H. R. 10, 86th CONGRESS

Present Law

Employees who are covered by a pension plan, which is qualified under the Internal Revenue Code, are not currently taxed on employers' contributions made on their behalf to these plans. Instead, the employees are taxed on pension benefits when they are received. Subject to maximum limitations, employers are permitted to take current tax deductions for their contributions to qualified pension plans.

Such plans may be funded in two ways: (1) The employer may set up an employees' trust, make contributions to the trust and have the trust pay the retirement benefits, or (2) The employer may purchase employees' insurance annuities.

Trusts established to administer qualified pension plans are exempt from income tax on earnings from investments. Similarly, insurance companies have been granted exemption under a new law (fully effective in 1961) on income earned on reserves established in connection with qualified pension plans.

The law grants this favored tax treatment only to pension plans which do not discriminate in favor of employees who are stockholders, officers, or who are highly compensated.

H.R. 10, 86th Congress

The Treasury objects to H.R. 10 on the ground that the bill would allow self-employed individuals to establish their own voluntary pension plans, with tax advantages, without making any provision for the retirement needs of their employees. Under the present law, the "owners" of a corporation cannot establish a qualified pension plan that is discriminatory. The Treasury is concerned that if H.R. 10 is enacted, the precedent will be established for allowing individuals who are not covered by a tax-deferred employees' pension plan to take tax deductions for their retirement savings.

Principal Provisions of the Proposal

The Treasury proposal suggests in lieu of H.R. 10 that self-employed individuals be permitted to establish a qualified pension plan for themselves and their employees and thereby secure tax treatment similar to that accorded to executives who control the affairs of corporations (called "owner-managers" in the Treasury proposal) and their employees.

The Treasury proposes certain new limitations with respect to maximum deductible contributions which would apply to corporate "owner-managers" as well as self-employed individuals. The principal limitations are:

(a) Provided such contributions are not discriminatory in favor of the owners as compared with employees, a basic contribution on behalf of each self-employed individual or "owner-manager" would be permitted, amounting up to 10% of earned income, *or* $2,500 whichever is less.

Illustration: Doctor A's earned income for the year is $35,000. He has one employee who received a salary of $5,000. The pension plan in effect provides for contributions in the amount of 10% of earnings. Applying limitation (a) he could nevertheless contribute no more than $2,500 on his own behalf to the pension plan. If Doctor A had no employees, the same "10%—$2,-500" limitation would apply.

(b) Regardless of the "10%—$2,500" limit, pension contributions on behalf of each self-employed individual or owner manager of a corporation could be as much as the largest annual deductible contribution vested in any covered employee who is neither an "owner" or a close relative of an "owner."

Continued

NEW FROM

SEARLE

INSTANT MIX METAMUCIL®

Psyllium hydrophilic mucilloid with citric acid and sodium bicarbonate







just pour powder from one packet

add cool water slowly... it's instantly mixed

and it's

EFFERVESCENT!

all the advantages of smoothage therapy in the relief and correction of constipation

- each packet is equivalent to one rounded teaspoonful of Metamucil powder
- stimulates normal peristalsis
- induces natural elimination
- promotes regularity
- keeps stools soft and easy to pass
- avoids harsh laxatives or purgatives
- convenient, premeasured-dose packets
- delightful mild lemon flavor

INSTANT MIX METAMUCIL
16 Packets

G. D. SEARLE & CO. • Chicago 80, Illinois

Treasury Proposal Continued

Illustration: Doctor B has a qualified pension plan for himself and his employees which provides for contributions in an amount equal to 10% of earnings. His earned income is $50,000. A physician whom he employs and who is covered by the plan earns $30,000. Doctor B would be allowed under limitation (b) to contribute $3,000, on his own behalf.

(c) The above limitations would not apply if the total amount of contributions for self-employed persons and corporate "owner-managers" did not exceed one-half of the *total* annual deductible contributions vested in all employees who are neither owners nor close relatives of an owner.

Illustration: Doctors C and D, who are partners, have earned income in the amount of $50,000 each. The total payroll of employees covered by their pension plan, none of whom are close relatives, is $200,000. The pension plan provides for contributions in the amount of 10% of earnings. Contributions for Doctors C and D may be made in the amount of $5,000, as permitted by limitation (c).

Non-deductible Contributions

Under contributory pension plans, self-employed individuals and "owner-managers" would be permitted to make additional *non-deductible* contributions consistent with those permitted for employees. To prevent tax advantages through the deferment of tax on earnings of large accumulations of funds, the *additional* non-deductible contributions by such individuals would be limited to 10% of earned income up to $2,500 a year. However, self-employed individuals without employees would not be permitted to make such additional contributions.

Withdrawals: Retirement benefits for self-employed individuals would be subject to penalties if withdrawals began prior to age 60 (except for disability) or after a fixed maximum age, say, 70.

Capital Gains: The Treasury proposes that the present long-term capital gains treatment accorded to lump-sum distributions be removed.

Trustees: Subject to local law, a medical society, or a corporation controlled by a medical society, may act as a pension plan trustee. ◄



President's Page

Another voting day is here and gone. The selection of candidates has been made and now the serious considerations of political issues begin. From now until the election is over in November, issues will be presented with glowing promises for legislation to correct all political ills that are now present. Possibly the central issue of this campaign will be in the field of health with special attention to health care of the aged.



Politicians realize the voting possibility of the 16,000,000 people over 65. However, one can hardly predict that these people will vote in a unified manner any more than one can predict a labor union will vote in a unified manner. Certainly the most conservative element of our population is found in this group. Also in this group are found the most financially secure people of our nation. Another factor in regard to this group is that most of these citizens have not always known socialism as it now is present in our government and its practices. Many of our older people have, by virtue of their own efforts, become self-supporting and want no other source of aid except that which their own efforts have produced. The idea of a hand-out is not popular with them. There are those in the older group who will need help with health problems. The same holds true for all groups.

Certainly when the future campaign begins to resound to claims about health needs for older people, one should realize that these needs do not apply to all the 16,000,000 but only to the segment which does need care. The number of those in actual need is much less than the total mentioned. In this campaign to come, as in all matters of public policy, medicine should speak out clearly and fearlessly against any blanket rule regarding health that applies to any group. Medicine should also fight federal intervention in any medical problem, as this introduces a third party into the privileged doctor-patient relationship. It should be clear to all that medicine will always take care of the medical needs of patients and with the same zeal regardless as to the patient's ability to pay.

The standard of health care in this country is the highest in the world. None of this excellence was brought about by federal action. It was brought about only by the efforts of doctors both individually and in organization. We are proud of this record. We need not apologize to anyone for the present level of competence nor do we need anyone outside our ranks in the future to help in regard to medical care.

It is the duty of every doctor and everyone in the ancillary fields to speak up in the next few months so that the public can be enlightened as to the facts about health needs of the aged. If we are led farther down the primrose path of socialism by any governmental plan the present high level of medicine in this country can only go down. All will lose by such unfortunate occurrence. The future is critical—let history record we made a valiant fight.

Earle W Bennett M.D.

The Women's Auxiliary

REPORTS TO ISMA



The aftermath of a lovely convention. . . . It's a little like putting your head under an enormous pillow —the mounting excitement of preparation . . . arrival —delegates streaming in . . . joyous greetings . . . exuberance of new and old friends; meetings — meetings — meetings — excitement mounting with every passing hour.

Then: . . . Installation . . . people talking all around you—suddenly you are alone, you are home—your senses numbed with fatigue. Yes, it is like putting your head under an enormous pillow.

REFLECTIONS . . .

Understanding is the key—it is the word which ties us all together. Without it we are adrift, like seamen attempting to steer a boat without its rudder. But even before understanding must come knowledge. We must know what we are to understand.

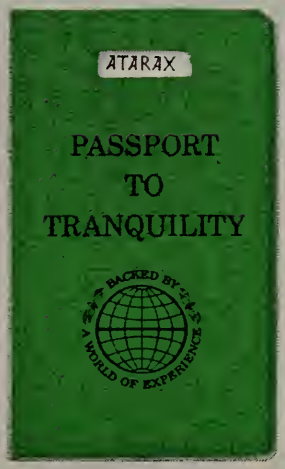
What is the Woman's Auxiliary? What is its scope? What does it encompass? How does it affect you and your wife . . . and even more important, how does it affect medicine and your neighboring community? What role should you play?

These are important questions—questions that if you haven't asked yourself, you should have. But if you haven't thought about it before, think about it now. Possibly, my inaugural address on page 1226 can answer a few of your questions.

Ina. Rigley

A GUIDE TO

THE REALMS OF THERAPY BEST ATTAINED WITH



ATARAX®

(brand of hydroxyzine)

World-wide record of effectiveness—over 200 laboratory and clinical papers from 14 countries.
Widest latitude of safety and flexibility—no serious adverse clinical reaction ever documented.
Chemically distinct among tranquilizers—not a phenothiazine or a meprobamate.
Added frontiers of usefulness—antihistaminic; mildly antiarrhythmic; does not stimulate gastric secretion.

Special Advantages	Supportive Clinical Observation	...and for additional evidence
IN CHILDREN unusually safe; tasty syrup, 10 mg. tablet	"...Atarax appeared to reduce anxiety and restlessness, improve sleep patterns and make the child more amenable to the development of new patterns of behavior...." Freedman, A. M.: Pediat. Clin. North America **5**:573 (Aug.) 1958.	Bayart, J.: Acta paediat. belg. **10**:164, 1956. Ayd, F. J., Jr.: California Med. **87**:75 (Aug.) 1957. Nathan, L. A., and Andelman, M. B.: Illinois M. J. **112**:171 (Oct.) 1957.
IN ELDERLY PATIENTS well tolerated by debilitated patients	"...seems to be the agent of choice in patients suffering from removal disorientation, confusion, conversion hysteria and other psychoneurotic conditions occurring in old age." Smigel, J. O., et al.: J. Am. Geriatrics Soc. **7**:61 (Jan.) 1959.	Settel, E.: Am. Pract. & Digest Treat. **8**:1584 (Oct.) 1957. Negri, F.: Minerva med. **48**:607 (Feb. 21) 1957. Shalowitz, M.: Geriatrics **11**:312 (July) 1956.
IN ALLERGIC PATIENTS useful adjunctive therapy for asthma and dermatosis; particularly effective in urticaria	"All [asthmatic] patients reported greater calmness and were able to rest and sleep better...and led a more normal life....In chronic and acute urticaria, however, hydroxyzine was effective as the sole medicament." Santos, I. M., and Unger, L.: Presented at 14th Annual Congress, American College of Allergists, Atlantic City, New Jersey, April 23-25, 1958.	Eisenberg, B. C.: **J.A.M.A. 169**:14 (Jan. 3) 1959. Coirault, R., et al.: Presse méd. **64**:2239 (Dec. 26) 1956. Robinson, H. M., Jr., et al.: South. M. J. **50**:1282 (Oct.) 1957.
IN HYPEREMOTIVE ADULTS does not impair mental acuity	"...especially well-suited for ambulatory neurotics who must work, drive a car, or operate machinery." Ayd, F. J., Jr.: New York J. Med. **57**:1742 (May 15) 1957.	Garber, R. C., Jr.: J. Florida M. A. **45**:549 (Nov.) 1958. Menger, H. C.: New York J. Med. **58**:1684 (May 15) 1958. Farah, L.: Internat. Rec. Med. **169**:379 (June) 1956.

SUPPLIED: Tablets, 10 mg., 25 mg., 100 mg.; bottles of 100. Syrup (10 mg. per tsp.), pint bottles. Parenteral Solution: 25 mg./cc. in 10 cc. multiple-dose vials; 50 mg./cc. in 2 cc. ampules.

Rx PFIZER

New York 17, N. Y.
Division, Chas. Pfizer & Co., Inc.
Science for the World's Well-Being

Lightning Does Strike!

*A. L. MARSHALL, JR., M.D.**
Indianapolis

DRIVING through the countryside, it is apparent that most individuals protect their homes, barns and other buildings against lightning with lightning rods. Everyone realizes that the chance of a lightning bolt striking a house or barn is fairly remote, yet everyone knows that if it does occur, terrific damage or irreparable loss will result. It is also common knowledge that most homes and buildings are covered by fire, wind and storm insurance.

Many persons spend large sums of money annually to protect their material belongings but put off, or scoff at, protecting themselves and their loved ones from the "lightning strike" of a preventable disease. A new house or barn can be built, but the damage inflicted by disease too often is permanent, and handicaps the individual for the rest of his life. In some cases, the disease strikes out and takes a human life.

Disease is as unpredictable as is disaster caused by lightning or storms. Many years may pass with little damage from storms or lightning. Yet the majority of people do not remove their lightning rods, or drop their insurance because nature was kind. Likewise, protection against the preventable diseases must be constant. During the time that cases of preventable disease are few we should check to make sure that our "lightning rods"—protection against disease —are still in good repair. By keeping immunization records on each individual in the family and taking booster doses of vaccine as recommended by the family physician we can rest assured that we are protected, should disease strike.

The immunization records have been tabulated for those children entering school for the first time in 1959. This yearly count first was required by law in 1957. A comparison of the reports for each of the three years shows only slight improvement for the entire state. (Table I.)

It should be pointed out that the figures in Table I cover only the children entering school for the first time each year. The immunization status of the other school children and the adults in the state is still doubtful. In order to prevent epidemics of these preventable diseases, booster doses of vaccine must be given periodically. The family physician will provide information concerning shots for each disease.

Too many people feel that once they have received an injection or a series of injections against a disease they are immune for life. This, unfortunately, is far from the truth.

Every patient admitted to a state institution is required by law to have a smallpox immunization. Recently, Hans Meyer, M.D., Medical Director of the Fort Wayne School, reported that he found the records inadequate as to immunization status and in order to be on the safe side, he reimmunized the approximate 2,000 inmates against smallpox. Of the 2,000 35.1% had primary "takes," indicating that at the time of immunization these people had no immunity against smallpox. If smallpox virus were to be introduced into the population of Indiana it is estimated that 50 to 70% of our people would be susceptible, and we would have an epidemic with many fatal cases.

In 1959, there were 151 cases of poliomyelitis reported: 109 cases were paralytic, and 11 were fatal cases. Investigation revealed that 81 of the 109 paralytic cases had received one to three doses of vaccine. The paralytic cases reported as having vaccine were not severely paralyzed and laboratory tests in many showed the paralysis to be due to viruses other than the polio viruses. Of the 151 cases of polio, 73.5% occurred in children 15 years of age or younger, while 60.0% of the 151 cases of polio occurred in children ranging from infancy to 10 years of age. This is rather shocking in view of the emphasis in the last six years to immunize children against poliomyelitis.

For complete information on the immunization status of children starting to school in 1959, see the following maps.

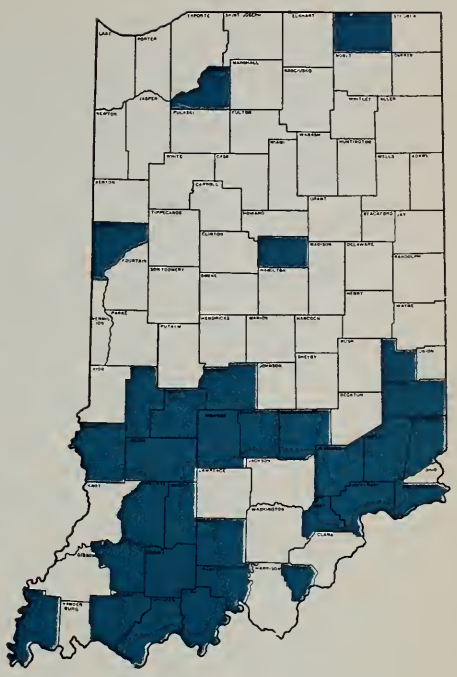
* Director of the Division of Communicable Disease Control, Indiana State Board of Health.

Reprinted from the *Monthly Bulletin*, Indiana State Board of Health, Vol. 62, No. 4, April, 1960.

SMALLPOX



DIPHTHERIA



The white areas of the accompanying maps reveal those counties which reported that 70% or more of the children entering school for the first time in September, 1959, had been immunized for the specific disease mentioned. The areas shaded in red cover those counties which reported that less than 70% of the youngsters had been immunized for the various diseases.

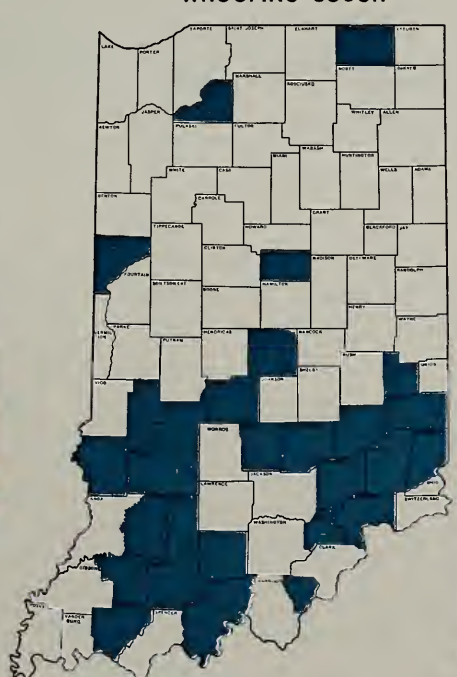
TABLE I

		Smallpox	Diphtheria	Tetanus	Whooping Cough	Poliomyelitis
Year	Pupils	Percent Immunized	Percent Immunized	Percent Immunized	Percent Immunized	Percent Immunized
1957	104,949	65	72	71	71	67
1958	100,713	64	73	71	71	69
1959	99,843	67	75	75	74	73

TETANUS



WHOOPING COUGH



POLIOMYELITIS



Facts about the prescription drug industry—its accomplishments, present state and aims for the future . . .

REPORT TO THE NATION

AUSTIN SMITH, M.D., President

Pharmaceutical Manufacturers Association

Prescription Drug Progress

THE YEAR 1959 has been one of remarkable achievement in the never-ending battle against disease. Pride of participation in this achievement can be held by the drug industry. In a few minutes I will tell you why I believe this. But 1959 also has been a year of accusations against many people, against various walks of life, in the health field. Frankly, I do not think that some of the accusers can rest on pride of achievement with the same easy conscience that is possible for those who help heal the sick.

Now, let me be specific. Time prevents relating the complete story. Furthermore, the members of one of our greatest protectors of freedom, namely, the press, in the weeks and months to come will, I hope, be telling this story in more detail.

Today, in a way, I want to discuss freedom. But I do not intend to approach it politically or emotionally; what I hope to be able to achieve is the telling of a story based on facts. As a doctor I believe in facts; they are essential for diagnosis and treatment. And as a citizen I hope to use the same facts to tell the people of this country what they have, how it was achieved and what it means to their health, their freedom, their happiness, their security.

I am here to tell a story that concerns an industry employing more than 100,000 men and women—the pharmaceutical industry. I want to show how it affects the lives of more than 170,000,000 people in the United States. I will report on the stewardship the pharmaceutical industry has held for the health of the nation up to 1959. I am here to help the industry to stand up and be counted. And as a physician and as a loyal citizen I am here to stand up to be counted with the industry for what it has done. This is a report to the nation.

We have lately been hearing and reading some rather severe criticism of the pharmaceutical manufacturing industry because some people in and outside government are saying the prices of prescription medicines are high. This question and other commercial aspects of the industry are under investigation by the Senate antitrust and monopoly subcommittee, and we hope that the facts will develop in open hearings and that they will come to public attention.

So I do not feel it necessary to comment directly on the charges or on the hearings. I am confident that the drug companies can and will show that this industry has labored conscientiously to provide the nation with the best possible medications at prices that are fair both to the public and to those who have invested their funds and dedicated their lives to serving the health needs of the nation.

But I do regard it as important that the public view this highly publicized hearing in proper perspective; that is, against the background of the great improvements for men that have been contributed by the pharmaceutical manufacturing industry, working in close harmony with the medical and pharmacal professions and the United States government.

In the past two decades—which have seen the introduction of nine-tenths of all the drugs now

Presented at the Annual Eastern Regional Meeting, Pharmaceutical Manufacturers Association, New York City, December 9, 1959.

now –

control

virtually all runaway diarrheas.. promptly, effectively with



Donnagel®

Robins

or Donnagel® with Neomycin

Prompt and more dependable control of virtually all diarrheas can be achieved with the comprehensive DONNAGEL formula, which provides adsorbent, demulcent, antispasmodic and sedative effects—with or without an antibiotic. Early re-establishment of normal bowel function is assured—for all ages, in all seasons.

DONNAGEL: In each 30 cc. (1 fl. oz.):

Kaolin (90 gr.)	6.0 Gm.
Pectin (2 gr.)	142.8 mg.
Hyoscyamine sulfate	0.1037 mg.
Atropine sulfate	0.0194 mg.
Hyoscine hydrobromide	0.0065 mg.
Phenobarbital (¼ gr.)	16.2 mg.

DONNAGEL WITH NEOMYCIN

Same formula, plus

Neomycin sulfate ..... 300 mg.
(Equal to neomycin base, 210 mg.)

A. H. ROBINS CO., INC., Richmond 20, Virginia · *Ethical Pharmaceuticals of Merit since 1878*

prescribed by doctors—10 years have been added to the normal life span of people in this country. Certain diseases have been all but wiped out and others made relatively impotent. The mortality of infants and mothers has been cut drastically.

We have become accustomed in our time to spectacular scientific breakthroughs. But whereas nuclear fission, jet propulsion and space flight all have some menace—as well as promise—for humans, the breakthroughs in medical science have all been in the direction of promoting the health and happiness of people.

This kind of progress has given every one of us the prospect of a longer, healthier and happier life. It has been estimated that because of the sulpha drugs and antibiotics alone, three million of us are still living who might otherwise be dead.

Meaning of Progress

As a measure of the advancing health of the nation, let's look briefly at nine specific facts about health and longevity that are related to medicine agents produced by pharmaceutical companies:

1. In the past 48 years, life expectancy at birth has been increased by a whopping 40%.

2. In the last quarter century alone the U. S. death rate fell from 12 per 1,000 population to 7.8 per 1,000. This is a reduction of more than one-third! By far the greatest extent of decline began in about 1940 and ensuing years when the sulphonamides, penicillin and even more potent medicinals came into common use.

3. At the turn of the century four diseases alone accounted for nearly a third of all deaths. They were pneumonia and influenza, tuberculosis and gastritis. Thanks principally to products of the pharmaceutical manufacturing industry, these diseases accounted for only one-twentieth of the deaths in the U. S. last year.

4. Diphtheria and bronchitis were the other two communicable diseases among the 10 leading causes of death in 1900, but in 1958 the death rate from diphtheria had dropped by 99.8% and from bronchitis, 95%.

5. The death rate from all communicable diseases declined 75% between the five-year period ending in 1934 and the four-year period ending in 1958. The major decline began in the early forties when the so-called "miracle drugs" began to come into common use.

6. The safety of mothers at childbirth has increased drastically from a mortality rate of 63.6 per 1,000 live births in 1930-34 to a low of 4.5 in the four years ended in 1958. In the same period the mortality of infants after their first week of life dropped from 33.9 per 1,000 live births to 9.6.

7. Diseases that once afflicted large portions of the population with serious illness are now either rare or far less serious. They include whooping cough, typhoid fever, measles, scarlet fever, malaria and undulant fever.

8. The steroid hormones have been developed to ease pain and restore to useful activity sufferers from specific ailments including arthritis, skin diseases, allergies, eye inflammations.

9. The development of tranquilizers has greatly advanced the treatment of the mentally ill. The Veterans Administration, for instance, is now discharging about 41,000 mental patients a year, compared with about 28,000 a year before the tranquilizing drugs were available.

This is a recitation of only a few key achievements of medical science.

Cost of Achievement

It is fair to ask at what cost to the public the progress set forth above has been achieved. Let's look at the key facts.

1. While the total volume of drug manufacturers' sales has risen from about half a billion dollars immediately after World War II to almost two billion this year, the wholesale price index has actually declined! This means that the volume of drugs in use has increased, but that the unit wholesale prices have decreased. Bureau of Labor Statistics data show that the *wholesale* price index of drugs, pharmaceuticals and cosmetics stood at 105.3 in 1947 but had descended to 94.0 last year. By contrast, the index for all items rose from 95.8 in 1947 to 123.3 in 1958.

2. On the *consumer* price index, the cost of prescriptions has lagged somewhat behind the increase of all items. The index for prescriptions advanced 19.5 points between 1948 and 1958, while the index for all items climbed 20.7 points. Moreover, drug prices have increased much less than the prices of other medical care items.

Continued on page 1172

when "Pollen Polly" rides the wind...

Triaminic®

...relief from pollen allergies

more complete than antihistamines alone... more thorough than nose drops or sprays

The miseries of respiratory allergy can be relieved so effectively with Triaminic.[1-5] Triaminic contains two antihistamines plus the decongestant, phenylpropanolamine, to help shrink the engorged capillaries, reduce congestion and bring relief from rhinorrhea and sinusitis.[1] Oral administration distributes medication to *all* respiratory membranes without risk of "nose drop addiction" or rebound congestion.[2,3]

Each Triaminic timed-release Tablet provides:

Phenylpropanolamine HCl	50 mg.
Pheniramine maleate	25 mg.
Pyrilamine maleate	25 mg.

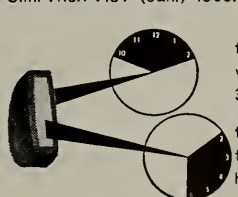
also available:

TRIAMINIC JUVELETS® ½ the formulation of the Triaminic Tablet with timed-release action.

TRIAMINIC SYRUP each teaspoonful (5 ml.) provides ¼ the formulation of the Triaminic Tablet.

References: 1. Fabricant, N. D.: E. E. N. T. Monthly **37**:460 (July) 1958. 2. Lhotka, F. M.: Illinois M. J. **112**:259 (Dec.) 1957. 3. Farmer, D. F.: Clin. Med. 5:1183 (Sept.) 1958. 4. Fuchs, M.; Bodi, T.; Mallen, S. R.; Hernando, L., and Moyer, J. H.: Antibiotic Med. & Clin. Ther. 7:37 (Jan.) 1960. 5. Halpern, S. R., and Rabinowitz, H.: Ann. Allergy **18**:36 (Jan.) 1960.

Relief is prompt and prolonged because of this special timed-release action



first—the outer layer dissolves within minutes to produce 3 to 4 hours of relief

then—the core disintegrates to give 3 to 4 **more** hours of relief

SMITH-DORSEY • A DIVISION OF THE WANDER COMPANY • LINCOLN, NEBRASKA

Continued from page 1168

3. According to figures of the U. S. Department of Commerce, we are spending today, as a percentage of disposable income, only one-tenth of one per cent more for drug preparations and sundries than we were a generation ago, in 1939. Yet virtually all of the high potency drugs have come into existence since then.

4. The use of today's highly effective drugs actually saves money. Miss Lucy Kramer, of the Public Health Service, has written as follows:

> "According to once source, 20 years ago a case of lobar pneumonia meant five weeks in a hospital, long convalescence and $300 to $400 for doctors, nurses, medicines, oxygen and hospital care. Today, it means two weeks of illness, generally at home, back to work immediately thereafter, and $15 to $30 for drugs. Thirty years ago the treatment of mastoiditis cost at least $1,000, required surgery, and involved the possibility of permanent impairment of hearing. Today $15 worth of antibiotics clears up most cases without surgery."

I ask you to imagine how much the family of a mental patient saves when the use of tranquilizers cuts the patient's stay in a mental hospital from several years to several months. A Veterans Administration official has estimated that the reduced incidence of tuberculosis patients alone in VA hospitals has saved the federal government about $107 million.

5. A national survey of retail prices made in April 1958 showed that fewer than 15% of prescriptions cost as much as $5. Nearly a third of all prescriptions were in the range from $1 to $1.99, and a fourth of them were in the range of $2 to $2.99.

In summary, it seems clear to me that the great advances in health have come at no excessive cost to the public.

We have seen that the pharmaceutical manufacturing industry has made real contributions to medicine, and we have seen that this progress has cost consumers no bigger a part of their income than they were spending for less effective medicine 20 years ago. In fact, Dan Rennick, Editor of *American Druggist,* has made studies which show that the average prescription today takes 17% less of the wage earner's money than 20 years ago.

Let's examine some of the effects of this progress on the drug manufacturing companies.

R and D to Rx—the Cost

What does it cost to develop an important new medication? The first cost, of course, is for research. The expenditures in the drug manufacturing industry for research have been phenomenal. The industry will spend about $194 million this year in the search for new medicines. This is a five-fold increase in research costs in the brief period of 10 years! And a projection of these figures to the year 1970 indicates that research expenditures may rise to a third of a billion dollars annually.

About one dollar out of every nine received in sales is now going into research in drug company laboratories. The result of this enormous expenditure over the past 10 years is the development of 392 previously unknown medicinal chemicals to improve health or reduce pain.

Some of these preparations have been revolutionary, but they have not become available without the expenditure of extraordinary sums. It is estimated, for instance, that the company which first synthesized cortisone poured more than $20 million into research on the steroid hormones alone between 1946 and 1951.

Last year the industry's laboratories worked with 114,600 different chemical substances. Nineteen hundred of these potential medicines showed enough promise for clinical testing. However, probably less than 40 of these will ever become prescription drugs.

Now, 40 new drugs in a year represent the kind of advance in medicine that would have astonished a physician in the 1920's and the 1930's, and therefore is a substantial achievement in improving the service of medical science to the public. But it is also a rather discouraging laboratory success rate of three ten-thousandths of one per cent. I hope these figures give a conception of the effort and expense that precede the introduction of a new medicine. Unfortunately, facts like these are not being developed at the Kefauver hearings at this time, but they have an extremely important bearing on the pricing of prescription medicine.

Research is, of course, only the starting expense that may lead to better health for the nation through new or improved chemical agents. The cost of development can be equally staggering,

Continued on page 1176



ALPEN is the oral penicillin that provides on a fasting stomach peak antibiotic blood levels approximately twice as high as oral potassium penicillin V... and significantly higher than I. M. penicillin G.

Some strains of staphylococci resistant to other penicillins exhibit *in vitro* sensitivity to potassium phenethicillin.

ALPEN has greater freedom from the G. I. sequelae (overgrowth of resistant flora) sometimes observed with broad spectrum -mycins.

ALPEN gives much higher antibiotic levels within the first hour of ingestion by the well-tolerated oral route.

WHEN TO USE ALPEN Recommended in the treatment of infections caused by pneumococci, streptococci, gonococci, corynebacteria, and penicillin-sensitive staphylococci.

HOW TO USE ALPEN Depending on the severity of the infection, 125 mg. (200,000 units) or 250 mg. (400,000 units) three times daily may be used. In more severe or stubborn infections, a dosage of 500 mg. (800,000 units) t.i.d. may be employed. In beta hemolytic streptococcal infections, treatment should be continued for at least ten days.

PRECAUTIONS The usual precautions in the administration of oral penicillin should be observed. For further details see package literature.

Tablets: 125 mg. and 250 mg., bottles of 25 and 100. Powder for Oral Solution (lemon-lime flavored), 1.5 Gm. bottle (125 mg. per 5 cc. teaspoonful).

this is the tablet that gives higher peak antibiotic blood levels

HIGHER THAN I. M. PENICILLIN G
HIGHER THAN POTASSIUM PENICILLIN V

ALPEN

ALPEN™—potassium phenethicillin

Schering

Continued from page 1172

and is compounded by competition that often makes obsolete a drug developed at great cost.

Range of Elements in Pricing

People outside the pharmaceutical industry often fail to understand the range of elements that go into pricing a drug. The costs include not only research but the complex and expensive process of developing a laboratory product into a prescription drug, involving lengthy clinical testing and evaluation, collaboration with Federal agencies, and possibly the evolution of an entire new manufacturing process, even for a drug that may have very limited sales potential.

In addition, just maintaining a product line in widespread distribution—so that any doctor anywhere can prescribe any drug with assurance that any pharmacist can provide it—creates the need for highly organized and costly activity. And after all this has been accomplished, the manufacturer is faced with the problem of informing doctors and pharmacists about the purpose, value, efficacy, dosage and clinical results of the drug itself.

At the end of this complex preparatory period, a manufacturer can only hope that the use of the chemical agent will be great enough to return all his costs and a reasonable profit before a competing company comes out with a similar but more potent product that will make the original drug obsolete.

Let me give you an example:

The company that developed cortisone first synthesized this hormone in 1944. Laboratory production began in 1946, but it was not until September 1948— two years later—that enough of the product was available for clinical testing. You know the results of those tests on arthritic patients. They were almost unbelievable. A young woman who had been crippled for four years went on a shopping spree less than a week after she began taking cortisone.

The discovery of cortisone's effectiveness in treating a wide range of inflammatory diseases touched off a fierce competition among drug companies to synthesize and develop other steroid hormones.

Meanwhile, the cost of producing cortisone was staggering because of the complexity of the process. It took 40 oxen to supply enough of the chemical to treat one arthritic sufferer for one day. Under these circumstances the availability of cortisone was relatively low and the price relatively high.

Competition Benefits Public

But now competition began to work to the benefit of the public. For six months after cortisone reached the market, scientists of a competing company discovered that microbes could be used to accomplish certain complex chemical operations beyond the skill of human chemists in the production of hormone drugs. This process broke the cortisone bottleneck in 1952 and freed the production of steroid drugs from the shackles of uncertain and costly raw materials. The production of cortisone skyrocketed and the price plummeted 90% in two years as a result of a radical advance in production methods.

Efficient as cortisone proved to be, it had drawbacks. Some of the side effects could be extremely serious in certain patients. So while production of this hormone picked up speed, research was intensified in the industry to find even better steroid preparations. The same company that synthesized cortisone later succeeded in synthesizing hydrocortisone, a far more powerful hormone that could be administered in smaller doses with hope of reduced side reactions.

Five years later two new products with three to four times the potency of hydrocortisone were on the market. In another two years a third and even more effective new steroid came out. In 1958 two drug companies almost simultaneously —and as a result of independent research and development — announced another steroid with still more effective properties, and since that time yet another has been put on the market.

While the initial dose of cortisone was 25 mg, the dosage for an equivalent amount of hydrocortisone was only 20 mg. Each new steroid hormone has been more potent than its predecessor, so that the newest on the market requires only three-quarters of one mg.

Now this category of medicine has been available in quantity only since 1952, so that all the steroid hormonal preparations are still being sold. But if the experience with antibiotics and other types of drugs holds true in the steroid field, competition will probably make obsolete some of the earlier medicines within a relatively few

Continued on page 1182

when she's not like herself anymore

Metalex® basic in the care of the aging



when body tone, mental and sensory faculties begin to fade—*she's irritable, confused, forgetful, apathetic*

when voices begin to fade—*in loss of auditory acuity, in tinnitus*

when vision begins to dim—*in loss of visual acuity, in loss of peripheral vision*

℞ Metalex® *cerebral stimulant / vasodilator*

The stimulant—pentylenetetrazol—facilitates cerebral and reflex nerve activity.

The vasodilator—nicotinic acid—augments blood and oxygen supply to vital areas—

Thus, METALEX increases body tone and aids mental and sensory faculties.

Composition: Each teaspoonful (5 ml.) of the Elixir and each Tablet contains: Pentylenetetrazol 100 mg., Nicotinic Acid 50 mg.

Dosage: One or two teaspoonfuls of the Elixir or one or two Tablets four times a day—one-half hour before meals and before bedtime.

Available: Elixir: Pint and Gallon bottles. Tablets: Bottles of 100 and 1000.

References: 1. Goodman, L. S. and Gilman, A.: The Pharmacological Basis of Therapeutics, 2nd Ed., New York, Macmillan Company, 1955. 2. O'Reilly, P. O., Demay, M. and Kotlowski, K.: Cholesteremia and Nicotinic Acid. A.M.A. Arch. Int. Med. 100:797-801 (Nov.) 1957.

STORCK Pharmaceuticals, Inc.,
2326 Hampton Blvd., St. Louis 10, Mo.

Continued from page 1176

years, with the risk that all the costs of research, development, production and distribution may not be recovered.

Forty per cent of the prescriptions written today could not have been filled as recently as five years ago. Few industries are faced with such a rate of product improvement and the consequent obsolescence of other products that represent substantial investments in research, development and plant facilities.

Trade Names and Quality

As an aside let me refer to another aspect of drug industry costs. I have heard quite a bit of discussion recently about discontinuance of trade names. Since a firm places its reputation behind a trade name it is prepared to make every effort to assure quality and purity, and any action which discourages dependence on this reputation is open to question. Responsible pharmaceutical manufacturers should rightly demand freedom for the physician to choose the drug he believes is best for a patient. In our country we do not recognize the existence of second class citizens. Why, then, should anyone want to encourage the creation of second class citizens simply because their health is involved. We have always believed the best is none too good; why not insist on the same attitude for those who are ill? Most of us think the practice of medicine is founded on the physician's best judgment and not on a nonmedical opinion as to what is cheapest. Safety and purity and effectiveness seem to me to be much more important than pennies for the seriously ill patient.

Being curious about the details of operation of this industry I have inquired into the controls that are necessary to maintain purity and quality of drugs. It's a fascinating story. A typical manufacturing process for a tranquilizer product when outlined step by step in ordinary typewritten form required a roll of paper almost 10 feet long. Another firm to set forth the control required for production of a corticosteroid would have needed a roll of paper 1,000 feet long!

For the tranquilizer there were required 38 employees, 14 departments, 114 operations, 134 tests, and assays, 24 days and 31 different raw materials.

For the steroid there are needed 174 workers in addition to professional people for one week and 5,200 separate analytical tests and the entire product from this week's work could be carried away in a suitcase by an average adult male.

After looking at such impressive figures one wonders how representative U. S. chemical and drug firms can produce more than $20,000.00 worth of goods per man as compared with, say, $9,000.00 per man by a well-known German firm in the same field.

These are some of the costs and hazards peculiar to the pharmaceutical manufacturing industry.

Need for Profits

Now let's talk briefly about profits. Are they high? The figures that are available show that the pharmaceutical manufacturing industry's net profit either as a percentage of investment or as a percentage of sales is exceeded by other important industries. This industry is therefore not at the top of the list although its performance at times has been above the median.

But how do you measure how high profits should be? Is the business so profitable that too many firms are being formed to produce and distribute too much medicine? Is it reasonable to suppose that a reduction in earnings will serve to increase the availability of medicine to the American people? I would say the answer to these questions is clearly no.

I have read recently a number of publicized letters from elderly people who told of buying drugs. One man said he paid 20 cents or more for each pill (an effective medicine, incidentally). Let us suppose this involved a manufacturer's price of say 10 cents. Let us also suppose we deducted from this about 15%, which is more than the net profit margin for the drug industry —what would happen? The purchaser might secure his pill for about two to three cents less but the manufacturer on the other hand without some profit would not be able to pay dividends, expand to meet increasing public needs or accumulate adequate funds for research in the areas now being so widely explored.

Basis of Criticism

No one decries the need for medicines, but I question the objectivity of critics who talk about lack of pennies for drugs but make no mention of expenditures for other more expensive items, whether they be essentials or luxuries. I must

Sterazolidin®

brand of prednisone-phenylbutazone

a well balanced therapy in all forms of rheumatic disorder

for rapid, effective relief

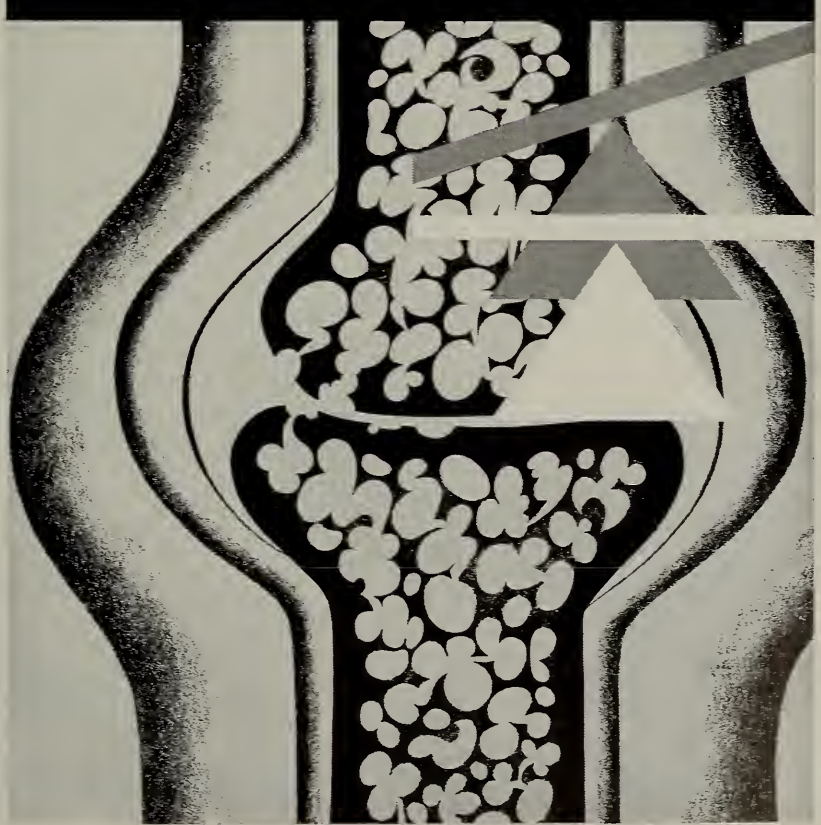
The combined action of phenylbutazone and prednisone in Sterazolidin results in striking therapeutic benefit with only moderate dosage of both active agents.

In long-term therapy of the major forms of arthritis, control is generally maintained indefinitely with stable uniform dosage safely below that likely to produce significant hypercortisonism.

In short-term therapy of more acute conditions Sterazolidin provides intensive anti-inflammatory action to assure early resolution and recovery.

Sterazolidin®, brand of prednisone-phenylbutazone: Each capsule contains prednisone, 1.25 mg.; Butazolidin® (brand of phenylbutazone), 50 mg.; dried aluminum hydroxide gel, 100 mg.; magnesium trisilicate, 150 mg.; homatropine methylbromide, 1.25 mg. Bottles of 100.

Geigy, Ardsley, New York



Geigy

SZ 1-60

admit that sometimes I wonder if the current criticism about drug prices is generated because of lack of proper perspective or because of a deeper and less obvious motivation, namely, a desire to enter the back door to government controlled medicine—or socialized medicine as it is so commonly called.

As I read the letters from people claiming to be in desperate straits I am impressed with the frequency with which they refer to medical and hospital care as a whole. How much would these people really be helped if drug prices were reduced by an amount equivalent to the net profits margin for the pharmaceutical industry? Such pennies will not pay for gas, light, rent, food, clothing or medical care in general. Isn't it time all of us tried to get things in proper perspective instead of looking for whipping boys?

The drug industry has helped advance medical science. Its contribution to the increase in longevity is documented. But our society in general, not the drug industry, has the concept that many millions of persons in this country are too old to work. How ironical it is, then, that the drug industry should be singled out as the whipping boy for the financial plight of these persons! The health team is among the best friends elderly people have; hysterical misstatements of fact about it will help no one.

The pharmaceutical manufacturing industry now requires a little over one dollar of gross assets to produce one dollar of salable goods per year. In a growing industry, this ratio demands a high annual increase of investment and a high reinvestment of earnings merely to keep pace with the demand for product.

If earnings were reduced, capital would tend to look for employment elsewhere, with the result that production and distribution might be diminished. On the other hand, if more medical service is needed, rewards must be such as to attract capital, not repel it.

Unlike other key industries, there are no giants in pharmaceutical manufacturing. No one company accounts for as much as 10% of prescription sales. Furthermore, a study just completed for PMA indicates that competition within the industry has been increasing over the years, rather than decreasing.

In the past 10 years there has been no significant change in the pattern of concentration. The pharmaceutical companies are growing at about the same rate as industry volume. But laboratory competition is intensifying, as shown by an increase in expenditures for research and development of 50% per dollar of sales in the period 1949 to 1958.

The major function of profits in the pharmaceutical industry is to assure that we will continue to grow and thus serve the people better. So far, this function has been fulfilled. The industry's prices must necessarily reflect all the costs of discovering, developing and distributing medicine, and they must also produce the profit so necessary to guarantee continued progress.

Control of Promotion

Recently we have heard accusations such as the pharmaceutical industry spends too much money on advertising and that drugs are misrepresented when advertised to the medical profession. Often it is obvious the complainant does not know what he is talking about. For example, he may include under advertising all educational aids for physicians. Can one use the label "advertising" for detailing, films, technical publications, scientific exhibits, lectures and televised medical and surgical clinics?

Unquestionably enthusiasm in promotional efforts can get out of hand at times when various people participate in a promotional program and for years I have watched such happenings as closely as anyone. But this is not unique to any industry. The important thing to know is that members of the pharmaceutical industry are setting up increasing controls to ensure the presentation of facts. The members of this audience know this, so I won't belabor the point.

But unfortunately no one seems to talk much about what they are going to provide as safeguards; we only hear of the slips here and there. There seems at times more defense than explanation. And, do we hear of the increasing recognition being paid to the establishment some months ago of a statement of principles of ethical drug promotion by the Pharmaceutical Manufacturers Association? Or of the principles set forth by groups such as the Pharmaceutical Advertising Club of New York, or of the advertising principles adopted by medical journals for their own pages? Somehow this criticism of adver-



Dianabol: new, low-cost anabolic agent

By promoting protein anabolism, Dianabol builds lean tissue and restores vigor in underweight, debilitated, and dispirited patients. In patients with osteoporosis Dianabol often relieves pain and increases mobility.

As an anabolic agent, Dianabol has been proved 10 times as effective as methyltestosterone. Yet it has far less androgenicity than testosterone propionate, methyltestosterone, or norethandrolone.

Because Dianabol is an oral preparation, it spares patients the inconvenience and discomfort of parenteral drugs.

And because Dianabol is low in cost, it is particularly suitable for the aged or chronically ill patient who may require long-term anabolic therapy.

Supplied: *Tablets,* 5 mg. (pink, scored); bottles of 100.

Complete information sent on request.

Dianabol®
(methandrostenolone CIBA)

converts protein to working weight in wasting or debilitated patients

CIBA
SUMMIT, NEW JERSEY

2/2829MD

tising suggests to me that too many people are trying to tell the doctors they shouldn't have freedom of choice of medicines, or even that they are not intelligent enough to use drugs wisely. Maybe I'm prejudiced, but I believe most of the doctors of this country are sufficiently wise and experienced to exercise their own judgment if given the facts.

Another matter of concern to me is the failure to make clear that some critical reports in the press are not directed at those whom the headlines suggest. For example, recently the headlines proclaimed criticism of the drug industry by a committee of the Arthritis and Rheumatism Foundation, and yet the report itself dealt primarily with items promoted to the public and not professional or prescription products. Yet here was another source of misunderstanding which when piled on top of others has a telling effect.

Perhaps before too much more criticism is directed at the industry critics might read the 1955 report from the Health Information Foundation entitled "Public Attitudes toward Prescription Costs and the Drug Industry" and the 1958 study sponsored by the American Medical Association entitled "Attitudes of U. S. Physicians toward the American Pharmaceutical Industry." Here are excellent and authoritative sources of information.

Competition

In the November, 1959, issue of *Current Medical Digest* is an editorial by Dr. Henry A. Davidson. As a physician Dr. Davidson can place in clear perspective the proper care of patients. As a fellow physician I can understand and applaud his desire to demand freedom to choose what he believes is best for those who are sick. So, there seems to be special significance in a statement prepared by a doctor for doctors. Let me read in part what he has written:

> "More than 1,000 pharmaceutical companies manufacture drugs for our use. That means a lot of competition, jostling and duplication. Theoretically, it would seem smarter to consolidate these companies into a single drugmaking unit. . . . Yet if this were done, it would be a massive blow to public health. The competitiveness of the drug industry . . . is a boon to our patients and to ourselves.

Continued

Report to Nation

Continued

"The most dramatic effect of this competition is the way it keeps prices down . . .

"More than that, competition compels companies to search for different and better ways of preparing an item . . .

"Then, too, competition rapidly makes drugs obsolete . . .

"So let Europe have its cartels, and Russia its state monopoly. We'll take a thousand fiercely competitive companies duplicating each other's efforts, driving each other's prices down, and striving mightily to win the blue ribbon for the most effective, least toxic drug of its kind. It is no coincidence that competitive American drug enterprise has given us the finest pharmaceuticals in the world."

Conclusion

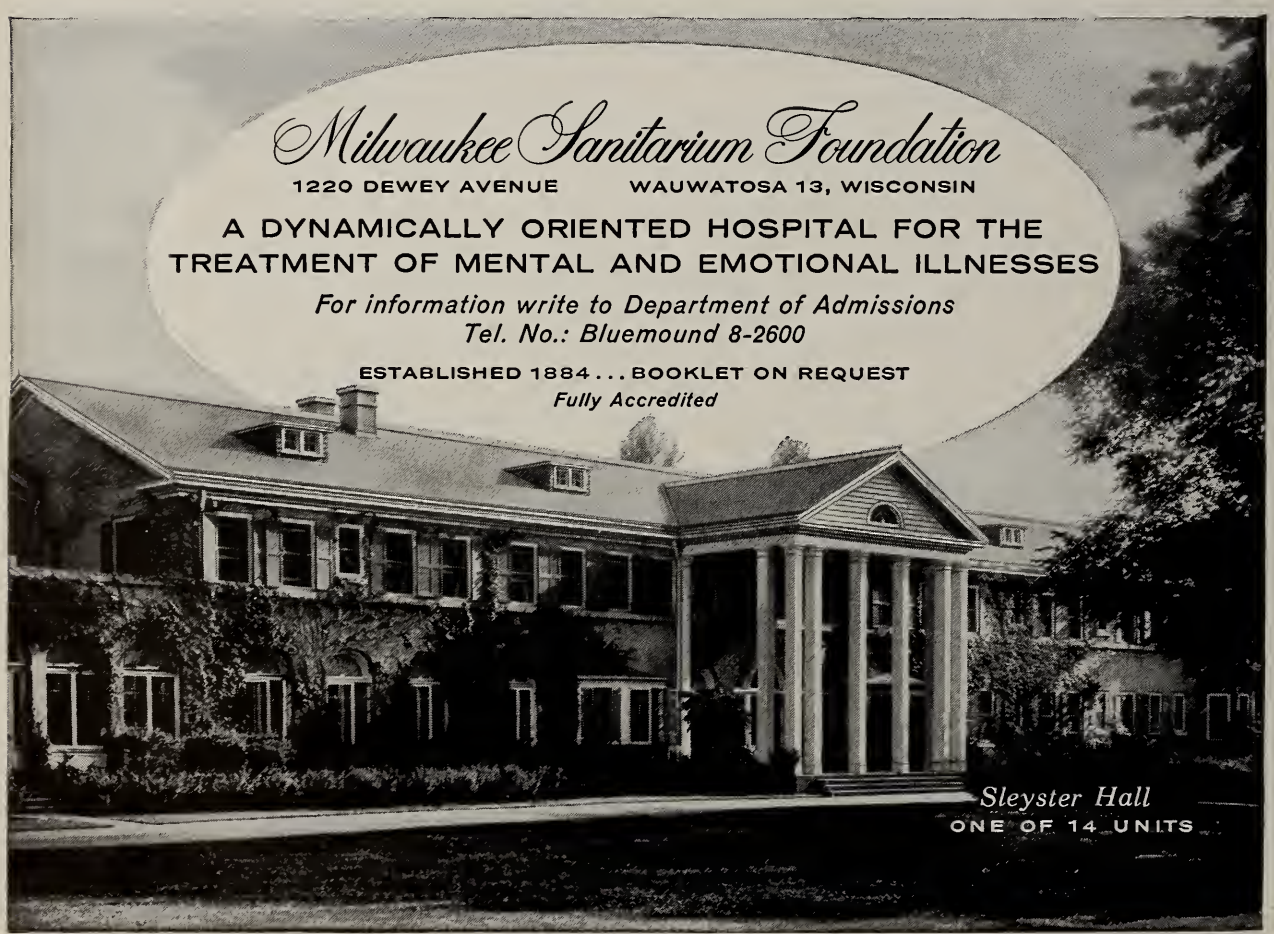
This is my report to the nation for 1959. It is lengthy, yet time has caused brevity to leave questions unanswered, not because there are no answers.

The story of the pharmaceutical industry, like that of medicine as a whole, is one of achievement based on a desire to do better.

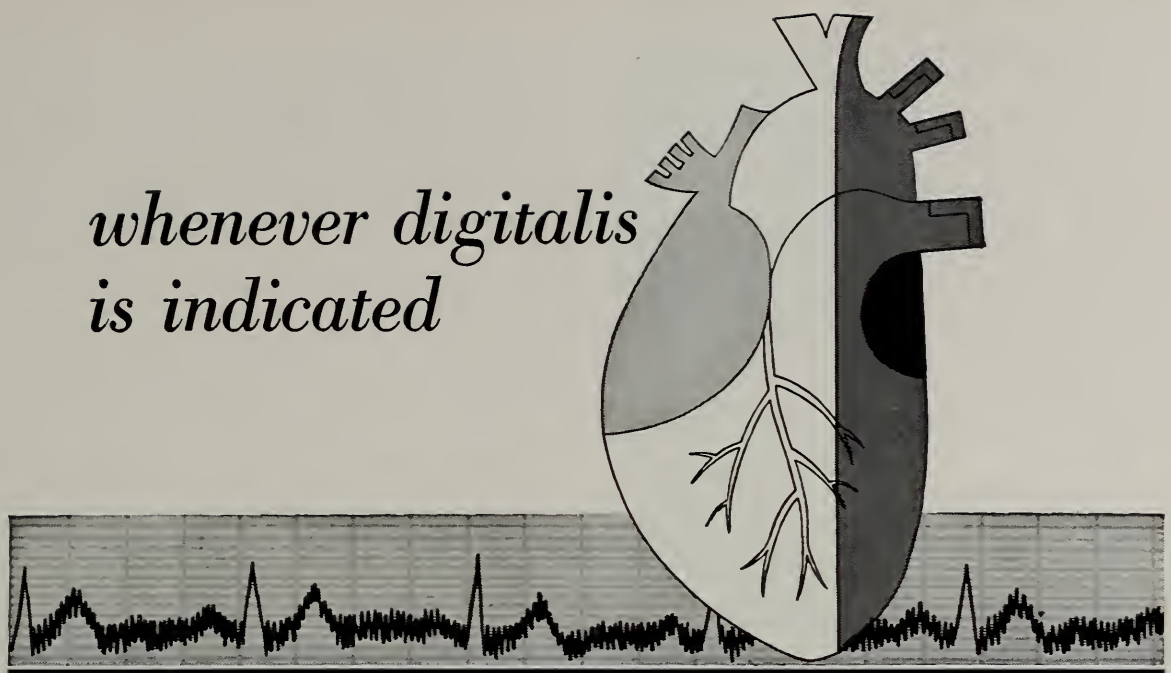
The industry's progress offers some interesting and important possibilities. The search for better antibiotics, new steroids, and more potent analgesics goes on. At the same time the pharmaceutical industry is directing a many-sided attack at the main medical problems of mankind; for example, malnutrition, heart disease, mental illness, parasitic diseases, cancer, virus diseases, metabolic diseases and even the aging processes. None of these problems is going to be solved easily, but it would take a gloomy pessimist to doubt that we shall find solutions to at least some of them in time.

These, then, are some of the facts about the prescription drug manufacturing industry—what it has done, what its present state is, and what its aims are for the future. It is an industry that has been little known to the public, for its communications have been largely with the medical and pharmaceutical professions. Its products are sold only on the recommendation of physicians and dispensed only by pharmacists.

Continued



whenever digitalis is indicated



'LANOXIN'® brand DIGOXIN

formerly known as Digoxin 'B. W. & Co.'®

"If one digitalis agent were to be recommended for its adaptability to the many and varied clinical contingencies, we believe Digoxin would be the drug of choice."

Lown, B., and Levine, S. A.: Current Concepts in Digitalis Therapy, Boston, Little, Brown & Company, 1954, p. 23, par. 2.

'LANOXIN' TABLETS	'LANOXIN' INJECTION	'LANOXIN' ELIXIR PEDIATRIC
0.25 mg. scored (white)	0.5 mg. in 2 cc. (I.M. or I.V.)	0.05 mg. in 1 cc.
0.5 mg. scored (green)		

BURROUGHS WELLCOME & CO. (U.S.A.) INC., Tuckahoe, N.Y.

ARTIFICIAL LIMB WEARERS



Hanger Limbs are being successfully warn by amputees of all ages. David Canfield, just 13 manths *(illustrated)*, is ane af the many yaung children growing up on Hanger Legs. In cantrast, Captain W. T. Traylar, over 75 *(illustrated)*, naw wears his fifth Hanger. He is a fire inspectar wha must cover cantinually haspitals, schools, sports events, etc., and be an his feet far hours at a time.

Age: 13 Months



The success of Hanger Limbs with amputees af such widely varying types can be largely attributed to custom manufacture and individual fitting. Unusual canditians are carefully investigated by experienced fitters, and limbs are manufactured to meet individual requirements. The experience of Hanger's 95 years is given to every amputee so that his rehabilitation may be successful.

Age: 78 Years

Hanger PROSTHESES

Air-Conditioned Offices

1529-33 N. ILLINOIS ST., INDIANAPOLIS 2, IND.
3108 BURNET AVENUE, CINCINNATI 29, OHIO
FAIRFIELD AT PONTIAC, FORT WAYNE, IND.
418 N. MAIN ST., EVANSVILLE, IND.

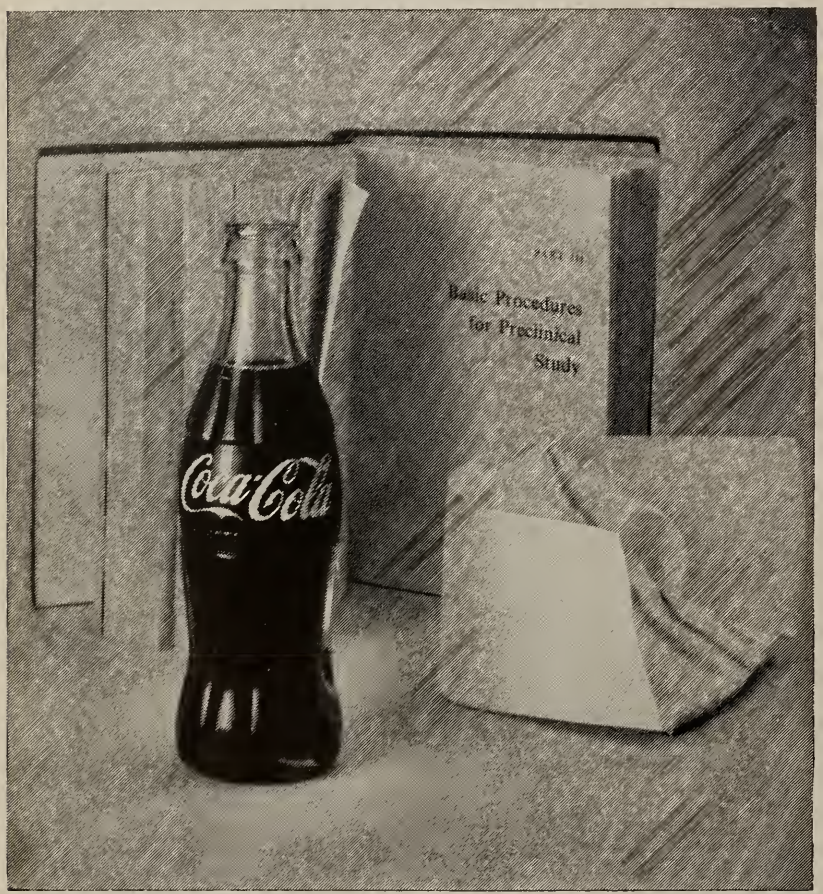
Report to Nation

Continued

The public has a big stake in the welfare of this industry, however, for its products have contributed to the revolution of medical science in our lifetime. It is my hope—and that of many of us in this industry—that the medical progress we foresee will help to bring about a closer relationship between the industry and the vast public that it serves.

I am proud to be a part of the medical care picture, as I have been for more than two decades. And I'm proud to tell the story of the members of the health team. But what pleases me most are the health prospects for the future if freedom to compete, to succeed and to serve remains with us. The past has been good, the future should be even better, and the industry deeply cherishes its opportunity to help. And so at this time I pledge to the nation the unending efforts of the Pharmaceutical Manufacturers Association and its members to assist the welfare of man. ◄

Volunteer instructors in Red Cross First Aid were on the go last year, giving a total of 13,928 hours of instruction to Indianapolis citizens.



When too many tasks
seem to crowd
the unyielding hours,
a welcome
"pause that refreshes"
with ice-cold Coca-Cola
often puts things
into manageable order.

DRINK
Coca-Cola
REG. U.S. PAT. OFF.

KANTREX®

INJECTION

Kanamycin Sulfate Injection

...a highly potent, bactericidal antibiotic for combating staph and gram negative infections

...well tolerated when used on a properly individualized dosage schedule which does not induce excessive blood levels

"In many instances its effect has been dramatic and life saving . . ."[1]

"Six of the patients who survived were considered to be terminally ill at the time kanamycin was started but showed dramatic improvement and eventual complete recovery."[2]

"... indeed, the results [with kanamycin] are the most remarkable ever achieved with otherwise fatal staphylococcal infections that we have ever seen."[3]

"There appears to be no doubt that kanamycin has been lifesaving in those instances in which organismal resistance precludes the use of other antimicrobials."[4]

Information on dosage, administration and precautions contained in package insert or available on request.

SUPPLY: KANTREX Injection, 0.5 Gm. kanamycin (as sulfate) in vial containing 2 ml. volume. KANTREX Injection, 1.0 Gm. kanamycin (as sulfate) in vial containing 3 ml. volume.

REFERENCES: 1. Yow, E. M.: Practitioner 182:759, 1959. 2. Yow, M. D., and Womack, G. K.: Ann. N. Y. Acad. Sci. 76:363, 1958. 3. Bunn, P. A., Baltch, A., and Krajnyak, O.: Ibid. 76:109, 1958. 4. Council on Drugs, J.A.M.A. 172:699, 1960.

BRISTOL LABORATORIES, SYRACUSE, NEW YORK

Text of a letter from Dr. Louis M. Orr, president of the American Medical Association, to George Meany, president of AFL-CIO, concerning the publication Feb. 1, 1960, by AFL-CIO Committee on Public Education of a political memorandum entitled . . .

'The Forand Bill and The Record of AMA'

March 15, 1960

Mr. George Meany
President
AFL-CIO
815 Sixteenth Street, N. W.
Washington 6, D. C.

Dear Mr. Meany:

On February 1, 1960, the AFL-CIO's Committee on Political Education issued a "political memo" entitled "The Forand Bill and the Record of the AMA."

This document charges the American Medical Association with being a leader "in the parade of reactionary forces marching against the passage of the Forand bill." Then, in an effort to support that charge, COPE's memorandum lists a series of alleged actions by the AMA over a period of years.

The allegations contained in the memorandum consist of deliberate distortions of the truth, perversions of the truth and outright untruths. Not only do they attempt to impugn the motives and competence of the nation's physicians, but they seek to mislead labor's rank and file, the members of Congress and the American people as a whole.

This action by COPE compels the AMA to reply, not only because such scurrilous allegations demand a forthright answer, but because the falsehoods uttered would, if allowed to go unchallenged, succeed in their purpose of smearing the entire medical profession.

When the AMA opposes any legislative health measure, it does so because its members believe that it would lead to poorer—not better—health care for the people of this country.

This is the Association's main reason for opposing H. R. 4700, 86th Congress—the so-called Forand bill. That many of the leaders of organized labor disagree with the collective judgment of medicine is not the main issue. It is labor's prerogative to oppose or support as it sees fit.

It is not labor's right to attack the medical profession, or any other group, with the ugly weapons of falsehood.

The AMA has checked the COPE allegations thoroughly, and the document attached answers them one by one. I ask that you examine this refutation of an unwarranted attack on the American Medical Association, and on the men and women who serve the American people in their role as physicians.

As President of the AMA, I demand in their behalf a full retraction of these accusations, and an apology from those who made them.

In my view, responsible labor leadership will wish to disavow the technics of deliberate untruth and make whatever amends it belatedly can.

I would appreciate a reply from you on this matter as soon as possible.

Very truly yours,
Louis M. Orr, M.D.

In Refutation . . . .

Released by the American Medical Association in refutation of charges made by the AFL-CIO's Committee on Political Education in its *Political Memo* dated February 1, 1960 and entitled "The Forand bill and the Record of the AMA."

THROUGHOUT the many years of its existence, the American Medical Association has spoken frankly—and bluntly, when necessary—on matters affecting the nation's health.

As a federation composed of some 175,000 individual physicians, the AMA has sought to reflect their collective judgment, and to do so constructively.

Yet the AFL-CIO's Committee on Political Education has not only attempted to impugn the motives and competence of the nation's physicians, but to mislead labor's rank and file, the members of Congress and the American people as a whole with deliberate distortions of the truth, perversions of the truth and outright untruths.

This recent action by COPE compels the AMA to reply, not only because such scurrilous allegations demand a forthright answer, but because the falsehoods uttered would, if allowed to go unchallenged, succeed in their purpose of smearing the entire medical profession.

When the AMA opposes any legislative health measure, it does so because its members believe that it would lead to poorer—not better—health care for the people of this country.

This is its main reason for opposing H.R. 4700, 86th Congress—the so-called Forand bill. Testifying before Congressional committees on this measure, the AMA has given its reasons honestly, candidly, and on the basis of its members' daily experience with the medical problems of aging.

That many of the leaders of organized labor reject the collective judgment of medicine is not the main issue. It is labor's prerogative to support or oppose as it sees fit.

It is not labor's right to attack the medical profession, or any other group, with the ugly weapons of falsehood.

COPE's "political memo" of Feb. 1, 1960, entitled "The Forand Bill and the Record of the AMA" charges the American Medical Association with being a leader "in the parade of reactionary forces marching against the passage of the Forand bill."

In the effort to support that charge COPE's memorandum then lists a series of alleged actions by the AMA over a period of years.

The allegations are false. And the facts given here will make this plain.

But before embarking upon a point by point refutation, a word must be said about the source of COPE's allegations.

A COPE spokesman has informed an AMA official that the charges made in the memorandum were based upon the remarks of former Rep. Eugene D. O'Sullivan of Nebraska.

Rep. O'Sullivan made these allegations in a campaign speech of Oct. 27, 1950. Defeated for re-election, Mr. O'Sullivan then had the speech printed as an extension of remarks in the *Congressional Record* of Dec. 8, 1950.

Based on 1950 Speech

COPE's memorandum is indeed based entirely on the O'Sullivan speech; for the wording is in many cases identical with that used by the former congressman, and in other cases is recognizably paraphrased.

In most instances, O'Sullivan attempted to back up his sweeping statements with citations of his sources. These have been carefully checked by the AMA and found wanting. Usually, they were unresponsive to the allegations they pretended to support; sometimes they were completely unrelated to the subject at hand.

COPE obviously did not bother to check these sources.

Continued

In Refutation

Continued

In its haste to smear the nation's physicians, COPE accepted, without question, the reckless accusations made in a 10-year-old campaign speech, by a proponent of national compulsory health insurance who, having been defeated for re-election, entered his remarks in the *Congressional Record* as a lame duck congressman.

Not content with this knowledge, the AMA went further. It sought the source of ex-Rep. O'Sullivan's extraordinary supply of misinformation.

It quickly found out. Mr. O'Sullivan had taken the liberty of borrowing a sizeable portion of a speech made by former Rep. Andrew J. Biemiller of Wisconsin on August 30, 1950.

He, too, was a staunch supporter of national compulsory health insurance.

Andrew J. Biemiller is now Director of the American Federation of Labor's Legislative Department.

In the final analysis, therefore, COPE'S allegations stem directly from a speech delivered by Mr. Biemiller 10 years ago.

COPE'S ALLEGATIONS

1. "A generation ago, the AMA opposed the requirement that all cases of tuberculosis be reported to a public authority—the foundation for all T.B. control methods."

The facts: The AMA has been fighting for tuberculosis control since 1899, when a committee was appointed to report on the nature of the disease, means for controlling it, public education and the advisability of establishing national and state sanitariums.

The most recent AMA action was in 1944, when a resolution on tuberculosis control was passed by the Association's House of Delegates. That resolution said in part "that it is necessary to extend procedures for careful, continuous supervision of the tuberculous by practicing physicians, who *in cooperation with duly constituted health authorities—federal, state and local*—are in a position to deal with these problems by modern methods to prevent the spread of this communicable disease."

The AMA has never opposed the reporting of all cases of tuberculosis to a public authority. The allegation is false.

2. "The AMA opposed the National Tuberculosis Act a week before Congress passed it unanimously."

The facts: The AMA was in sympathy with the purposes of the National Tuberculosis Act, and said so. Its objection to the bill was twofold: (1) Money could not be appropriated or expended for the purposes of the legislation without the approval of the Federal Security Agency; (2) The AMA believed the objectives of the legislation could be achieved in other ways —as, for example, direct aid to needy communities under the Lanham Act.

This allegation is typical of some other COPE accusations, in that it is a deliberate distortion of the truth instead of an outright falsehood.

The grain of truth in this charge is that the AMA did oppose the bill as written, although it suggested changes and favored the measure's purpose.

Each year, thousands of bills are introduced in Congress. Many die in committee without hearings. Few bills are so flawless as to pass in their original form.

This is why Congress holds hearings on them and seeks guidance. This is why Congress debates its measures on the floor. And this is why the AMA and others testify—to help Congress legislate effectively on measures involving the public health.

Whether a legislative proposal is good or bad involves far more than the praiseworthy intentions of its sponsors. COPE knows this well, as does any person with the most rudimentary knowledge of the legislative process.

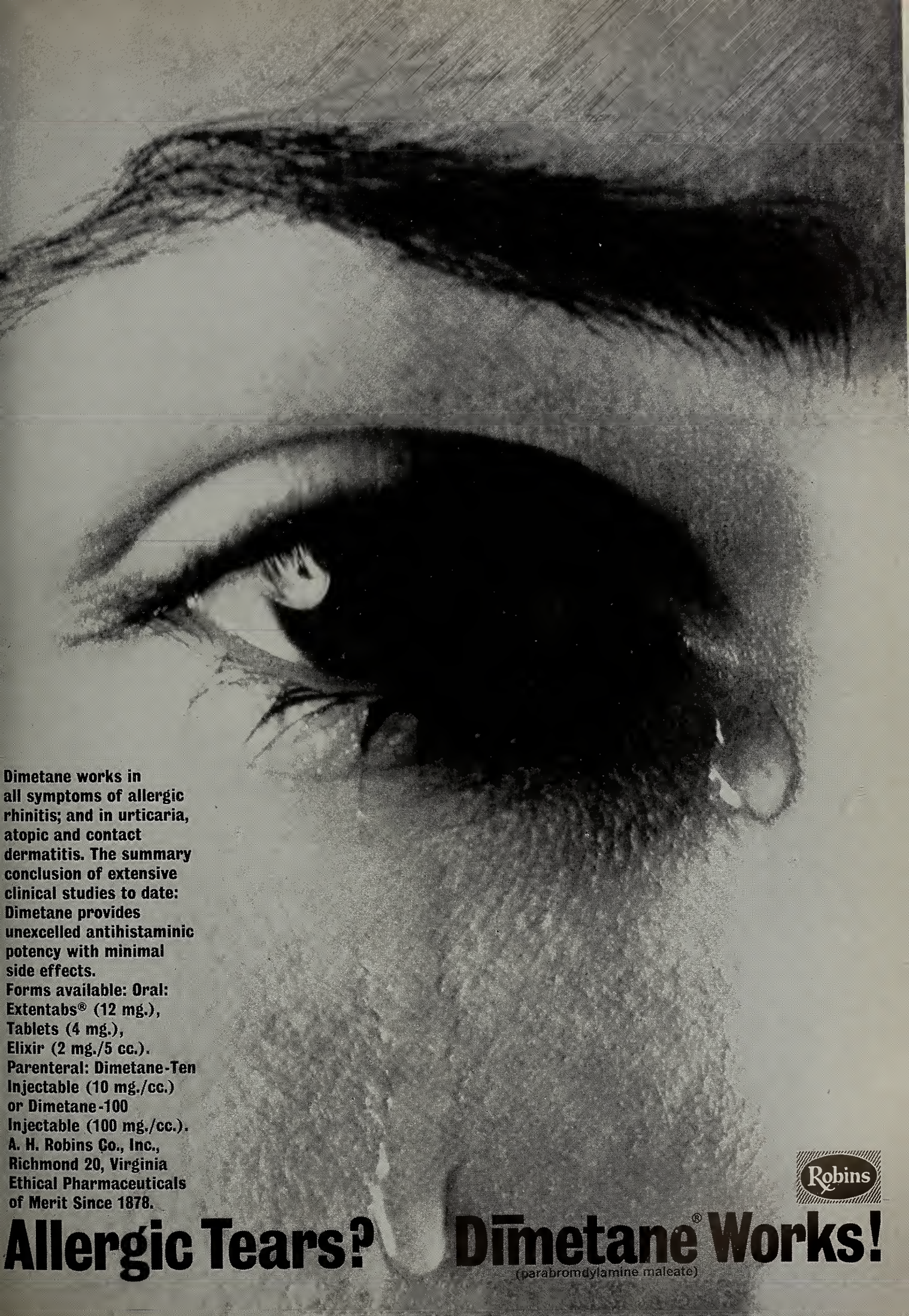
For COPE to state that the AMA opposed the National Tuberculosis Act is to suggest that the AMA opposed its purpose, which is totally untrue.

3. "The AMA fought compulsory vaccination for smallpox."

The facts: The AMA has fought for compulsory vaccination since 1863. In that year it appointed a committee on compulsory vaccination "to educate the public on the value and necessity of universal vaccination."

This committee did report that general compulsory vaccination was impracticable in 1863. No doubt it thought so because a civil war was raging, thus making general compulsory vaccination difficult — particularly in the confederate states.

In 1899, the AMA's House of Delegates resolved that it was the physicians' duty "to insti-



Dimetane works in all symptoms of allergic rhinitis; and in urticaria, atopic and contact dermatitis. The summary conclusion of extensive clinical studies to date: Dimetane provides unexcelled antihistaminic potency with minimal side effects.
Forms available: Oral: Extentabs® (12 mg.), Tablets (4 mg.), Elixir (2 mg./5 cc.). Parenteral: Dimetane-Ten Injectable (10 mg./cc.) or Dimetane-100 Injectable (100 mg./cc.).
A. H. Robins Co., Inc., Richmond 20, Virginia
Ethical Pharmaceuticals of Merit Since 1878.

Robins

Allergic Tears? Dimetane® Works!

(parabromdylamine maleate)

tute measures looking to the vaccination, ultimately, of every person living within the limits of the country," and urging local boards of health to adopt laws requiring compulsory vaccination for smallpox.

This allegation is an out-and-out falsehood.

4. "The AMA attacked provisions for immunization against diphtheria and other preventive measures against contagious diseases by public health agencies."

The facts: The AMA has cooperated with public health agencies in the prevention of contagious diseases for more than 80 years. From 1875 to 1879, the AMA was urging "that state boards of health be established in those states where such boards do not exist."

In 1884, the AMA recommended that Congress appropriate money "for the prosecution of scientific research relating to the cause and prevention of the infectious diseases of the human race, to be expended under the direction of the National Board of Health."

In 1905, the AMA recommended that Congress aid the U.S. Public Health and Marine Service "in prosecution of its important duties and in its efforts to protect and improve public health."

And in 1950, a report adopted by the AMA's House of Delegates said, in part: "The basic services of the departments of health should be . . . the fields of vital statistics, public health education, environmental sanitation, public health laboratory services, prevention of disease and control of communicable diseases, such as the diseases of childhood, venereal diseases and tuberculosis."

5. "The AMA opposed the first bills to grant Federal aid to the states to reduce infant and maternal deaths."

The facts: The AMA has long favored maternal and infant welfare programs, but felt they would be most effective if each state were free to set up its own plan in cooperation with the U.S. Public Health Service. The AMA has recommended that any legislation involving cooperation between the Federal government and the separate states should be jointly administered by the U.S. Public Health Service and state health authorities.

Legislative proposals based on other approaches were opposed by the AMA on that basis—not because the association felt that infant and maternal deaths should not be reduced. Yet this is what COPE's allegation has the temerity to suggest.

6. "The AMA opposed the Social Security Act passed in 1935."

The facts: As originally drafted, this measure dealt with unemployment compensation, old age security, security for children and extension of public health. Mention was also made of national health insurance. This section was deleted when the bill was redrafted.

The AMA testified only on the section of the Social Security Act dealing with the extension of public health services. The following is taken from that testimony:

CHAIRMAN: (Mr. Doughton) Doctor, are you supporting that section of this bill as it is, without the suggestion of amendments or modifications?

DR. BIERRING: From my knowledge of the needs of the country, I would say that it should be supported.

CHAIRMAN: We understand that it is one of the paramount needs, but do you have any changes or anything like that in mind that would help to better the bill?

DR. BIERRING: No, sir, I believe it is under good supervision if it is under the expert guidance of the United States Public Health Services.

The allegation is false.

7. "In 1939, in behalf of the AMA Board of Trustees, Dr. Morris Fishbein condemned old-age and unemployment insurance as a 'definite step to either communism or totalitarianism.'"

The facts: As Editor of the *Journal of the American Medical Association,* Dr. Fishbein exercised an editor's right to comment freely. The quote attributed to him is taken out of context, since the major portion of his remarks were directed to the intrusion of the Federal government into the field of medical care. Dr. Fishbein said:

"The introduction into this nation of a federal security plan whereby the nation itself, as a federal agency, will step intimately into the sickness and life of every person in the country, will be the first step in the breakdown of American democracy. Indeed, all forms of security, compulsory security, even against *old-age and unemployment,* represent a beginning invasion by the state into the personal life of the individual, represent a taking away of individual responsibility, a weakening of national caliber, a *definite*

step toward either communism or totalitarianism . . . ."

This statement represented Dr. Fishbein's opinion as an editor. His comments on old-age and unemployment security did not constitute the official viewpoint of the AMA, which did not oppose old age and unemployment security provisions of the Social Security Act.

8. "The AMA opposed the creation of public veneral disease clinics."

The facts: Since its inception the AMA has fought to eradicate venereal disease. In 1907 the Association declared it the duty of "state boards of health to disseminate literature to educate the people on the subject of the great black plague (venereal disease) as they do tuberculosis and other infectious diseases."

The AMA has called upon its doctor members to cooperate with the U.S. Public Health Service for better control of venereal disease. It has declared that members of the medical profession should cooperate with the official health agencies charged with the responsibility for an expanded program to control venereal disease made possible by Federal grants-in-aid.

The association has also approved the treatment of non-indigents for venereal disease in public health units in those instances where such treatment is not available through private sources.

The allegation is totally unfounded.

9. "The AMA opposed the creation of free diagnostic centers for tuberculosis and cancer."

The facts: In 1948 the House of Delegates approved a resolution which authorized the Association to cooperate with the American Cancer Society and other agencies engaged in cancer detection "for the purpose of formulating standards of procedure and conduct in the operation of cancer detection and diagnostic centers and that the results of these studies be adequately publicized to those concerned, including the medical profession and the public."

As part of its program for improved medical care, the AMA has also approved the diagnosis of tuberculosis by public health centers, and treatment of the disease by those centers, for indigent patients. In those instances where treatment is not otherwise available, the AMA has approved treatment of non-indigent patients.

The AMA has been cooperating with cancer-fighting groups since 1913, when an AMA resolution, noting the recent founding of the American Society for the Control of Cancer, stated that "this movement deserves the cooperation of the medical profession of America, and this Association heartily commends its worthy purpose."

The allegation is without foundation.

10. "The AMA fought the American Red Cross plan to set up a nationwide reserve of civilian blood banks."

The facts: The House of Delegates approved the Red Cross plan in principle shortly after it was announced, but with the understanding that the program should be maintained on the community level.

In 1949, the House of Delegates accepted a report from its Committee on Blood Banks, which stated that there was an urgent need for a national blood program capable of continued expansion, and that the Red Cross was the logical agency to assume the responsibility for such a program.

In 1953, the House of Delegates urged the establishment of a coordinated national blood program to be jointly organized by the American Red Cross, the AMA and other qualified organizations interested in blood banking. The plan which resulted was adopted by the House of Delegates the following year, and unanimously approved by representatives of the American Red Cross, the American Hospital Association, the American Association of Blood Banks, the American Society of Clinical Pathologists and the Committee on Blood of the American Medical Association.

In 1955, the House approved the establishment of the Joint Blood Council, Inc., formerly the Blood Foundation. And in 1957, it was resolved that the AMA would continue to encourage and support the Joint Blood Council in carrying out its stated objectives.

To sum up, the AMA has continually and consistently supported the Red Cross plan.

The allegation is false.

11. "The AMA opposed Federal aid to medical education even after AMA representatives had testified before Congress that the medical schools were in dire financial emergency and that there was a serious shortage of doctors in the U.S. Organized medicine's stand was directly contrary to the stand of the nation's medical school deans, the American Hospital Association, the American Dental Association, the armed services and a large number of the country's public health administrators."

Continued on page 1202

The first synthetic penicillin available for general clinical use

FOR YOUR NEXT PATIENT WHERE PENICILLIN IS INDICATED

SYN C

PEAK BLOOD LEVELS HIGHER THAN POTASSIUM PENICILLIN V

ORAL ROUTE PROVIDES HIGHER INITIAL PEAK BLOOD LEVELS THAN INTRAMUSCULAR PENICILLIN G

IMPROVED ANTIBIOTIC ACTION FROM ISOMERIC COMPLEMENTARITY

SUPPLY: SYNCILLIN TABLETS–250 mg. and SYNCILLIN TABLETS–125 mg.
SYNCILLIN FOR ORAL SOLUTION–60 ml. bottles–when reconstituted, 125 mg. per 5 ml.
SYNCILLIN FOR PEDIATRIC DROPS–1.5 Gm. bottles. Calibrated dropper delivers 125 mg.





CONSIDER THESE 6 IMPORTANT THERAPEUTIC ATTRIBUTES OF

SYNCILLIN™

potassium phenethicillin (POTASSIUM PENICILLIN-152)

ANTIBIOTIC ACTIVITY DIRECTLY PROPORTIONAL TO ORAL DOSE	*REDUCED RATE OF INACTIVATION BY STAPH PENICILLINASE*	*SOME STAPH STRAINS MORE SENSITIVE TO SYNCILLIN IN VITRO*

BRISTOL LABORATORIES, SYRACUSE, NEW YORK

BRISTOL





In Refutation Continued from page 1199

The facts: In 1949, the AMA stated that since medical schools were finding it difficult to secure sufficient funds to maintain their standard of training, it might become necessary for some schools to accept financial aid from the Federal government. The association made it clear, however, that it would prefer to see the necessary support come from private philanthropies or local public funds. Federal aid, the AMA said, should be the last resort; and if it became necessary, it should be accompanied by the assurance of freedom from political control and regulation.

The AMA opposed S. 1453, 81st Congress, because the bill did not make this guarantee of freedom to the medical schools.

In 1951, the AMA endorsed the principle of one-time grants-in-aid on a matching basis, using the Hill-Burton Act formula and administrative machinery—provided those grants were used for construction, equipment and renovation of the physical plants of medical schools and not for operational expenses or salaries.

In 1955, the association supported such a bill before the 84th Congress. It also opposed, in that year and since, measures which deviate from the AMA's recommended approach.

The allegation is a distortion of the truth.

12. "The AMA attacked voluntary health insurance plans as 'socialism, communism—inciting to revolution.' (Ho Hum.)" "The AMA dismissed Blue Cross as a 'half-baked' scheme."

The facts: The first quotation is taken out of context. It is from an editorial in the *Journal of the American Medical Association,* printed December 3, 1932, and dealing with the two reports of a committee on the costs of medical care. The majority report urged medical practice by organized groups of physicians associated with hospitals. Commenting on this, the *Journal* said: "The alignment is clear—on the one side, the forces representing the great foundations, public health officialdom, social theory—even *socialism* and *communism—inciting revolution;* on the other side, the organized medical profession of this country, urging an orderly *evolution.*" It should be noted that this same editorial referred to health insurance as "foresighted, American, economical."

The second quotation apparently refers to a *Journal* editorial of March 25, 1933, on the attempts by some to make large profits from health insurance. The *Journal* said: "It is unfortunate that lay and medical organizations in many cities were urged . . . to embark on *half-baked* experiments in changing the nature of medical practice." The editorial does not mention Blue Cross.

As early as 1917, the AMA policy was to cooperate in the development of health insurance legislation which would benefit the public.

The fact is that the American Medical Association has never opposed the development of voluntary sickness insurance plans in this country as they exist today. The first plans, initiated in the early 1930's, were very different from contemporary voluntary sickness insurance plans.

The association's support of voluntary health insurance, as that term is now generally understood, has been consistent.

The AMA frequently objected to certain features of the early plans which it considered harmful to both patient and physician. For example, when the free choice of physician by the patient was prevented, when the patient-physician relationship was endangered, when plans were based upon an uncertain actuarial basis, the AMA opposed them.

However, the AMA has continuously encouraged the development of the voluntary plans along a sound financial and medical care basis, and as early as 1934 drew up a set of principles to guide in the development of these plans and to insure soundness in their execution. Through experience, a new type of voluntary insurance developed in which the harmful features were gradually eliminated; and with the establishment of this new type of insurance, the House of Delegates in 1938 gave its wholehearted approval to voluntary sickness insurance as a means of meeting the costs of medical and hospital care.

13. "The AMA opposed school health service legislation."

The facts: Presumably the reference is to testimony given before the 81st Congress on two specific bills. The AMA spokesman said, on these measures, that the association was in full agreement with the general purpose, and considered it so worthwhile that the AMA would not oppose the measure if it did not feel that the bills, as then drafted, would fail to accomplish their purpose.

Dr. Walter Martin, a member of the AMA's Board of Trustees, then told the House Subcom-

mittee on Public Health, Science and Commerce *why* the AMA felt this was the case.

14. "The AMA fought Federal aid to public health units."

The facts: The AMA record speaks for itself.

The association supported federal aid to public health units in testimony before various congressional committees in 1948, 1949 and 1951. The following statement, taken from testimony, reflects the AMA's position on the subject:

"We, the AMA, have long believed that the existence of public health units is basic to the maintenance of and improvement of the health of our people. Recognition of this conviction was reflected in action taken by the association as early as 1883, when a report was made at our annual meeting for that year covering a survey conducted to ascertain what states and counties had at that time health departments."

15. "The AMA blasted a Defense Department request to Congress to give Government medical care to dependents of men in the armed forces, with particular reference to the men then fighting in Korea, as 'unpractical and harmful to National Defense.'"

The facts: The AMA testified on a bill at the time of the Korean War to provide hospitalization and medical care to the dependents of men in the armed services. Nowhere does that testimony include the quote used by COPE in its memorandum.

In his testimony on behalf of the AMA, Dr. Martin stated seven reasons why the bill, in its present form, would not be as effective as Congress hoped. Among other things, he said: "If it is the purpose of Congress—*and I think the purpose is a perfectly proper one*—to provide medical and hospital care for dependents of enlisted service personnel, it can be provided more readily, more cheaply and more effectively through existing civilian facilities."

In questioning, Rep. Furcolo said: "I think the AMA is certainly to be commended for the patriotic interest it has shown in presenting its opinion on this bill. As I understand it, the AMA, and the people in it, are willing to go along and do what they can. . . ."

Mr. Furcolo interpreted the AMA's testimony correctly: as a constructive effort to help the members of Congress accomplish a worthwhile legislative purpose as effectively as possible.

Continued



Summertime

Is Jaguar

XK 150 Time!

Drive the Jaguar XK 150 Sports Convertible

For the greatest driving adventure of your life, take the wheel of a Jaguar XK 150, the world's most famous sports car! Amazing acceleration, dazzling speed . . . with the famous Jaguar XK engine that has earned its reputation for endurance in countless international competitions. Clean, classic styling. Unmatched riding luxury. Unequalled safety with road-race-proved disc brakes. Convertible, hardtop coupe, roadster models. See also the new Jaguar 3.8 litre family sports sedan and the luxurious Mark IX. Convenient terms available.

JAGUAR MIDWEST DISTRIBUTORS, Inc.
2330 NORTH MERIDIAN STREET • INDIANAPOLIS

In Refutation

Continued

After the Medicare law was passed, it should be noted, the AMA's House of Delegates urged its constituent state and component county medical societies to cooperate fully with the Defense Department in the provision of medical services to dependents, as provided in the Act.

To sum up, the COPE memorandum is a composite of outright falsehoods and twisted half-truths.

It is a scurrilous attack on the American Medical Association and the men and women who serve the American people in their role as physicians.

In their behalf, the American Medical Association demands a full retraction of these accusations and an apology from those responsible for making them.

In Answer to Mr. Meany's Response...

April 8, 1960

Mr. George Meany
President
AFL-CIO
815 Sixteenth Street, N. W.
Washington 6, D. C.

Dear Mr. Meany:

In response to your letter received March 25, I am glad to learn that COPE's political memorandum of February 1, 1960 was not an attempt to impugn the motives and competence of the nation's physicians and that any such interpretation by us "is completely erroneous."

You cannot, however, wonder at our interpretation of COPE's motives. An attack upon the American Medical Association must, it seems to me, be interpreted as an attack upon the 175,000 physicians who are members of the association. By the same token, if we were to attack the AFL-CIO (which we have not) would this not be tantamount to an attack upon its rank and file?

In your letter you say the leadership of organized labor has "frequently lauded the contribution the American Medical Association has made in the field of its competence." The implication is clear that COPE's attack, therefore, was based upon AMA actions in areas outside its field of competence.

I suggest you review COPE's allegations, which deal with such matters as: the reporting of tuberculosis cases to a public authority; opposition to the National Tuberculosis Act; compulsory vaccination for smallpox; immunization against diptheria; infant and maternal death prevention; venereal disease clinics; diagnostic centers for tuberculosis and cancer; blood banks; medical education; health insurance; school health; public health units and Medicare.

Are you suggesting that the medical profession is not competent to act or comment in these areas? Further, are you suggesting that the nation's physicians were incompetent to testify relative to the medical and hospital provisions of the Social Security Act?

If this is your position, I must emphatically disagree. The COPE charges dealt with AMA positions on matters directly affecting the nation's health. They cannot, therefore, be passed off as allegations directed against the AMA for its stand on subjects outside the association's field of competence.

Further, it seems to me that your letter begs the main issue: Were COPE's charges true or false?

The record we documented showed your charges were untrue. Therefore, I must admit to total surprise at your statement that "we have re-examined this record and find no basis for retraction." COPE recited no "record," but simply listed a series of unsupported allegations.

In fairness, Mr. Meany, you must admit that the shortcomings of the COPE memorandum extended a great deal further than "its failure to bring the record up to date."

There is one other point I should like to make:

Physicians have not been disfranchised, nor is it likely that they will be. They are entitled to express their opinion on any matter of government, just as are all other citizens of the United States. The men and women of labor have an identical right, and exercise it freely—as I believe you will be the first to admit.

And so I am somewhat puzzled when you draw your analogy of "Doctor Jekyll and Mr. Hyde." Must I conclude that you deny the right of a physician to speak, as a citizen, on matters affecting him as a citizen? Would this not be the same as denying organized labor the right to speak on any subject not involving collective bargaining, or labor-management relationships?

Further, let me repeat what I said in my letter of March 15 on H. R. 4700—the so-called Forand bill:

"That many of the leaders of organized labor disagree with the collective judgment of medicine is not the main issue. It is labor's prerogative to oppose or support it as it sees fit."

The American Medical Association does not seek to halt labor's "efforts to secure its (the bill's) enactment." But the association does ask that the AFL-CIO's political arm, COPE, put aside the weapons of untruth and base its efforts on appeals to logic, instead of appeals to emotion and bias.

We too believe that a constructive endeavor should be made to understand and meet whatever problems exist in improving the health care of our aged. We are prepared to make that constructive endeavor, now as in the past, in cooperation with any group—including labor—which brings to the common task the requisites of good faith and open minds.

Sincerely yours,
Louis M. Orr, M.D.

◄

Reliable

PROFESSIONAL LIABILITY
INDIVIDUAL INSURANCE

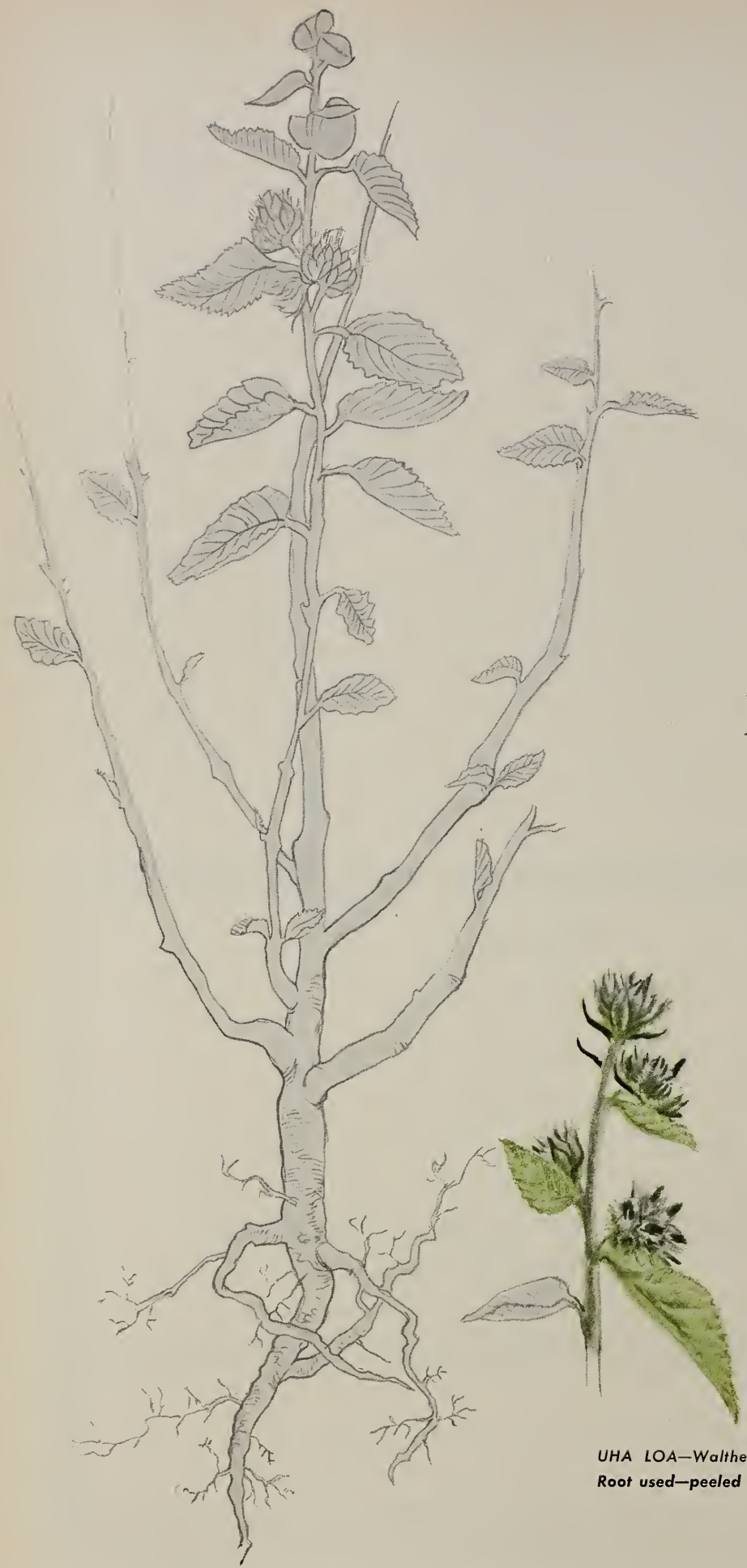
with proficient defense
that cuts the cost

Unparalleled Experience ● Specialized Service ● Saving in Cost

THE
MEDICAL PROTECTIVE COMPANY
FORT WAYNE, INDIANA

Professional Protection Exclusively since 1899

INDIANAPOLIS OFFICE: Kenneth W. Moeller, Rep.
5950 Indianola Avenue Tel. CLifford 5-6525



HAWAII—

UHA LOA—Waltheria Americana
Root used—peeled for sore throat 2′.

Rich in Lore of Medicinal Herbs

MIKI WILSON
San Francisco

Presenting a medical salute to our newest state, Hawaii, rich in lore of herbs as used medicinally. Miki Wilson, artist and originator of the JOURNAL's herb series, here searches the Islands for traditional Hawaiian treatments of physical ills with local flora.

THE HAWAIIAN ISLANDS, formerly called the Sandwich Islands, are one of the most remote groups of islands in the world. Strange it does seem to have our newest state 3,000 miles from our shore, sandwiched between the vast Pacific and the limitless skies.

What is left of the original population has merged and mingled with successive migrations of peoples from other islands, other countries . . . Chinese, Portugese, Tahitians, Samoans and English, Filipino, American and Japanese.

Hawaiian life and culture has, however, infiltrated through the layers of alien population tinging them with a distinction that is of Hawaii. The legends, stories, beliefs and crafts still permeate these lovely, haunted isles.

Some of the charming customs have been taken over by those making their homes in Hawaii. People of all races gaily plant TI (Taetsia fruticosa) around their homes as protection against evil spirits, for which it is excellent; although, it may well be just for decoration.

This lovely plant with its broad green leaves has a long and intimate association with Hawaiian life. It is used in making of grass skirts, for cooking and for medicine. It was worn as decoration denoting station by the old royalty and the kahunas. Its great green leaf is still used as a table covering for luaus, for packaging laulaus (a combination of butterfish, pork and taro leaf wrapped in Ti and steamed), and even is used rolled and folded into a kind of flute.

Continued

Hawaii

Continued

But it is most famous for the potent drink made from it . . . okolehao. This amazing beverage, some say, was invented by a stranded Australian sailor. It became so famous—or infamous—that it was banned for many years. Just recently the ban was lifted; 'oke' can again be made legally and from the same Ti as before.

And this extraordinary plant has a built-in cure for the drink made from it. The freshly picked leaves bound around the forehead are a sure cure for headache!

It is impossible to think of the Hawaiian Islands without conjuring up a picture of tall coconut palms bending in the breeze and fringing the long, white beaches. This delightful scene only changes during storms that sweep across the Islands causing the nuts to drop and creating more damage than they can cure.

For NUI (Cocos nucifera) has medicinal as well as other uses. Almost every part of this tree has been used in the Islands: the trunk for canoes and drums, the bark for strainers or twisted into rope. Its leaves still are woven into fences and thatch, and into the popular 'coconut hats.'

Versatile for Travel

The nuts were carried by the seafaring Hawaiians on their long ocean voyages as food and water in unbreakable 'self' containers. The oil from the nuts was fine for shampoo and the shells made practical cups.

Nui, in its 'spoon nut' stage can be used to cure gall stones! When the nut is in this soft, unripe stage, a hole is made in the 'eye' and the milk drunk through a straw. This is continued until the stones are sufficiently dissolved to be passed.

Colorful GUAVA* (Psidium guajava) produces a deliciously tart fruit and also has curative powers. Oddly it is not native to the islands, but was probably introduced by the Spanish as late as the 1700's. Hawaiians did not take long to discover its advantages as a cure for dysentery and diarrhea.

The smallest and most tender leaves are gathered, pounded and made into an infusion, which, when drunk, immediately relieves that aforementioned unpleasant condition. Just as PAPAYA (Carica papaya) is another delicious fruit bearing tree with leaves, which when pounded and made into a poultice, is effectively applied to lacerations and especially to the common and most painful coral cuts.

Hawaiian herb medicine developed in scope through the years, the people using native and imported plants and trees to great effect; while surgery was relatively overlooked, due, perhaps, to a general lack of need. The war-like Fiji Islanders are credited with having introduced the art of surgery through the islands of the Pacific, due, no doubt, to their greater need and, therefore, greater skill.

Today it might well be that the same holds true, barring the accidents in modern mechanized life, for many and varied are the uses of the Islands' luxuriant flora.

There is a truly magnificent tree, native to the Islands, called KUKUI (Aleurites moluccana) which has always been of importance in Hawaiian life. Before the days of easy illumination, the Kukui nuts, strung on the midriff of the coconut leaf, were used as torches. For more elaborate occasions, the oil was extracted and used in stone vessels 'pohokukui' equipped with one or more 'kapa' wicks. Various parts of the tree have been used for dyes. And long before the advent of the fine local police, the Kukui nuts were absolutely essential in the detection of criminals.

Insures Stomach's Laboring

The nut, which has the bitter flavor of a green walnut, has the effect of a rather violent purge if taken even in small quantities. In this regard it is used at luaus. A small amount of the nut is ground and mixed with Hawaiian salt (sea salt) and used as a side dish in which the tip of the finger can be dipped and minute bits absorbed along with the excellent but heavy eating and drinking. Thus, through the long feast, the stomach can continue to labor effectively.

There are odd things that can occur in Hawaii and it is well to be warned in advance. For instance, the pivot of the luau is the Kalua pig—the pig which is buried in the Ti lined 'imu' preheated by hot stones. Never take any of this pork home in your car if your way passes a cemetery. The car will stop and nothing will start it until the pork is disposed of. Kukui will not help this situation at all—but it *will* cure tonsillitis!

And this latter is an interesting procedure.

* Fruit shown in black in the illustration, but a lovely yellow in Miss Wilson's original drawing.

When the nuts are gathered for this purpose, they must not be broken from the branch. Branches and all are brought in intact. The index finger is then wrapped in bandage so as to make a swab, and the ailing child is placed, mouth open, ready for treatment. As the nuts are broken off the branch and peeled, a thick sap is exuded which is taken on the wrapped finger and the tonsils are gently swabbed. Generally a week's treatment with about 30 to 40 nuts should suffice.

Now, anyone possessing a NONI* (Morinda citrifolia) is very fortunate indeed. This rather small tree, bearing an unusual fruit, is considered an excellent medicine.

In the past the leaves and bark were made into a tonic; however, today it is the fruit which is highly prized in the care of asthma and high blood pressure. The strange little pentagonal or hexagonal fruit, looking like a miniature pale green pineapple, contains in its chemical nature something not as yet identified which is of great value in the treatment of kidney diseases. For general use in kidney troubles, the fruit is mashed and made into a 'tea' which is taken until the condition improves.

Not only are the fruits and nuts of the larger trees valuable in this respect, but all the Islands abound in small undistinguished weeds and grasses growing in untended gardens and along the country roads that are of value to those who recognize them.

* Shown on our cover this issue.

Best for Sting

There is even a cactus, ALOE (Aloe ciliaris), which is very highly regarded—every garden should have one growing and many of them do. Swimmers in these Islands know its value and their gardens are never without the spiky Aloe because it is the best thing available for the electric sting of the Portugese man-of-war.

These little jellyfish with long blue tentacles float into shore seasonally by the hundreds. When one makes contact with the barbed tentacles which float beneath the surface of the ocean, it is the stinging of nettles, sometimes creating a brief paralysis, nausea and raising of painful welts. The leaf of the Aloe, cut lengthwise and rubbed directly on the welts, immediately relieves the pain and eliminates further swelling.

Continued



Hawaii

Continued

For burns it is also very well known. Applied directly, it relieves pain and prevents scars.

There is another unusual use for this remarkable plant—that is in the cure of diabetes. The leaf must be peeled and scraped, getting all the fibrous meat. A cup of this pulp is added to one gallon of water and the whole put into a mixer until well blended. One cup a day is taken from Monday through Friday. The length of treatment varies with the condition of the patient in some cases one month will cure the disease!

Finding the 'medical weeds' is becoming more and more difficult. The bulldozers turning over ground to make place for an increasing number of homes destroy many of the wild plants. Going farther afield, one finds the weeds fighting a losing battle with livestock.

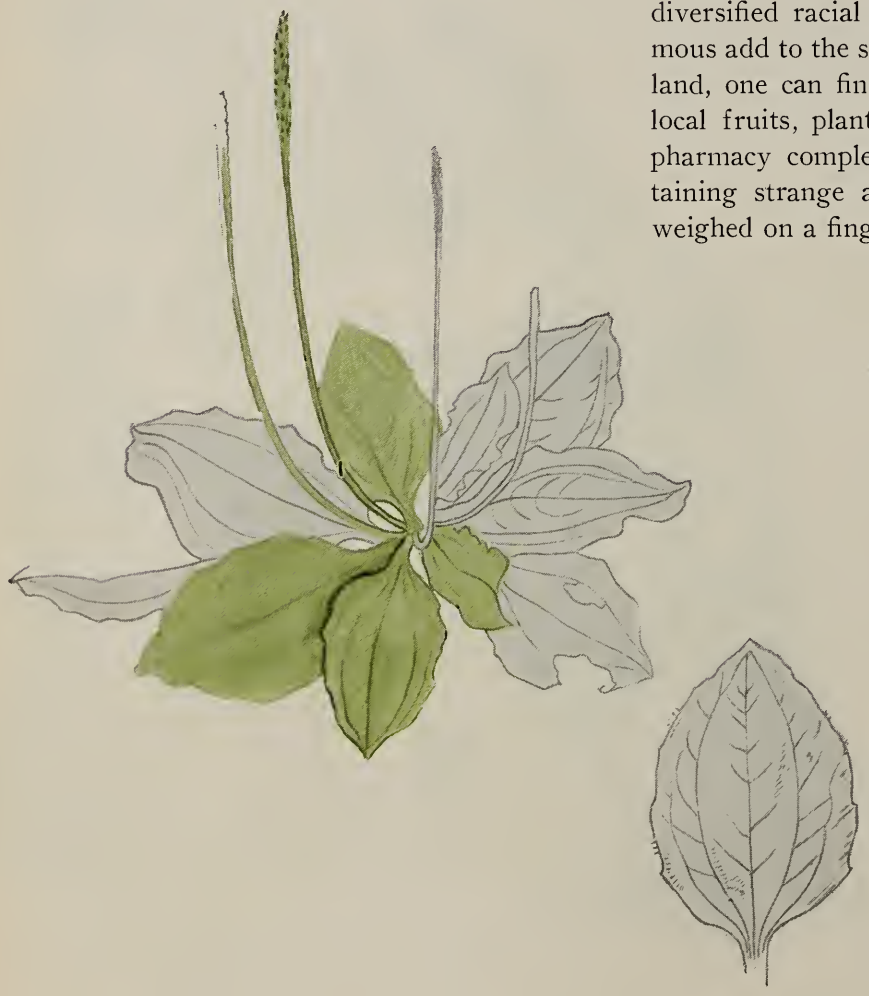
Cattle are particularly fond of HAU WEE WEE and are making it very difficult to find. This is unfortunate since Hau Wee Wee is exceptionally fine for serious cuts and lacerations, and helps to stop excessive bleeding. Its leaves are made into a poultice, pounded with Hawaiian salt, and, as its name implies, dampened with male urine. The latter is not absolutely necessary but considered definitely advisable.

One little weed that is surviving the depredations of civilization and livestock fairly well, perhaps because its rosette of pale leaves lie flat to the ground, is LAUKAHI (Plantago virginica). Laukahi, easily found, is very popular for a number of things. Made into a tea, it is helpful in the relief of asthma and high blood pressure. As a poultice, mixed with pure olive oil, it cures water on the knee, and the sap from the freshly picked leaves is applied directly to minor cuts as a styptic.

To Alleviate Itch . . .

It is also still fairly easy to find HONO HONO (Commelina), another valued weed which sports a lovely little blue flower. Besides being very attractive to horses and undoubtedly good for them, its sap, applied directly, is excellent for alleviation of the itch.

The sharing of knowledge, the overlapping of diversified racial pasts for which Hawaii is famous add to the scene where, within this small island, one can find the Hawaiian herbalist using local fruits, plants and berries . . . the Chinese pharmacy complete with walls of drawers containing strange and interesting dried things, weighed on a finger scale and counted on an aba-



LAUKAHI—Plantago virginica
Asthma—water on knee—high blood pressure



ALOE—Aloe ciliaris
Diabetes—burns—Portugese man-of-war.

In this case, however, the effect is much like the tonic value of cod liver oil, but is handled in a rather unusual manner. Popolo produces small berries which, when black, are ready for use. These are gathered and mashed into a pulp. The pulp is put in a clean cloth and placed on the 'soft spot' of the baby's head where the juice is absorbed through the delicate membrane. It can also be liquified and poured 'drop by drop' on the soft spot and taken into the system in that way.

Whatever opinion might be held on this method of strengthening babies, it must be admitted the results have not impaired the beauty of these healthy Island children.

It is only to be hoped that as they grow up they do not forget entirely the old Hawaiian songs and crafts and legends which have given substance and beauty to the varied peoples who have made the Islands home. ◄

See "Add 1" in the March, 1960 Journal, pp. 370, 372 for excerpts from a letter by Miss Wilson telling of her escapades in searching for these herbs in an Hawaiian "forest."

cus . . . the Japanese gardener carefully picking and drying Laukahi for his Mainland friends . . . the Portugese making a tisane from plants brought from their homeland.

The different bits and pieces that contribute to Hawaii's charm are many, varied and interesting, just as are the flower, leaf, stem and root that make up her greenness . . . to be able to pick from the rich earth the cure for some distress.

If, for instance, one has a sore throat, it is simplicity itself to pull up a plant of UHA LOA (Watheria americana), peel the large root and chew it. The soreness will disappear.

These plants, and many more (some 280 are known to Hawaiian herbalists) have power to help ailing humanity, but there is one that is particularly known for giving the Island babies a good start in life. Oddly enough, this plant, POPOLO (Solanum nigrum), belongs to the nightshade family not usually connected with 'starts' in life.



GUAVA—Psidium Guajava
Tender shoots for dysentery—high blood pressure

Proven

in over five years of clinical use and more than 750 published clinical studies

Effective

for relief of anxiety and tension

Outstandingly Safe

- simple dosage schedule produces rapid, reliable tranquilization without unpredictable excitation
- no cumulative effects, thus no need for difficult dosage readjustments
- does not produce ataxia, change in appetite or libido
- does not produce depression, Parkinson-like symptoms, jaundice or agranulocytosis
- does not impair mental efficiency or normal behavior



when that early Monday morning telephone call is from a weekend do-it-yourselfer

"...and this morning, Doctor, my back is so stiff and sore I can hardly move."

now...there is a way to prompt, dependable relief of back distress

the pain goes while *the muscle relaxes*

POTENT – **rapid relief in acute conditions**

SAFE – **for prolonged use in chronic conditions**

notable safety – extremely low toxicity; no known contraindications; side effects are rare; drowsiness may occur, usually at higher dosages

rapid action, sustained effect – starts to act quickly, relief lasts up to 6 hours

easy to use – usual adult dosage is one 350 mg. tablet 3 times daily and at bedtime

supplied – as 350 mg., white, coated tablets, bottles of 50; *also available for pediatric use:* 250 mg., orange capsules, bottles of 50

WALLACE LABORATORIES, New Brunswick, New Jersey

SOMA™

(CARISOPRODOL WALLACE)

Group Clearance Eliminated In Quarantine Procedures

PUBLIC HEALTH SERVICE has announced the adoption of simplified quarantine procedures at international airports, the principal change being elimination of group clearance which preceded individual quarantine clearance on arrival of planes from foreign countries.

Under the new procedures, if the aircraft captain certifies that no illness has been observed during flight, only individual clearance of passengers is required. Group clearance had been maintained to prevent spread of disease by travelers who might have symptoms of quarantinable illness on arrival. If such illness is reported aboard a plane, or there is an unusual disease problem in the country where the flight originates, the strictest quarantine procedures will be applied. The only major airport where passengers will be kept in groups is Miami, Florida, where the means of access to quarantine facilities makes the change impractical.

Additional streamlining of quarantine procedures is being made wherever possible.

New procedures stress the responsibility of travelers for maintaining valid immunization records and the responsibility of airlines for reporting illness observed among passengers.

Airline and Public Health Service officials consider this streamlining of entrance procedures an aid toward the objective of making visits to this country more attractive. This objective is in line with the President's action in proclaiming 1960 "Visit the United States of America Year."

Visitors from foreign countries and United States citizens returning from abroad will benefit alike from the new quarantine procedures. Immigrants and certain other non-citizens will continue to receive special Public Health Service inspection or examination as necessary to determine compliance with health provisions of the immigration law.

Diseases Defined

The quarantinable diseases defined by international sanitary regulations are smallpox, yellow fever, cholera, plague, louse-borne typhus and louse-borne relapsing fever. None of the quarantinable diseases are known to have been introduced into the United States from foreign countries since a smallpox outbreak in the New York City area in 1947, although quarantinable disease continues to occur widely in other parts of the world.

Modern international quarantine emphasizes the prevention of illness through immunization of travelers, control of insects, cleanliness of conveyances, and safeness of food and water supplies.

Vaccination against smallpox is of basic importance for international travelers. Both citizens and aliens entering the United States (except persons coming from exempt areas) must have an international certificate of smallpox vaccination, received within three years of arrival. Persons not properly immunized may be vaccinated by a quarantine officer or released subject to further examination at their destination. If they have recently been in an infected area, they may be detained for medical observation for a period up to 14 days.

Smallpox vaccination usually is not required for travelers who have been only in certain quarantine exempt areas if they arrive on a conveyance that has touched only at those areas. (The exempt areas are Canada, the Islands of St. Pierre and Miquelon, Iceland, Greenland, the West Coast of Lower California, Cuba, the Bahama Islands, the Canal Zone, the Bermuda Islands, the British Virgin Islands and the Islands of Aruba and Curacao.)

For personal protection it is recommended by the Public Health Service that individuals planning trips to an area where smallpox is epidemic should be successfully vaccinated, or revaccinated, within six months of arrival in the infected area.

Travelers who have been in a yellow fever infected area within six days of arrival at United States ports are required to present an international certificate of yellow fever vaccination received within six years of arrival. This requirement applies when the traveler is bound for the



"MY DOCTOR SAYS YOU CAN KEEP YOUR BLUE SHIELD – THEY DON'T CANCEL YOU OUT WHEN YOU'RE OLD AND SICK!"



Blue Shield

Mutual Medical Insurance, Inc.
110 N. Illinois St., Indianapolis 9, Ind.
Phone MElrose 5-9411

THE DOCTORS' PLAN — Sponsored by the Indiana State Medical Association

Group Clearance

Continued

"yellow fever receptive area" in the southern part of the United States and its possessions. The nation has not had a yellow fever outbreak since 1905, but in several southern States and United States possessions the mosquito that transmits this disease is still present. The Public Health Service and state and local health departments are cooperating in a mosquito control program at critical points.

anorectic-ataractic

BAMADEX®

meprobamate 400 mg., with d-amphetamine sulfate 5 mg., Tablets

FOR THERAPY
OF OVERWEIGHT PATIENTS

- d-amphetamine depresses appetite and elevates mood
- meprobamate eases tensions of dieting (yet without overstimulation, insomnia or barbiturate hangover).

Dosage: One tablet one-half to one hour before each meal.

A LOGICAL COMBINATION
IN
APPETITE CONTROL

Lederle

Exposure to Cholera

Travelers who have been in a cholera infected area within five days of arrival at United States ports are required to present an international certificate of cholera vaccination received within six months of arrival.

In preparing to travel abroad where a passport is required, individuals receive the international certificates of vaccination form with the passport application. The form may also be obtained from travel agencies, transportation companies, local and State health departments and offices of the Public Health Service, Department of Health, Education and Welfare. Detailed information on vaccination requirements and recommendations may also be obtained from those sources or from Public Health Service Publication No. 384 (revised 1959), "Immunization Information for International Travel," for sale by Superintendent of Documents, U. S. Government Printing Office, Washington 25, D. C., at 30 cents; reduction of 25% is given on purchases of 100 or more copies. ◄

As a result of the First Aid classes offered by the Indianapolis Area Red Cross, last year more than 6,000 people were taught how to give emergency care to victims of accidents or sudden illnesses. Some of these people took first aid from qualified Red Cross instructors through the companies where they were employed.

Each year more than 100,000 students in Indianapolis and Marion County participate in the Junior Red Cross program of the Indianapolis Area Red Cross chapter. Last year they made tray favors and table centerpieces for patients in the two Indianapolis veterans hospitals, the Fort Harrison hospital, as well as for several homes for the aged, children's homes and other hospitals and institutions.



WABASH VALLEY
SANITARIUM—HOSPITAL

Lafayette, Indiana
Telephone Riverside 3-1679

A hospital for the treatment of neuro-psychiatric disorders.

Custodial cases are accepted in limited numbers.

— OPEN STAFF —

DONALD R. KINZER
Manager

For topical infections, choose a 'B. W. & Co.'® 'SPORIN'...



Each gram contains:
'Aerosporin'® brand Polymyxin B Sulfate 5,000 Units
Zinc Bacitracin ..... 400 Units
Neomycin Sulfate ..... 5 mg.
Hydrocortisone ..... (1%) 10 mg.
in a special petrolatum base.



Each gram contains:
'Aerosporin'® brand Polymyxin B Sulfate 5,000 Units
Neomycin Sulfate ..... 5 mg.
Zinc Bacitracin ..... 400 Units
in a special petrolatum base.



Each gram contains:
'Aerosporin'® brand
Polymyxin B Sulfate ..... 10,000 Units
Zinc Bacitracin ..... 500 Units
in a special petrolatum base.

BURROUGHS WELLCOME & CO. (U.S.A.) INC., Tuckahoe, N. Y.

"Preferred" Sales in Relation to Income

One of a series of articles prepared by Blue Cross-Blue Shield

One of our big goals in 1960 is selling the "Preferred" programs covering surgery and in-hospital medical. We are convinced that many of our problems would be solved if most members had this coverage. The solution to the problem of achieving this goal is not a simple one.

Blue Shield is operating in a competitive situation. We can't dictate—we can only attempt to sell the program that best matches the needs of our members. We can't guarantee how much medical care costs will be—we can only sell coverage that will pay most of the bill most of the time.

We know through past experience that our selling problem is not the same in each county in the state. In the past the more expensive schedules have been sold in counties where there is a concentration of industry, people and greater income. We also know that these areas have higher medical care costs. There is a definite correlation between income in a county, and payments made by Blue Shield to doctors in the county.

For example, in 1959 more than 70% of the households in Lake, Marion and St. Joseph counties had an income of more than $4,000. Blue Shield payments for the year totaled more than $500,000 per county for these same three counties—payment totals indicating a concentration of industry, people, higher costs—as well as "Preferred" Blue Shield protection.

Again, in a broader grouping of 20 Indiana counties where more than 60% of the households had incomes over $4,000—we find 14 counties where Blue Shield payments totaled more than $100,000 during the year.

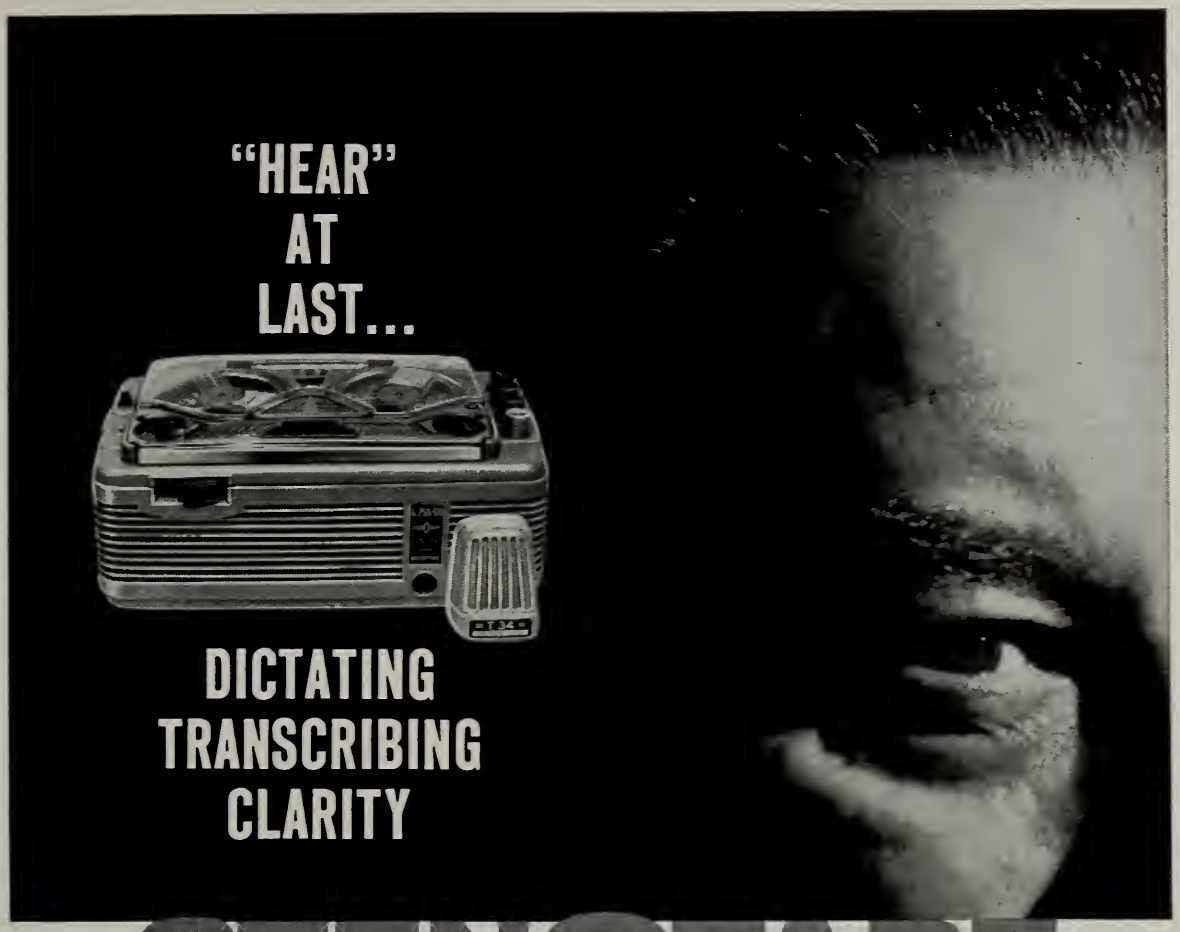
In 1959 a total of 38 Indiana counties had only 50% or less of households with more than $4,000 income. These counties are weak in industrial development, low in population and constitute a very poor potential market for getting any degree of saturation of the Blue Shield "Preferred" schedule.

The table below shows graphically that the "Preferred" schedule sells well in counties with higher income, and not so well in counties with low income. This is true in terms of totals and percentages.

No matter what kind of a selling job is done, this situation will have an effect upon the end result. The probability is that our best potential market will continue to be in the counties with a concentration of industry, people and income. We will continue to have a very real problem in getting any degree of "Preferred" saturation in counties with a low income.

	Income Data		Contracts in Enrolled Accounts		
County	Average per Household	Percent of Household above $4,000	Preferred (Steel) Certificate	Standard Certificate	Percent Enrolled with Preferred Cert.
St. Joseph	$6,406.00	77.4	11,909	10,047	54.2
Lake	6,146.00	74.4	33,738	21,934	60.6
Marion	6,027.00	71.2	37,505	48,856	45.0
Lawrence	4,226.00	47.4	1,248	3,883	24.3
Daviess	4,100.00	42.8	384	2,107	15.4
Putnam	3,881.00	42.9	8	1,396	0.6

W. C. Huddlestone
Public Relations Division ◄



STENOTAPE GELOSO

offers true "professional" dictating transcribing sound and efficiency

Doctor, Lawyer, Office Chief . . . here is the soundest practice you can establish to end paperwork problems. LISTEN: StenOtape gives you the greatest clarity of sound in the dictating field today. This 6½ lb. compact unit, with its extremely sensitive microphone records every word perfectly at 1⅞ speed, within a 30 foot radius. You can actually dictate comfortably from any point in the room. Seated and relaxed, you can tape interviews with a patient or client; and because of StenOtape's unique sound-fidelity, your secretary will hear and enjoy every word of your error-free dictation. Doctors and Dentists can play their post graduate educational tapes on StenOtape and enjoy superb playback quality. At the office, home or away, StenOtape records everything up to 2 hours on one 3½ in. tape . . . phone calls, conferences, dictation, *even music!* Hear the StenOtape difference now . . . it's an exceptional value!

only $179.95

FULL YEAR GUARANTEE Federal Tax Included

Check These Other Major StenOtape Features:

● Accurate word-counter. ● Built-in Speaker. ● 4″ high, weighs only 6½ lbs. ● Travels in handsome attache case. ● Low-cost accessories available to cover every dictating-transcribing-recording situation. ● Precision designed by Geloso, Europe's largest integrated electronics manufacturer of communication equipment. ● Sales and Service Coast to Coast.

FREE! LIFETIME SUPPLY OF MAGNETIC TAPE MAIL THIS COUPON NOW!

AMERICAN GELOSO ELECTRONICS, INC.
251 Park Ave. So., Dept. 70, New York 10, N. Y.

Gentlemen: Please rush, without obligation, illustrated booklet "The Facts About Dictating Machines." I understand that should I decide to purchase a StenOtape this coupon entitles me to a lifetime supply (6 rolls) of reusable Magnetic Tape worth $15.00.* **Offer expires July 31, 1960*

Name_____

Address_____

City_____ Zone___ State_____

Recent JAMA editorial statement clarifies the current controversy about dietary fats

Excerpted from the March 12, 1960, issue of The Journal of The American Medical Association:

"It is accepted generally that specific alteration in the diet will lower the concentration of cholesterol in the blood. The most effective results to date have been achieved by increasing consumption of polyunsaturated fatty acids, particularly linoleic acid. However, indefinitive and conflicting information has left much to the imagination of some food processors. Some of the largest vegetable oil processors in the United States have implied in advertisements that the cholesterol level can be lowered merely by adding polyunsaturated fatty acids to the diet. This selling campaign has created confusion among lay people, making it increasingly important that the physician clarify for his patients the conditions under which changes in the diet will be effective.

The patient should understand that if he increases his consumption of polyunsaturated fatty acids without reducing his intake of other fats, little is gained save for additional calories which could lead to obesity. A particular regimen will be effective only if polyunsaturated fatty acids are responsible for an appreciable percentage of the total fat calories. That is, they must replace rather than supplement some of the saturated fats and oils already in the diet.

* * *

Some manufacturers cite the "iodine number" of a fat or oil as evidence of the unsaturated fatty acid content of their product. This number is not a reliable indicator of therapeutic value because it measures monounsaturated and polyunsaturated fatty-acid content at the same time. A monounsaturated acid, like oleic, takes up two iodine atoms but does not affect the cholesterol concentration of the blood. A polyunsaturated acid, like linoleic, takes up four iodine atoms. In a product containing large amounts of oleic acid and small amounts of linoleic acid, the iodine number is nearly the same as it would be for a product containing little oleic acid and a modest amount of linoleic acid. Cottonseed oil has an iodine number of 110 and corn oil a number of 127; yet they each have about the same amount of linoleic acid.

* * *

Low-fat diets will not reduce the concentration of circulating cholesterol and lipoproteins as effectively as will diets containing an adequate percentage of polyunsaturated fatty acids. Weight-reduction regimens are basically low in fat, and if a lowered cholesterol level is necessary, planning must be done to maintain the proper ratio of saturated to unsaturated fats."

* * *

Herbert Pollack, M.D.
Associate Professor of Clinical Medicine
Postgraduate Medical School
New York University, New York

Where a vegetable (salad) oil is medically recommended for a cholesterol depressant regime



Lean Beef Tips Veronique an example of glorious eating from Wesson

Wesson is unsurpassed by any readily available brand

WESSON'S IMPORTANT CONSTITUENTS

Wesson is 100% cottonseed oil–winterized and of selected quality

Linoleic acid glycerides (poly-unsaturated)	50-55%
Oleic acid glycerides (mono-unsaturated)	16-20%
Total unsaturated	70-75%
Palmitic, stearic and myristic glycerides (saturated)	25-30%
Phytosterol (predominantly beta sitosterol)	0.3-0.5%
Total tocopherols	0.09-0.12%

Never hydrogenated—completely salt free

Each pint of Wesson contains 437-524 Int. Units of Vitamin E

FREE Wesson recipes, available in quantity for your patients, show how to prepare meats, seafoods, vegetables, salads and desserts with poly-unsaturated vegetable oil. Request quantity needed from The Wesson People, Dept. N, 210 Baronne St., New Orleans 12, La.

Wanted: Locations Physicians

Following is a list of physicians who made inquiry at our office during the latter part of March and in April 1960 concerning openings in our state for practice.

General Practice

J. B. Titmarsh, M.D., U.S.P.H.S. Hospital, Rosebud, S. D.

Louis C. Huesmann, II, M.D., 848 Glenwood Avenue, Cincinnati 29, Ohio.

David E. Waugh, M.D., 122 S. E. 52nd Street, Des Moines, Ia.

Edmond Alfille, M.D., 208 W. 23rd Street, New York 11, N. Y.—also industrial medicine.

Jay C. Timmerman, M.D., 1722 Morningside Drive, Iowa City, Ia.

Nobutaka Azuma, M.D., Lutheran Hospital of St. Louis, 2639 Miami St., St. Louis 18, Mo.

Edgar Cantwell, M.D., St. Vincent's Hospital, Indianapolis 7, Ind.

Joseph P. Yut, M.D., 219 King Malcom Avenue, Odenton, Md.

Specialists

Hiroharu Nakazato, M.D., 412 West 22nd Street, New York 11, N. Y., *orthopedics.*

Samuel R. Joseph, M.D., 1107 Porter Street, Columbia, Mo., *surgery.*

Joseph Devitofranceschi, M.D., c/o J. Mestichelli, 46-11 104th St., Cornoa, N. Y., *anesthiology.*

Locations

Adams County—GENEVA—pop. 1,000 with a large surrounding territory. Office available. One physician in the community. Contact Joseph Schetgen, M.D., Geneva, Ind.

Elkhart County—GOSHEN—pop. 13,000. Office and equipment of the late Dr. Cecil K. Bender available. Contact Mr. George L. Pepple, Spohn Building, Goshen or Mrs. Cecil K. Bender, Goshen.

Howard County—KOKOMO—pop. 39,000. Office space available located in a small shopping center on a well traveled street. Opening for general practitioner. Contact Carl Ault, M.D., or Mr. Carl Hynds, 429 West North Street, Kokomo.

Huntington County—HUNTINGTON—pop. 16,000. Opening for general practitioner. Office available July 1960. Contract Wayne Miller, M.D., 354 E. Washington St., Huntington, Ind.

Lake County—CEDAR LAKE—unincorporated area of two townships with a population of 15,000 year around and 25,000 in the summer. Twenty miles from Hammond. Opening for a partnership. Contact Donald Miller, M.D., P. O. Box 297, Cedar Lake, Ind.

Pulaski County—FRANCESVILLE—pop. 900. The only physician in the community is leaving July 1960 for further work. Office and home available. Contact Mr. Henry F. Sullivan, Francesville, Ind.

Warrick County—ELBERFELD—pop. approximately 1,000. 17 miles northeast of Evansville. Home and office available. Contact Rev. Wm. T. Barker, Elberfeld, Ind.



OVER 80 YEARS' SPECIALIZED EXPERIENCE IN THE RESTORATIVE TREATMENT OF

"THE PROBLEM DRINKER"

At The Keeley Institute your patients are assured of receiving:

- the most modern, coordinated, comprehensive, rehabilitative regimen
- in addition to medical, nutritional and physiotherapeutic treatment, we also offer psychiatric diagnosis and psychotherapy
- full cooperation throughout with the referring physician
- in addition to the care of the alcoholic we also treat narcotic and drug addiction
- surprisingly low cost—to cover all medical care, medicines, laboratory work, room and excellent cuisine

You can obtain more detailed information by writing us direct.

WE WELCOME YOUR REFERRALS...

THE KEELEY INSTITUTE
DWIGHT, ILLINOIS

Member American Hospital Association, Member Illinois Hospital Association. Licensed by the Department of Public Health, State of Illinois.

for adults and children



Prompt 4 way check of diarrhea

- Curbs excessive peristalsis
- Adsorbs toxins and gases
- Soothes inflamed mucosa
- Provides intestinal antisepsis

POMALIN

TRADEMARK

Liquid

EFFECTIVE ANTIDIARRHEAL

FORMULA: *Each 15 cc. (tablespoon) contains:*

Sulfaguanidine	2 Gm.
Pectin	225 mg.
Kaolin	3 Gm.
Opium tincture	0.08 cc.
(equivalent to 2 cc. paregoric)	

DOSAGE: **Adults:** Initially 1 or 2 tablespoons from four to six times daily, or 1 or 2 teaspoons after each loose bowel movement; reduce dosage as diarrhea subsides.

Children: ½ teaspoon (=2.5 cc.) per 15 lb. of body weight every four hours day and night until stools are reduced to five daily, then every eight hours for three days.

SUPPLIED: *Bottles of 16 fl. oz. (raspberry flavor, pink color)*
Exempt Narcotic. Available on Prescription Only.

Winthrop LABORATORIES
New York 18, N. Y.



Presented at the House of Delegates
Meeting of the Woman's Auxiliary
to the ISMA—April 29, 1960

INAUGURAL ADDRESS

By MRS. INA RIGLEY
South Bend

DISTINGUISHED GUESTS and members of the House of Delegates:

I accept with gratitude this high honor you have bestowed upon me. I realize fully that this position carries with it certain responsibilities—and I will try to discharge them with credit to you—and to myself. Please have patience with me.

We have just completed a most successful year. The reports that we have heard during this convention indicate that every facet of our auxiliary has met with outstanding success. I feel that we owe much to the charming and gracious lady who presided last year. Unquestionably, her flair for leadership and her happy knack of getting us all to work together had a marked bearing upon our success. We are indeed indebted to our capable past president, Mary Black.

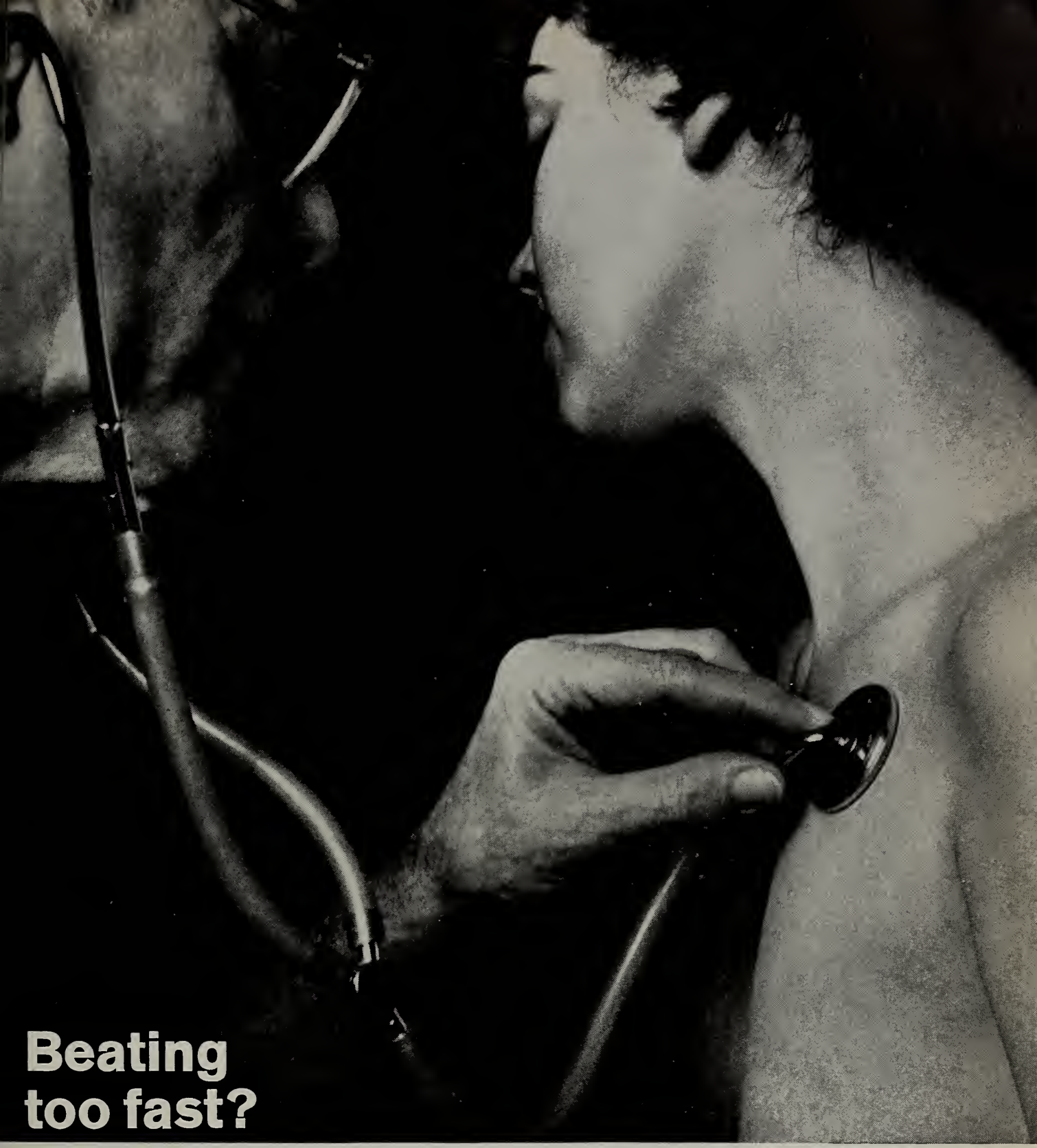
Naturally, I hope to continue that success. However, this can be done only through the cooperation of all of us. Without your help we can achieve little. We must educate ourselves and others. In fact, the key thought this year should be education. I'm certain you are all more than familiar with the word. As doctors' wives you have all been "well educated." If patience was not one of your virtues when you walked down the aisle of matrimony, I'm sure it is now. There is a little saying that I sometimes paraphrase—"She who waits dinner also serves." The skill of our respective husbands within their own field can be matched only by our own skill in attempting to warm up a cold meal. You have my sympathy—and I am sure I have yours.

To our parent organizations, the American Medical Association and the Indiana State Medical Association, we have pledged our efforts—promising to assist them in their objectives. In our changing world it is more important than ever before that we fulfill these obligations. As priority projects this year, we are emphasizing legislation, the American Medical Education Foundation and community services.

A Most Serious Challenge

Through the current system of free enterprise, American medicine has given this nation the best health care in the world. But it now faces one of the most serious challenges in its history—namely, legislation—legislation which would destroy the continued freedom in the practice of medicine. This cannot be allowed to happen. The American Medical Association and the Indiana State Medical Association urge every doctor's wife to stand beside her husband in opposing any legislative proposal which calls for a compulsory health care tax. The AMA is opposed to national compulsory health insurance. They believe, and rightly so, that any such control would endanger the continued high quality of care now provided. To combat this threat, strong legislative committees are recommended for every county. Apart we are nothing more than a weak voice in the wilderness—but together, we constitute a sword of opinion—a sword, I might add, with a fine cutting edge.

The American Medical Education Foundation remains one of our top priority projects. As most of you know, it was created in 1951 by leaders in medicine and sponsored by the AMA. Its purpose—to raise funds from the medical profession for our country's medical schools. It is essential that we give our all to this program—the future of tomorrow's doctors depends on it. Indiana has a proud record. We will continue to strive for one hundred percent county participation. By giving to A.M.E.F. we move close to



Beating too fast?

Slow it down with SERPASIL®

(reserpine CIBA)

Serpasil has proved effective as a heart-slowing agent in the following conditions: mitral disease; myocardial infarction; cardiac arrhythmias; neurocirculatory asthenia; thyroid toxicosis; excitement and effort syndromes; cardiac neurosis; congestive failure. Serpasil should be used with caution in patients receiving digitalis and quinidine. It is not indicated in cases of aortic insufficiency.

SUPPLIED: Tablets, 0.1 mg., 0.25 mg. (scored) and 1 mg. (scored). Complete information available on request.

CIBA

SUMMIT • NEW JERSEY

2/2819MB

Inaugural Address

Continued

our ultimate goal of "every member" participation.

Each year, new approaches to health education and community services are presented. In 1958, the Joint Council for Health Care of the Aged was formed. The needs of our senior citizens constitute one of the greatest challenges to both medical and non-medical organizations. It is a challenge which must affect each of us. A positive health program for older citizens has been developed by the AMA, but auxiliary action is needed to help develop community interest and participation. The broadening of our auxiliary program to include the aged does not mean that we shall lose interest in local community organizations or voluntary health agencies. On the contrary, we shall increase our efforts.

You have just heard me list our priority projects for 1960. They are important, but just as important are our continuing projects such as: membership, para-medical careers recruitment, mental health, safety and civilian defense. I realize you have heard much of this before, but it is worth repeating.

I cannot emphasize enough the importance of membership. It is on this point that we stand or fall. Our program for membership must be continuous. Indiana has reached only 62% of her membership potential. I wish I could say that the remaining 38% who are not members live in unorganized counties, but this is not true. Over 32% of them live in organized counties—a deplorable situation. It is imperative that we give this situation our personal and immediate attention.

Committee Name Change

You heard me mention para-medical careers recruitment. Some of you may be wondering what this is. It is nothing more than an old bottle with a new label. Effective May 1, the name of our present committee, "Nurse Recruitment" is to be changed to Para-Medical Careers Recruitment. The purpose of this is to broaden our objectives. Para means besides or along side of. Para-medical careers, therefore, refer to all fields related to medicine and health. Medicine and its related sciences in recent years have taken tremendous steps, and in so doing, have

A
logical
prescription for
overweight patients

anorectic-ataractic

BAMADEX®

meprobamate 400 mg., with d-amphetamine sulfate 5 mg., Tablets

meprobamate **plus** d-amphetamine... depresses appetite...elevates mood... eases tensions of dieting...**without** overstimulation, insomnia or barbiturate hangover.

Dosage: One tablet one-half to one hour before each meal.

Lederle

COOK COUNTY
GRADUATE SCHOOL OF MEDICINE

ANNOUNCES A
GENERAL PRACTICE REVIEW
JULY 11-22, 1960

A two-week intensive postgraduate course oriented to those problems which regularly confront the physician engaged in the general practice of medicine. History taking, physical examination and modern therapy will be stressed. Staff members from the following Departments of Cook County Hospital will present lectures and demonstrations: Internal Medicine, Surgery, Obstetrics, Gynecology, Pediatrics, Radiology, Dermatology, Fractures, Urology, and E.E.N.T.

Category I Credit: Seventy-five hours.

For application form address:

Registrar
707 South Wood Street
Chicago 12, Illinois

Squibb Announces Chemipen

Squibb Alpha-Phenoxyethyl Penicillin Potassium

new chemically improved penicillin which provides the highest blood levels that are obtainable with oral penicillin therapy



As a pioneer and leader in penicillin therapy for more than a decade, Squibb is pleased to make Chemipen, a new chemically improved oral penicillin, available for clinical use.

With Chemipen it becomes possible as well as convenient for the physician to achieve and maintain higher blood levels—with greater speed—than those produced with comparable therapeutic doses of potassium penicillin V. In fact, Chemipen is shown to have a 2:1 superiority in producing peak blood levels over potassium penicillin V.*

Extreme solubility may contribute to the higher blood levels that are so notable with Chemipen.* Equally notable is the remarkable resistance to acid decomposition (Chemipen is stable at 37°C. at pH 2 to pH 3), which in turn makes possible the convenience of oral treatment.

And the economy for your patients will be of particular interest—Chemipen costs no more than comparable penicillin V preparations.

Dosage: Doses of 125 mg. (200,000 u.) or 250 mg. (400,000 u.), t.i.d., depending on the severity of the infection. The usual precautions must be carefully observed with Chemipen, as with all penicillins. Detailed information is available on request from the Professional Service Department.

Supply: Chemipen Tablets of 125 mg. (200,000 u.) and 250 mg. (400,000 u.), bottles of 24 tablets. Chemipen Syrup (cherry-mint flavored, nonalcoholic), 125 mg. per 5 cc., 60 cc. bottles.

*Knudsen, E. T., and Rolinson, G. N.: Lancet 2:1105 (Dec. 19) 1959.

'CHEMIPEN' IS A SQUIBB TRADEMARK.

SQUIBB

Squibb Quality—the Priceless Ingredient

Inaugural Address

Continued

increased the career opportunities available to young people.

But at the same time, vacancies in a great many health fields have been created. You are all well aware of the acute shortage of qualified personnel to do the specialized work so essential to continued progress in public health. This is the purpose of our expanded recruitment program. Over 150 types of careers are available in the allied fields of medicine. We must help students choose the para-medical field best suited to their abilities.

Now this does not mean that we shall neglect our "first born"—the Future Nurses Clubs. On the contrary, we shall increase our energies in this direction. We will encourage counties to sponsor the type club that is best suited to their individual community needs.

Education of the individual physician's wife in the principles of good mental health so that she can foster the state in her own family and interpret it to the community will again be the medium of approach. The White House Conference on Ageing, planned for January, 1961 will be preceded by conferences in each state. All auxiliaries have been asked to participate in their respective state conferences—it will especially be the responsibility of the mental health chairman to participate, since many of the problems involved in this developing national health problem are those of mental health.

Concerning public safety, the AMA recommends a six-point program. There is no need to go into details—study it, and present it to your community. Start by forming a safety team. Remember, safety concerns us all.

And just as safety concerns us, so does civilian defense. Let's accept the fact there is no magic in the field of disaster. Emergencies declare themselves. It can be compared to a game of chance. The more prepared we are, the better our odds for survival. The civilian defense program prepares us to care for ourselves as well as our neighbors. It is our voice that must bring the civilian defense story to the communities that have no program.

You have been an attentive and charming audience, but I'm afraid I'm going to ask a little more of you than that. Being human, we all desire approval, but are we willing to risk even that, if necessary, and supplement it by hard work—and lots of it, These programs are essential—they need your time and effort to put them across. This is not much to ask when the objectives are considered. Ethel Gastineau, Indiana's first National Auxiliary president, has coined the slogan, "Individual responsibility for better community health." Let us accept this as our slogan as we plan a positive program for action.

In passing, let me mention our *Bulletin*. It keeps us informed of all aspects of the auxiliary program and right proud of it, we are. It is the official publication of the auxiliary for the entire membership, so let's have every member a subscriber.

As you have accepted an area of service this year, whether large or small, you have said in your heart that you would do the best that you could. The same is true of myself. I will work with you—for you—and among you, and with that thought in my heart, let me again thank you and assure you of my desire to justify the confidence you have reposed in me. ◄

The Norbury Sanatorium

Established 1901 — Incorporated
Licensed — Jacksonville, Illinois

FRANK GARM NORBURY, A.M., M.D., Medical Director
HENRY A. DOLLEAR, M.D., Superintendent
FRANK B. NORBURY, M.D., Physician

Operating

Maplecrest—

Restful, congenial, homelike surroundings are combined with the most modern diagnostic and therapeutic equipment.

Maplewood—

Most comfortable home for individuals requiring rest, scientific diagnosis and treatment. Fireproof construction.



Three I.U. Students Among Winners In SAMA Annual Competition

Three Indiana University medical students walked off with top prizes for exhibits and a scientific paper at the annual meeting of the Student American Medical Association in Los Angeles last month.

Rod Perkins, junior from Evansville, took his first place scientific exhibit entitled "Disc Oxygen-Thermal Exchange" to the AMA meeting in Miami this month. In addition to the trip, Mr. Perkins was awarded a $500 cash prize.

An Indianapolis sophomore, Robert Begley, was second in the scientific exhibit division with the subject Neuro-Pharmacology of the Gamma Loop. Mr. Begley won a $250 cash prize.

Placing third in the research paper division was Paul Riley, Monroe, Ind. His paper was entitled "Study of Drugs in Upper Respiratory Infections."

ISMA Officer Named President-Elect of Indiana Specialty Group

Dr. Guy A. Owsley, president-elect of ISMA, was elected president-elect of the Indiana chapter of the American Academy of Ophthalmology and Otolaryngology at a meeting in West Lafayette, Ind., last month.

Dr. Owsley will take office as president of the ISMA in October, 1960. He previously served as chairman of the ISMA Council, and is a former president of the Delaware-Blackford Medical Society.

Dr. Gardiner Re-elected

Dr. Sprague Gardiner of Indianapolis was re-elected as assistant secretary of the American College of Obstetricians and Gynecologists at a recent annual meeting. Dr. C. Paul Hodgkinson, chairman of the Department of Gynecology and Obstetrics of the Henry Ford Hospital, was installed as president.

Status of Hill-Burton Grants Announced for Indiana

The Department of Health, Education and Welfare reported that as of Feb. 29, 1960, status of all Hill-Burton grants for Indiana included 66 projects, costing $70,456,347, with a federal contribution of $23,137,575 and supplying 3084 additional beds completed and in operation.

Twenty-three projects were under construction, at a total cost of $24,321,851, including a federal contribution of $6,299,687 and designed to supply 879 additional beds.

One project, at a total cost of $2,155,450 and including a $717,333 federal contribution, is approved, but not yet under construction. It will supply 65 additional beds.

I.U. Faculty Member Honored

Dr. Julius J. Friedman of Indiana University is one of 14 young medical school faculty members from throughout the U. S. to receive Medical Faculty Awards given by Lederle Laboratories Division of American Cyanamid Company.

The awards, which will total $250,000 this year, and which have amounted to more than $1,750,000 during the past seven years, are given to assist able young men and women who are working and contemplating further full-time academic careers in the pre-clinical and certain clinical departments of medical schools.

J. Patrik Gillotte, M.D., recently joined Drs. L. L. Blum and J. G. Weinbaum in the practice of pathology in Terre Haute. Dr. Gillotte is a graduate of the University of Maryland School of Medicine where he has been instructor in pathology. He is a Diplomate of the American Board of Pathology.

Continued

'Indiana Diet Manual' Available For Nursing Homes, Small Hospitals

A second edition of the *Indiana Diet Manual,* prepared by a joint committee of the Indiana State Board of Health, the Indiana Dietetic Association and the Indiana Hospital Association will soon be available, according to a recent announcement.

With the increasing number of patients being cared for in nursing homes and small hospitals in Indiana, many physicians find they must order modified diets for such patients. These diets are frequently planned, prepared and served in institutions which do not employ a qualified dietitian or trained food service supervisor, and it seems doubtful that many of the nursing homes will be able to have the services of a trained dietitian.

Members of the State and local dietetic associations and the nutrition staff of the Indiana State Board of Health are available upon request, to meet with the medical societies to discuss the *Indiana Diet Manual* and its use in nursing homes and small hospitals.

The Committee pointed out that those physicians who have used the manual have expressed the opinion that it will do much to strengthen and standardize dietary services in the medical care facilities which do not employ a qualified dietitian.

This publication is now in its second printing and may be obtained at $1.00 per copy from Mrs. Katherine Sheedy, chairman, Indiana Shared Dietitian Project Committee, Lilly Laboratory for Clinical Research, Marion County General Hospital, Indianapolis.

AMA Exhibit Applications Due Before Aug. 1

Application forms for space in the scientific exhibit at the Washington, D. C. clinical meeting of the American Medical Association, Nov. 28 to Dec. 1, are now available. They may be procured by writing directly to Charles H. Bramlitt, M.D., Director, Department of Scientific Assembly, American Medical Association, 535 N. Dearborn St., Chicago 10. Applications close on Aug. 1.

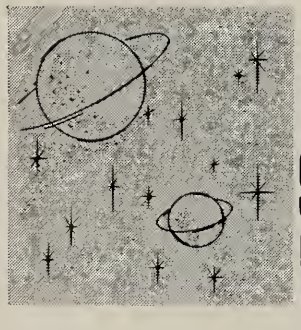
The "Hull" award will be presented for the first time at this meeting to the best exhibit on a scientific subject which has not been previously shown at a medical meeting. It will consist of a gold medal and an honorarium of $250. The winning exhibit will be approved for showing in the Scientific Exhibit at the 1961 Annual Meeting of the AMA which will be held in New York City.

Dr. Thomas G. Hull will personally present the award to the recipient.

1959 Foundation Grants Total $735,611

The Smith Kline and French Foundation, established in 1952 to support charitable, scientific and educational activities, reports gifts totaling $735,611 for the year 1959. In Indiana grants were made to Earlham College, Evansville College, Hanover College and Valparaiso University. The foundation has disbursed over three million dollars since 1952.

Continued



VISION STIMULATES KNOWLEDGE

Truly, the age we live in is the age of vision — of far-sighted plans for a future totally different from the past. Such vision must, however, be based on past performance . . . the foundation from which to build. Just as the more than a half-century of White-Haines experience in fine ophthalmic craftsmanship is your guarantee of professional performance in the years to come.

THE White-Haines OPTICAL COMPANY
34 Modern Laboratories
OHIO • PENNSYLVANIA • MARYLAND
KENTUCKY • W. VIRGINIA • INDIANA
MICHIGAN • ILLINOIS

ANOTHER YEAR OF SYMPOSIA . . .

Recognizing that the exchange of ideas is fundamental to medical progress, Lederle continues its Symposium program with the 9th year of scheduled meetings. Through these Symposia, sponsored by medical organizations with our cooperation, over 50,000 physicians have had the opportunity to hear and question authorities on important advances in clinical medicine and surgery. You have a standing invitation to attend any of these Symposia with your wife, for whom a special program is planned.



ANCHORAGE, ALASKA
Saturday, June 11, 1960
The Westward Hotel

WEST POINT, NEW YORK
Thursday, Friday, Saturday,
June 16, 17, and 18, 1960
United States Thayer Hotel

***MADISON, WISCONSIN**
Thursday, June 23, 1960
The Holiday Inn

***SPRINGFIELD, MISSOURI**
Sunday, June 26, 1960
The Holiday Inn

***ROANOKE, VIRGINIA**
Saturday, July 16, 1960
The Hotel Roanoke

***SANTA ROSA, CALIFORNIA**
Friday, September 16, 1960
The Flamingo Hotel

***KANSAS CITY, KANSAS**
Friday, September 23, 1960
Battenfeld Memorial
Auditorium

HOUSTON, TEXAS
Saturday, September 24, 1960
The Shamrock Hilton Hotel

DEFIANCE, OHIO
Wed., September 28, 1960
Defiance College

PHILADELPHIA, PENN.
Sunday, October 16, 1960
The Sheraton Hotel

***HARTFORD, CONNECTICUT**
Thursday, October 20, 1960
The Statler Hotel

***GREAT FALLS, MONTANA**
Saturday, October 22, 1960
The Rainbow Hotel

ROCHESTER, NEW YORK
Wednesday, October 26, 1960
The Manger Hotel

CHARLESTON, WEST VIRGINIA
Sunday, October 30, 1960
The Daniel Boone Hotel

SIOUX FALLS, SOUTH DAKOTA
Tuesday, November 1, 1960
The Sheraton-Cataract Hotel

***CHARLOTTE, N. CAROLINA**
Thursday, November 3, 1960
The Hotel Charlotte

***CLEVELAND, OHIO**
Wednesday, November 9, 1960
Pick Carter Hotel

***SOUTH BEND, INDIANA**
Friday, November 18, 1960
The Pick-Oliver Hotel

WESTCHESTER COUNTY, N. Y.
Wednesday November 30, 1960
Westchester Country Club

ST. PETERSBURG, FLORIDA
Saturday, December 3, 1960
Tides Hotel and Bath Club

*Acceptable for Category I Credit for members of American Academy of General Practice

Lederle LEDERLE LABORATORIES, a Division of AMERICAN CYANAMID COMPANY, Pearl River, N. Y.

Many Hoosiers Take Active Part At AMA Meeting in Miami

In addition to the five delegates from the ISMA, Indiana was represented at the Miami Beach AMA meeting by Dr. Lester Bibler of Indianapolis who served as the delegate from the Section on General Practice, and by Dr. Lall Montgomery, of Muncie, delegate from the Section on Pathology and Physiology. Indiana's regular delegates are Drs. Eli S. Jones, Hammond; Francis L. Land, Fort Wayne; Harold C. Ochsner, Indianapolis; Wendell C. Stover, Boonville, and Gordon B. Wilder, Anderson.

Dr. Cleon A. Nafe, Indianapolis, boosted Hoosier participation in the official family by his service as a member of the AMA Board of Trustees.

Mrs. Frank Gastineau, Indianapolis, presided over the many functions of the woman's auxiliary. She was assisted during the opening phases of the meeting by Mrs. Joseph Black, past-president of the Woman's Auxiliary to the ISMA.

In addition to the two section delegates, Hoosier officials of section organizations include Dr. Charles R. Alvey, Muncie, vice-chairman of the Section on General Practice, and Dr. Myron Nourse, Indianapolis, assistant secretary of the Section on Urology.

Dr. Arthur J. Kuhn, Hammond, read a paper entitled "Cystadenoma of the Parotid and of the Larynx (Case Reports)" before the Section on Laryngology, Otology and Rhinology.

Drs. Leslie M. Bodnar, South Bend, and Joseph B. Crowley, Notre Dame, presented a motion picture on "Surgical Repair of the Ligaments of the Knee and Ankles in Acute Injuries" to the Section on Orthopedic Surgery.

Drs. John A. Campbell and Robert L. Campbell, Indianapolis, read a paper on "Angiographic Diagnosis of Traumatic Head and Neck Lesions" before the Section on Radiology.

Dr. W. D. Snively, Jr., Evansville, served as chairman of the committee in charge of and participated in the program of the special exhibit and clinical forum on body fluid disturbances.

Drs. K. C. Kohlstaedt, S. O. Waife and J. M. Maas, Indianapolis, authored a scientific exhibit on the subject "Clinical Evaluation of New Drugs."

Drs. Charles E. Jackson, Pierre C. Talbert and Harold D. Caylor, Bluffton, presented a scientific exhibit on "Hereditary Hyperparathyroidism."

Drs. Lall Montgomery and Ruth Drummond of Muncie presented a scientific exhibit on "Certification of Medical Technologists."

AMA Exhibits Not Loaned to Group; Previous Misrepresentations Cited

AMA HEADQUARTERS, CHICAGO—An organization called the American Association of Doctors' Nurses recently issued a news release stating that "the American Medical Association will loan a part of its large collection of exhibits" to this group's convention in Miami, Fla., June 23 to 26, 1960.

This is an incorrect statement. The American Medical Association has not loaned any exhibits to this group.

Originally known as the American Registry of Doctors' Nurses, this organization, which mailed its promotional materials from Marianna, Fla., was said to be in violation of the Nurses Practices Act in Florida in 1958 by the attorney general in that state.

The group moved to Washington, D. C. Last summer the Federal Trade Commission charged this group with misrepresenting itself as a nonprofit organization and with giving customers the means to misrepresent themselves as registered, graduate or licensed nurses. The organization changed its name to the American Association of Doctors' Nurses and in a news release issued some months ago stated that"The American Association of Doctors' Nurses . . . has assumed the membership of the old American Registry of Doctors' Nurses."

Dr. Henry G. Nester, Indianapolis, chairman of the ISMA Section on Public Health and Preventive Medicine, has been named president-elect of the American Association of Public Health Physicians. He will take office in October.

INDIANA STATE BOARD OF HEALTH

Monthly Report — April, 1960

Disease	Apr. 1960	Mar. 1960	Feb. 1960	Apr. 1959	Apr. 1958
Animal Bites	633	340	224	641	531
Chickenpox	548	885	1068	636	562
Conjunctivitis	130	190	152	151	22
Diphtheria	0	1	2	1	4
Dysentery, Unspecified	25	121	50	17	19
Impetigo	84	70	76	67	23
Infectious Hepatitis	77	143	91	36	27
Infectious Mononucleosis	20	23	19	17	2
Influenza	781	3720	11387	2992	675
Measles (Rubeola-Rubella)	2028	1835	940	998	5130
Meningitis, Meningococcal	5	3	2	6	6
Meningitis, Other	12	6	12	11	14
Mumps	441	600	298	467	886
Pertussis	38	28	39	76	64
Pneumonia	159	286	341	331	141
Poliomyelitis	1	1	0	1	1
Streptococcal Infections	1098	1501	1048	1032	674
Tinea Capitis	39	19	38	35	19

Acog Sets up Plan to Aid Study of Obstetrics and Gynecology

The American College of Obstetricians and Gynecologists has set up a higher education loan program (H-E-L-P) to enable resident physicians to complete their training in obstetrics and gynecology. Loans up to $5,000 will be made to help physicians through their specialty training period and early practice.

H-E-L-P will start operations with an initial working fund of $36,000, contributed by ACOG and its district organizations. This will be added to through individual contributions and grants if necessary.

For information, write to Mr. Donald F. Richardson, Executive Secretary, ACOG, 79 West Monroe Street, Chicago 3.

Arthritis, Rheumatism Awards Available

The Arthritis and Rheumatism Foundation will offer predoctoral, postdoctoral and senior investigatorship awards in the fundamental sciences related to arthritis for work beginning July 1, 1961. Deadline for applications is Oct. 31, 1960.

These awards are intended as fellowships to advance the training of young men and women of promise for an investigative or teaching career. They are not in the nature of a grant-in-aid in support of a research project.



"Honestly, I tried to taper off, Doc! But the other day I had an alcohol rub!"

Add 1



'Not Lost but Gone Before'

by corki

10 May 1960

It's sorta' sad, cleaning out an office desk for the last time; like toasting an old friend you know you'll never see again.

There's pencils and pens and paper clips, scotch tape—these you put in a stack for the new occupant. And calling cards which you go thru, remembering the person each represents and the time you received each. Maybe find a few with names but no faces in your mind's eye. You stop shuffling through them when you hit this kind of snag and stare at the faceless name and wonder why you can't remember. A mental block? A blah personality that just didn't register with you. Who? Oh well—maybe Sally will be able to use it. You make a stack for her and drop three or four on your own little stack.

Here's that news story you missed and here a memo to yourself—a job lost in the shuffle of things. A few negatives—they go to the photo lab files. A few miscellaneous portraits—they go to the photo file. Here's a letter—that's for File 13. In fact, out of the jumble most odd little bits of paper go into File 13. The cleaning lady will hate you. Oh well.

In the typewriter well you find the boxes for your personal desk set. Sadly you wrap them up to muse on whatever desk sets might muse on until there's another desk for it to set on. Briefly your mind flits over the thought of another desk in the future and wonders if it'll be pretty and new or more like the proverbial old shoe—comfortable fit. There's something satisfying about an old desk.

Here's a little box of assorted headache remedies, vitamins, etc. Some bandaids. Always be prepared! Leave some of them for Sally. She'll have a few headaches and papercuts at this desk! And some fizzy stuff for the stomach. Keep that. Couple of days left here.

Some paper sacks. Been saving these to take home to bring lunch back in. The white ones look so much nicer than brown paper sacks. Especially downstown. Or is there a bit of snobbishness in that thought? They look better anywhere.

Here's a scribbled telephone number. Wonder whose? Could call it and see who answers! Not worth the trouble. So to File 13 again.

That waste basket sure is full. Is this a tribute to my work? So very little worth keeping.

An old emery board. Some brochures—on mental health, one on an unpronounceable illness of some sort, three on photography (those to the photo file), a booklet by the American Medical Writers' Association. A clipping about art therapy and mental patients—was going to send that to a friend who used to teach painting to psychiatric patients. Too old now. File 13.

Sometimes it's hard to say goodbye—even to a desk. It's an old friend, like I said. Even when excited over future plans, it's hard. Even when leaving some things (like Indiana winters!) and some people, too! It's still hard to say goodbye. Hard because you've put a part of yourself in this job; at times almost too much. You'll leave a part of yourself with good friends, with chance acquaintances. But this is the way of things.

On the other side of the ledger, the happy side, you take a lot of good things—new-found knowledge and technics, good friends—with you. You've fallen in to a few pits here, but you hope you've learned to avoid them the next time. You hope you're leaving a few accomplishments, too.

Yes, it is hard to say goodbye to the *Journal* and to "Add 1." Both have been fun—work but fun. You feel a warmth for all the good people—coworkers, bosses, association members with whom you have worked, auxiliary members, printers, engravers, salesmen, drug company representatives. All the good people who have helped so much.

To these people I give my heartfelt thanks and hope they'll give the new assistant editor, Sally Snyder, as much help as they've given me.

For this is my last "Add 1." With luck, by the time my reader(s?) has stumbled through these thought-meanderings caused by cleaning out a desk, I'll be in California again where the winds blow warm and the Pacific splashes on rocky shore and sandy beaches.

Thank you, kind reader, most of all. A new column from California has been discussed. If it materializes, I'll be most happy to say hello from the West Coast.

I'll bet to win or place, but not to show! ◄

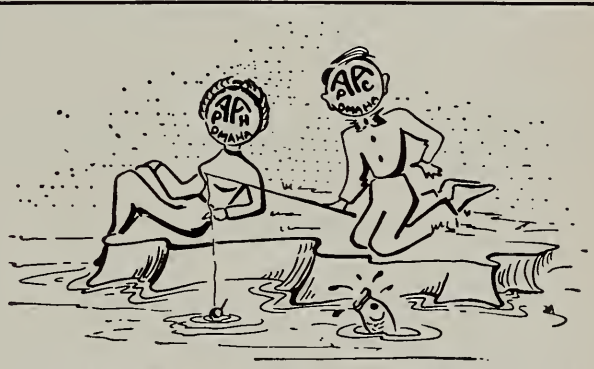


"Please, nurse, when you look in on a patient, stop saying 'Well, they said it COULDN'T BE DONE!' "



"Oh, stop blubbering over the doctor bill! Didn't you take me for 'in sickness and in health'?"

During April, 1959, the Indianapolis Red Cross introduced a Radiological Instrument Operators Course, which taught the use of instruments for measuring nuclear radiation such as the Geiger counter. The course is now being offered at regular intervals for any persons in the community who wish to learn how to operate these instruments. The course is designed to prepare citizens to help meet emergencies which might be created by nuclear accidents or attack.



PROTECTION AGAINST LOSS OF INCOME FROM ACCIDENT & SICKNESS AS WELL AS HOSPITAL EXPENSE BENEFITS FOR YOU AND ALL YOUR ELIGIBLE DEPENDENTS

ALL PREMIUMS COME FROM — PHYSICIANS SURGEONS DENTISTS — ALL BENEFITS GO TO

PHYSICIANS CASUALTY & HEALTH ASSOCIATIONS
OMAHA 31, NEBRASKA
Since 1902
Handsome Professional Appointment Book Sent to you FREE upon request.

Deaths . . .

Cecil K. Bender, M.D.

Dr. Cecil K. Bender, 53, a Goshen, Ind., general practitioner since 1934, died unexpectedly at his office April 7.

A graduate of the Northwestern University Medical School, Dr. Bender was on the staff of the Goshen General and Elkhart General hospitals, and a member of the Masonic and Elks lodges.

William F. Englebert Jr., M.D.

A former Fort Wayne physician, Dr. William F. Englebert Jr., died at Tuscaloosa, Ala., April 12 at the age of 53. He had practiced in Fort Wayne from 1931 until he entered the Armed Forces in 1942, and was psychiatrist at a Tuscaloosa hospital at the time of his death.

Clarence P. Hinchman, M.D.

Dr. Clarence P. Hinchman, Geneva, Ind., physician since 1916, passed away April 22 at Ball Memorial Hospital, Muncie. He was 68.

Dr. Hinchman graduated from the Indiana University School of Medicine in 1916.

Howard E. Rothring, M.D.

Dr. Howard E. Rothring, head of the x-ray department of Schneck Memorial Hospital, Seymour, died March 27 at the age of 40.

A graduate of Xavier University and the Cincinnati Medical School, Dr. Rothring was a former resident at Marion County General Hospital, Indianapolis. Before coming to Seymour, he had served on the staffs of Muscatatuck State School, Bartholomew County Hospital and Scott County Hospital.

C. Richard Schaefer, M.D.

Dr. C. Richard Schaefer, who practiced medicine for 65 years in Indianapolis, died April 12 at the age of 90.

According to medical authorities, he was believed to have practiced longer than any physician on record in Indianapolis.

Dr. Schaefer was a former professor of therapeutics at the I. U. School of Medicine and at one time was clinical lecturer at Marion County General Hospital. He also acted as superintendent of the old Indianapolis Deaconess Hospital.

Dr. Schaefer was a 61-year member of the Masonic lodge and belonged to Scottish Rite and Murat Shrine.

District, County News

12th District

Capt. Alvin S. Hyde, Assistant Chief of Aero Medical Laboratory, Wright Patterson Air Force Base, spoke on Medical Problems in Aerospace Flight at the annual meeting of the 12th District Medical Society, May 3.

Adams

"Kidney Disease" was the title of a paper given by Dr. Charles Cooney at the March 8 meeting of the Adams County Medical Society at Decatur. Ten members attended.

The group met again for a business meeting on April 12.

Bartholomew-Brown

Twenty-one members of the Bartholomew-Brown Medical Society met for a business session at Columbus April 13.

Boone

Newly-elected officers of the Boone County Medical Society are Drs. Paul R. Honan, president; Jack L. Lenox, vice-president; H. B. Grigsby, secretary-treasurer; C. G. Kern, delegate, and Dr. Grisby, alternate delegate.

Cass

Dr. Pasquale Genovese of Indianapolis spoke on "Pericardial Diseases" at the April 4 meeting of the Cass County Medical Society. The 30 members present also discussed federal legislation.

Decatur

Dr. Wyndham H. Nutter, Rushville, spoke to 16 members of the Decature County Medical Society at their April 21 meeting.

Continued

In your July Journal

Preliminary program

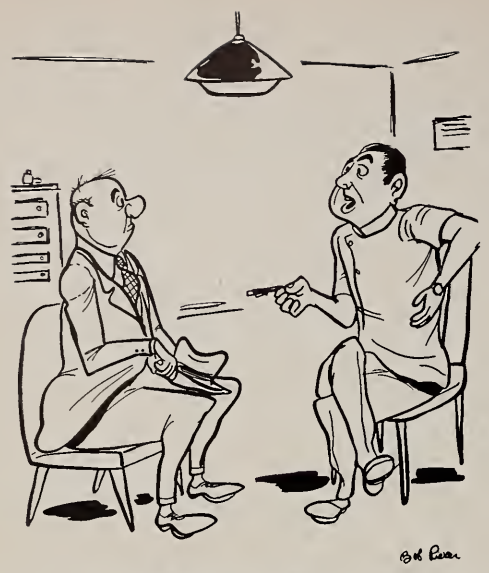
outline of ISMA'S

111th Annual Meeting

OCTOBER 3-5, 1960

FRENCH LICK - SHERATON HOTEL

French Lick, Indiana



"Our work with the fall-out problem, sir, deals with radiation . . . not with your hair!"

District, County

Continued

Elkhart

Members of the Elkhart County Medical Society and their wives met March 10 at Elkhart for a legislative discussion. There were 87 present.

On May 5, at the "General Practitioners' Road Show," Dr. Charles Anderson spoke on "New Drugs for Mental Depression" and "Faces of Depression." Dr. Stewart T. Ginsberg, who also participated in the program, addressed the group on "Relation Between Psychiatrist and General Practitioner" and "Mental Health Picture in Indiana."

A South Bend attorney, Mr. George Beamer, spoke at the group's May 19 meeting in Elkhart.

A LOGICAL ADJUNCT TO THE WEIGHT-REDUCING REGIMEN

meprobamate **plus** d-amphetamine . . . reduces appetite . . . elevates mood . . . eases tensions of dieting . . . **without** overstimulation, insomnia or barbiturate hangover.

Dosage: One tablet one-half to one hour before each meal.

anorectic-ataractic

BAMADEX®

meprobamate 400 mg., with d-amphetamine sulfate 5 mg., Tablets

Lederle

Floyd

Rev. Donald Morse gave a report on the Joint Hospital Advisory Commitee to 30 members of the Floyd County Medical Society at the April 8 meeting.

Fountain-Warren

The Fountain-Warren Medical Society met at Attica April 7 to make final plans for the annual fish fry and scientific "road show" on May 25.

Greene

Twelve members of the Greene County Medical Society met at Linton April 14 for a general business meeting.

Hendricks

Eighteen members of the Hendricks County Medical Society met at Plainfield April 12 for a legislative discussion.

Jasper

Nine members of the Jasper-Newton Medical Society met April 13 for a general business meeting.

Lake

Dr. Milton M. Mosko of the University of Illinois College of Medicine spoke on "Immunology and Allergy" at the April 13 meeting of the Lake County Medical Society at Whiting.

Laporte

"Intra-epithelial Carcinoma and Other Lesions of the Cervix" was the title of a paper given by Dr. Lowell Peterson at the April 19 meeting of the Laporte County Medical Society. Thirty-six members attended.

Lawrence

A pharmaceutical company representative spoke on fluids and electrolytes at the April 6 meeting of the Lawrence County Medical Society at Bedford. Twenty members attended.

Marshall

Eleven members of the Marshall County Medical Society met at Plymouth April 6 for a legislative discussion.

Miami

Judge Ralph Hamill spoke on medico-legal problems and the Forand bill at a March 8 joint meeting of the Miami County Medical Society, and dentists and attorneys from that area.

Montgomery

Dr. Richard S. Griffith spoke on "Antibiotics—Their Use and Abuse," at the April 21 meeting of the Montgomery County Medical Society. Twenty-eight members attended.

Noble

Eight members of the Noble County Medical Society met at Kendallville April 25 for a general business meeting.

Perry

Members of the Perry County Medical Society approved at their April 5 meeting a proposal for a Joint Crawford-Perry County cancer education demonstration project.



"Poor old George. He finally got his divorce but alimony payments gave him ulcers . . . in other words, he traded his headache for an upset stomach!"

Putnam

Dr. Stephen Alexander, Crawfordsville, spoke on new events in ophthalmology at the April 8 meeting of the Putnam County Medical Society. The fourteen members present elected Dr. Anne S. Nichols secretary of their group during a business session.

St. Joseph

Members of the St. Joseph County Medical Society met April 12 to view the BBC film on British medicine and for a discussion on Federal legislation. Fifty-three were present.

Starke

Six members of the Starke County Medical Society met at Knox on April 5 for a general business meeting and legislative discussion.

Vanderburgh

American Medical Association President Dr. Louis M. Orr spoke at the annual Medical Civic dinner, sponsored by the Vanderburgh County Medical Society to give representatives of business, industry, education, religion; labor, government and civic affairs an opportunity to meet physicians.

At the group's May 10 meeting, Mr. Thomas P. Cook, Executive Secretary of the Hennepin County Medical Society, Minneapolis, Minn., discussed medical society organization and activites.

Vigo

Seventeen members of the Vigo County Medical Society met for a general business meeting on April 12 at Terre Haute.

Wayne-Union

A Dayton Ohio neurosurgeon, Dr. Thomas A. Weaver, spoke before 44 members of the Wayne-Union Medical Society on "Intervertebral Disc Syndrome" at the April 12 meeting.

Warrick

Members of the Warrick County Medical Society heard a paper on Dual Morality at the April 14 meeting.

Wells

Dr. Tracy M. Sonneborn of Indiana University spoke on "Recent Advances in Understanding the Gene" at the April 19 meeting of the Wells County Medical Society, at Bluffton. Guests included the North-East Indiana Medical Technologists Group. ◄

Association News

EXECUTIVE COMMITTEE

April 9, 1960.

Roll call showed the following present: Wendell E. Covalt, M.D.; Earl W. Mericle, M.D.; Guy A. Owsley, M.D.; Maurice E. Glock, M.D.

Frank B. Ramsey, M.D., Editor of the *Journal*; James A. Waggener, executive secretary.

Guest: Ralph V. Everly, M.D., chairman of the Building Committee.

Treasurer's Office

The statement of income and budget balances for March, 1960, and the treasurer's report were approved by consent.

Membership Report

Number of members as of March 31, 1959 3,942

1960 members as of March 31, 1960:

Full dues paying	3,513
Interns	21
Residents	161
Council remitted	29
Senior	380
Military	34
Honorary	1

Total 1960 members as of March 31, 1960 4,139

Gain over last year 197

Number of members December 31, 1959 4,256

Number of AMA members as of March 31, 1959 3,590

1960 AMA members: Dues paying 3,377

Exempt but active 633

Total 1960 AMA members as of March 31, 1960 4,010

Gain over last year 420

Number of AMA members as of December 31, 1959 4,120

Number who have paid state dues but not AMA dues in 1960 118

Headquarters Office

Letter received from the Floyd County Medical Society concerning the Counseling Service being offered in that community was discussed and the report of the chairman of the Commission on Special Activities was read. By consent it was agreed to inform the county society that the association did not approve of the group charging a fee for service for the operation of the counseling bureau.

Guide for Industrial Immunization Programs. The recommendation of the Commission on Public Health for approval of the *Guide for Industrial Immunization Programs,* as pronounced by the AMA, was discussed. On motion of Drs. Glock and Covalt this question was referred to the Council with the recommendation that the Council refer it to the House of Delegates at its October meeting.

National Foundation meeting. The request of the Commission on Voluntary Health Agencies for permission for Dr. Wendell Shullenberger to attend the meeting of the National Foundation in Chicago April 25 and 26 was approved on motion of Drs. Owsley and Glock.

Tuberculin testing. The recommendation of the Commission on Voluntary Health Agencies that the Association approve a statement on tuberculin testing, as proposed by the Tuberculosis Association and the State Board of Health, was referred to the Council by consent.

Physicians on hospital boards. Upon motion of Dr. Owsley, and taken by consent, it was decided to refer to the Commission on Legislation the request for preparation of appropriate legislation to permit physicians to serve on hospital boards, with the requirement that not more than one physician shall serve and his term shall be limited to one term.

Annual Convention, French Lick, October 2-5, 1960

Chairman of Fifty-Year Club Reception. Upon motion of Dr. Glock, taken by consent, Dr. Lillian Mueller of Indianapolis is to be asked to serve as chairman for the reception for Fifty-Year Club members.

Organization Matters

H. R. 3465 (independent living bill) and *H. J. Res. 494* (to provide for training of teachers of the deaf and speech pathologists and audiologists). A letter was read from the House Committee on Education and Labor, inviting the Association to appear and give testimony at a meeting in Chicago on May 14 and 15.

Joint Committee on Improvement of Patient Care in Indiana. Letter read from Dr. Joseph B. Davis, chairman of the Joint Committee on the Improvement of Patient Care in Indiana, informing the association that dues in the amount of $25.00 were due this organization at this time. Payment of this sum was approved on motion of Drs. Glock and Covalt.

Another letter was read from Dr. Davis concerning whether or not the existing Joint Committee on Improvement of Patient Care in Indiana could be expanded to include the Indiana Association for Licensed Nursing Homes and this group undertake the additional responsi-

NEW MEDICAL SCHOOL FACILITIES

Indiana University recently dedicated its Medical Science Building, a major step in improvement of medical education. Despite these increased facilities and partly due to the depreciating dollar, the medical schools need your financial support. Please help the school of your choice through American Medical Education Foundation.

"Only when people make some kind of financial sacrifice for their schools do they take an active and wholesome interest in education."

Mail your AMEF Contribution to

AMEF—Indiana State Medical Association

1021 Hume Mansur Bldg.

Indianapolis, Ind.

bility of acting as a Joint Council on Health Care of the Aged. By consent it was agreed that the Joint Committee on Improvement of Patient Care could well get into this area, but it was felt that the Joint Council should be established specifically for the purposes as outlined by the Joint Council organized by the national associations.

Hospital Licensing Council. Dr. Owsley further discussed the request for a liaison committee of physicians to act with the Hospital Licensing Council. The secretary was instructed to write Dr. Davis requesting that three of his physician members on the Joint Committee on Improvement of Patient Care be named to act as a liaison committee with the licensing council.

A letter from the Connecticut State Medical Society regarding the use of generic terms in prescribing drugs for welfare cases in their state was read for the information of the committee.

The bulletin which had been sent to the component county medical societies regarding the time question, and the hearing which was to be held by the Interstate Commerce Commission in Indianapolis on April 25, was presented to the committee for its information.

The proposal of Mr. Long of Louisville, representing the Northwestern National Life Insurance Company of Minneapolis, for a term life insurance plan for members of the Indiana State Medical Association, was discussed, and by consent the offer was rejected.

Medicare

Several contracts for the Medicare program were presented and they were approved for the president's signature, providing they are approved first by the attorney.

Woman's Auxiliary

The Woman's Auxiliary presented to the Executive Committee the entries for the Auxiliary health awards recognition, and after reviewing the applications the committee selected Mrs. Eck of Plymouth as the recipient of this award.

New Business

Letters from Dr. Dan Tucker Miller and Dr. James Doenges reporting on the White House Conference on Children and Youth, and a letter from the radiological and pathology group, were read for the information of the committee.

The matter of transfer of professional services from the Blue Cross to the Blue Shield certificate was discussed, and on motion of Drs. Glock and Covalt, President Mericle was authorized to talk with Jack L. Hahn concerning the hospital administrators' opposition to this transfer.

The president also brought up a matter which had been referred to him by Dean Kaufman of the School of Pharmacy of Butler University concerning the mail order prescription business. By consent it was agreed that this subject should be discussed in *The Journal* of the Association.

Dr. Mericle read a letter from Mrs. Iva Leiferman, public health nursing instructor, addressed to Dr. Harold Burdette. By consent, it was agreed that this correspondence should be referred to the Commission on Interprofessional Relations.

The Journal

Dr. Ramsey stated there would be a meeting of the journal editors and their staffs at Lexington, Ky., Oct. 15 and 16, 1960, and asked permission for *The Journal* staff to attend along with the editor. This was approved on motion of Drs. Glock and Covalt.

Building Committee

Dr. Ralph Everly, chairman of the Building Committee, appeared before the Executive Committee with the information that the City of Indianapolis had advertised for sale the Governor's Mansion on Fall Creek Boulevard, the sale to be held at 2:00 p.m., April 28. He described the method of sale: that the Association would have to deposit a certified check in the sum of $1,000.00, made payable to the City of Indianapolis, as an eligibility requirement to bid on this property.

Future Meetings

Tenth Annual Group Health Institute, May 24, 25, 26, 27, 1960, Columbus, Ohio, sponsored by the Group Health Association of America. It was agreed that no one should attend this meeting from the Indiana State Medical Association.

AMA meeting on 1961 White House Conference on Aging, Chicago, April 22 and 23, 1960. By consent it was agreed that Dr. O. W. Sicks, Dr. Nathan L. Salon, Dr. Emmett B. Lamb and the secretary should attend this meeting.

There being no further business, the committee adjourned to meet again at noon on Sunday, May 15, 1960. ►



The Journal of the INDIANA STATE MEDICAL ASSOCIATION

July 1960

Office of Publication:
1019 Hume Mansur Building, Indianapolis, Indiana

$1.00 per copy
except Yearbook
$5.00 per copy

Contents

SCIENTIFIC

Early Active Motion in Joint Pain and Stiffness, E. B. Mumford, M.D., Indianapolis 1303
Tests of Duck Embryo (DE) Rabies Vaccine Against Street Virus in Rabbits and Guinea Pigs, H. M. Powell, Sc. D., C. G. Culbertson, M.D., F. B. Perk Jr., M.D., Indianapolis 1307
Hereditary Hyperparathyroidism, Charles E. Jackson, M.D., Pierre C. Talbert, M.D., Harold D. Caylor, M.D., Bluffton 1313
Gelfoam in the Treatment of Stasis Ulcers, M. Murray Nierman, M.D., Calumet City, Ill. 1317
Vaccinia Immune Globulin Used for Vaccinia of Eyelids, Robert William Harger, M.D., Indianapolis, Lucian Arata, M.D., Shelbyville 1323
The Case of Hypothyroid Constipation, Arnold Lieberman, M.D. New York, N. Y. 1324
PATHFINDER: Why a Change in Method of Payment? 1328
CONDENSED CARDIOLOGY: Transient Nature of Depression of Arrhythmias by Potassium, Charles Fisch, M.D., Indianapolis 1331

EDITORIALS

111th Annual Convention 1336
Increase in Hospital Admittance and Prepayments 1337
Medicolegal Digest 1338
Homely But Helpful 1338

SPECIAL FEATURES

Child Psychiatry in Indiana, James E. Simmons, M.D., Indianapolis 1348
How Something for Nothing Legislation Hurts Those Who Are Supposed to Benefit 1358
What Is a Congressional Investigation? The Drug Industry's Trial—by Publicity, Sen. Alexander Wiley, Wisconsin 1362
Basil (A Journal Special), Miki Wilson, San Francisco 1380
1960 Science Fair—Youngsters Have Future Well In Hand 1382
Auxiliary Meeting Spotlights Accomplishments, Aims 1386
President's Report, 1959-1960, Mrs. Mary Black, Seymour 1388

REGULAR FEATURES

Month in Washington 1264
Fourth Estate 1276
Letters to the Editor 1292
Abstracts, Book Reviews 1298
Wanted: Locations, Physicians 1299
President's Page, Earl W. Mericle, M.D. 1340
The Women's Auxiliary Reports to ISMA, Mrs. Ina Rigley, South Bend 1344
About Our Cover 1360
Indiana State Board of Health Report 1378
Federal Employees Choose a Health Program (Blue Shield Series) 1384
News Notes 1390
Indiana Groups Organize Council to Improve Health, Care of Aged 1390
Improve Total Care of Surgical Patients Is Theme of College of Surgeons Meeting 1391
75 I.U. Seniors to Intern in Indiana 1392
Deaths 1397

BUSINESS

Commission Meetings 1402
Association News, The Council, April 10, 1960 1407

EDITORIAL AND ADVERTISING INFORMATION

All articles must be typewritten, double-spaced with margins of one inch.

Photographs should be printed on glossy paper. Negatives cannot be used.

Illustrations are desirable. Selection of illustrations submitted at discretion of editor and editorial board members. Cost of color illustrations must be shared by the author.

Contributors are responsible for all statements made in their articles. The editors and editorial board members may not be in agreement with all views expressed by authors, but it is desired to give all authors as great latitude as possible. However, the right is reserved to reduce in length or reject any article.

Articles are accepted for publication with the understanding that they are submitted for exclusive publication in THE JOURNAL of the Indiana State Medical Association.

Communications dealing with editorial matter should be sent to Frank B. Ramsey, M.D., Editor, 1802 North Illinois Street, Indianapolis 2, Indiana. All other communications should be sent to THE JOURNAL of the Indiana State Medical Association, 1019 Hume Mansur Building, Indianapolis 4, Indiana.

Advertising rates will be furnished on request. Copy must be received by the 5th of the month preceding month of issue. (Scientific manuscripts must be received at least two weeks earlier if geared for a specific issue.)

Entered as second class matter January 25, 1933, at the Postoffice at Indianapolis, Indiana. Copyright, 1960, by the Indiana State Medical Association. Published monthly at 1019 Hume Mansur Bldg., Indianapolis 4, Indiana.





1¼ Grs. Ea.
FLAVORED

Living up to a family tradition

There are probably certain medications which are special favorites of yours, medications in which you have a particular confidence.

Physicians, through ever increasing recommendation, have long demonstrated their confidence in the uniformity, potency and purity of Bayer Aspirin, the world's first aspirin.

And like Bayer Aspirin, Bayer Aspirin for Children is quality controlled. No other maker submits aspirin to such thorough quality controls as does Bayer. This assures uniform excellence in both forms of Bayer Aspirin.

You can depend on Bayer Aspirin for Children for it has been conscientiously formulated to be the best tasting aspirin ever made and to live up to the Bayer family tradition of providing the finest aspirin the world has ever known.

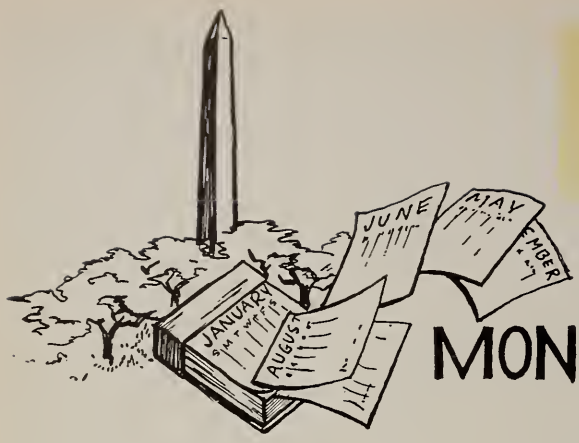
Bayer Aspirin for Children—1¼ grain flavored tablets—Supplied in bottles of 50.

● We welcome your requests for samples on Bayer Aspirin and Flavored Bayer Aspirin for Children.

New
GRIP-TIGHT CAP
for Children's
Greater Protection



THE BAYER COMPANY, DIVISION OF STERLING DRUG INC., 1450 BROADWAY, NEW YORK 18, N. Y.



This summary of what is happening in Washington is prepared by A.M.A.'s Capital office and airmailed to *The Journal* on the ninth of each month preceding month of issue.

MONTH IN WASHINGTON

WASHINGTON, D. C.--An omnibus bill approved by the House Ways and Means Committee contains two provisions of major importance to physicians--Social Security coverage for doctors and a federal-state program to provide health care for older persons with low incomes.

About 150,000 self-employed physicians would be covered by Social Security on the same basis as lawyers, dentists and other self-employed professional people now are covered. Becoming effective for taxable years ending on Dec. 31, 1960, or June 30, 1961, self-employed physicians would be required to pay a Social Security tax of 4-1/2% of the first $4,800 of income. Physicians also would be subject to the automatic increases in the Social Security tax in future years.

Medical and dental interns would be covered for the first time also.

Rep. Wilbur Mills (D., Ark.), Chairman of the Ways and Means Committee, was the main architect of the health program for "medically indigent" aged. It was designed to provide a broad range of hospital, medical and nursing services for persons 65 years of age and older who are able financially to take care of their ordinary needs but not large medical expenses.

STATES MUST DECIDE ON PARTICIPATION

It would be up to each state to decide whether it participates in the program. The extent of participation--the number of benefits offered to older persons--also would be at the option of individual states.

The states would determine the eligibility of older persons to receive benefits under the program. However, the legislation laid down a general framework for eligibility: persons 65 years and older, whose income and resources—taking into account their other living requirements —are insufficient to meet the cost of their medical care.

The program couldn't become effective until July 1, 1961. Before putting such a program into effect, a state would have to submit to the Federal government a plan meeting the general requirements outlined in the legislation.

The program would be financed jointly by the Federal and state governments. Federal grants would have to be matched by participating states on the same basis as under the present old-age assistance formula.

States could elect to provide, with Federal financial aid, any or all of the following benefits:

Continued on page 1268

THE ORIGINAL potassium phenethicillin

SYNCILLIN®

(Potassium Penicillin-152)

BRISTOL



higher peak blood levels
than with potassium penicillin V

higher initial peak blood levels *orally*
than with intramuscular penicillin G

increased dosage increases
serum levels proportionally

superior to other penicillins
in killing many staph strains *in vitro*

A dosage form to meet the individual requirements of patients of all ages in home, office, clinic and hospital:

Syncillin Tablets—250 mg. . . . Syncillin Tablets—125 mg.
Syncillin for Oral Solution—60 ml. bottles—when reconstituted, 125 mg. per 5 ml.
Syncillin Pediatric Drops —1.5 Gm. bottles. Calibrated dropper delivers 125 mg.

Complete information on indications, dosage and precautions is included in the official circular accompanying each package.

BRISTOL LABORATORIES, SYRACUSE, NEW YORK

 Continued from page 1264

(1) Inpatient hospital services up to 120 days per year; (2) skilled nursing-home services; (3) physicians' services; (4) outpatient hospital services; (5) organized home care services; (6) private duty nursing services; (7) therapeutic services; (8) major dental treatment; (9) laboratory and x-ray services up to $200 per year and (10) prescribed drugs up to $200 per year.

The committee put a $325 million price tag on the program for the first full year of operation--$185 million Federal and $140 million state. However, this estimate could hardly be more than an educated guess of sorts. The actual cost would depend upon unpredictable factors--how many states would participate, how many benefits they would offer, and how many older persons would qualify and what services they would require.

The committee estimate was based on between 500,000 and one million older persons a year receiving health services under the program. If all states participated fully, the committee said, potential protection would be provided as many as 10 million aged whose financial resources are so limited that they would qualify in case of serious or extensive illness.

Payments under the program would go directly to physicians and other providers of medical, hospital and nursing services.

In addition to the federal grants for the "medically indigent," about $10 million more in federal funds would be authorized for payment to states for raising the standards of medical care benefits under present public assistance programs for older persons.

SIMILAR TO AMA PROGRAM

The approach of the Mills program was similar to that of Point 2 of the American Medical Association's 8-point program for health care of the aged. Point 2 stated that the AMA supports federal grants-in-aid to states "for the liberalization of existing old-age assistance programs so that the near-needy could be given health care without having to meet the present rigid requirements for indigency." Such a liberalized definition of eligibilty should be determined locally, the AMA said.

Approval of the Mills plan by the committee marked a sharp setback for organized labor leaders. But they continue their all-out pressure campaign in an effort to get Congressional approval of Forand-type legislation that would use the Social Security system to provide hospitalization and medical care for the aged. After being defeated in the Ways and Means Committee, labor union leaders and other supporters of Forand-type legislation directed their major efforts to trying to get the Senate to substitute the Social Security approach.

The committee had been considering health-care-for-the-aged legislation intermittently for more than a year. Hearings were held on the Forand bill last summer but action was postponed until this year.

Prior to approving the Mills plan, the committee rejected the Forand bill (three times) and the Eisenhower Administration's far-reaching public assistance alternative. Both plans were opposed by the medical profession and allied groups.

Continued on page 1272



CHICKEN SESAME—with its crunchy nutlike flavor from the Indies—is typical of the glorious eating contained in this new Wesson cook book.

WESSON'S IMPORTANT CONSTITUENTS

Wesson is 100% cottonseed oil . . .
winterized and of selected quality

Linoleic acid glycerides (poly-unsaturated)	50-55%
Oleic acid glycerides (mono-unsaturated)	16-20%
Total unsaturated	70-75%
Palmitic, stearic and myristic glycerides (saturated)	25-30%
Phytosterol (predominantly beta sitosterol)	0.3-0.5%
Total tocopherols	0.09-0.12%

Never hydrogenated—completely salt free

Each pint of Wesson contains 437-524 Int. Units of Vitamin E

Send coupon for quantity needed for your patients.

The Wesson People, 210 Baronne Street, New Orleans 12, La.

Please send me . . . free copies of the Wesson cook book "101 Glorious Ways to Cook Chicken."

Name.....

Address.....

City.....Zone.....State.....

 Continued from page 1268

NEW LAW HELPS CHILDREN OF ILL DEPENDENTS

While these legislative proposals were in the limelight, a little-noticed bill was enacted into law to give $50 million in relief to taxpayers burdened with taking care of ill dependent parents.

The new law permits taxpayers full deduction on federal income taxes for medical and dental expenses paid for a dependent parent 65 years of age and older. Previously, such a deduction was limited to costs in excess of three percent of the taxpayer's adjusted gross income.

Changes in the Social Security program called for in the catch-all bill approved by the Ways and Means Committee included:

1) Eliminate the requirement that a disabled person must be at least 50 years old to be eligible for Social Security benefits.

2) Provide Social Security benefits for about 25,000 widows of workers who died before 1940.

3) Increase the benefits of 400,000 surviving children of workers covered by Social Security.

Although all these revisions will increase costs of the program, neither the Social Security tax rate nor tax base was increased.

The revisions will mark the fifth consecutive year of a national election that the Social Security program, originally enacted in 1935, has been expanded. Some of the expansions have been accompanied by tax increases. ◄

Tested... and proved...

ORAL therapy in diaper rash!



Convenient... simply open a capsule and add the contents to the baby's daily formula, or to fruit juice or water. No lotions... no rinses... no ointments... just oral therapy.

Send for samples and literature.

S. F. DURST & CO., INC.
Philadelphia 20, Pa.

Effective therapy! Thousands of pediatricians and general practitioners prescribe Pedameth for ammonia dermatitis—and they continue to prescribe it. Clinical tests have proved its effectiveness. Pedameth is safe because it contains only dl-methionine (0.2 Gm.) one of the essential amino acids. When Pedameth is administered, the pH of the urine is lowered and an as-yet-unknown antibacterial agent appears in the urine. Pedameth works... it's the safe, effective, convenient answer to ammoniacal diaper rash.

Prescribe

PEDAMETH®

(dl-methionine DURST)

KANTREX®

INJECTION

Kanamycin Sulfate Injection

...a highly potent, bactericidal antibiotic for combating staph and gram negative infections

...well tolerated when used on a properly individualized dosage schedule which does not induce excessive blood levels

"In many instances its effect has been dramatic and life saving . . ."[1]

"Six of the patients who survived were considered to be terminally ill at the time kanamycin was started but showed dramatic improvement and eventual complete recovery."[2]

"...indeed, the results [with kanamycin] are the most remarkable ever achieved with otherwise fatal staphylococcal infections that we have ever seen."[3]

"There appears to be no doubt that kanamycin has been lifesaving in those instances in which organismal resistance precludes the use of other antimicrobials."[4]

Information on dosage, administration and precautions contained in package insert or available on request.

SUPPLY: KANTREX Injection, 0.5 Gm. kanamycin (as sulfate) in vial containing 2 ml. volume. KANTREX Injection, 1.0 Gm. kanamycin (as sulfate) in vial containing 3 ml. volume.

REFERENCES: 1. Yow, E. M.: Practitioner 182:759, 1959. 2. Yow, M. D., and Womack, G. K.: Ann. N. Y. Acad. Sci. 76:363, 1958. 3. Bunn, P. A., Baltch, A., and Krajnyak, O.: Ibid. 76:109, 1958. 4. Council on Drugs, J.A.M.A. 172:699, 1960.

BRISTOL LABORATORIES, SYRACUSE, NEW YORK



LOOKS AT MEDICINE

This section of THE JOURNAL is devoted to the presentation of opinions which appear on the editorial pages of the public press, and which are of interest to the medical profession. Its function is to review comments which may be favorable or unfavorable to medicine. Members are invited to submit editorial clippings for this column.

Temporizing With a Miracle

The Public Health Service reports that 540 Americans died of poliomyelitis last year as against 225 the year before and 221 in 1957.

This is just why President Eisenhower called for observance of April 12 as a new kind of V-Day—Vaccination Day. Just five years ago, on April 12, 1955, medical scientists at Ann Arbor, Mich., announced that the great field trial of the previous year had clearly shown that the Salk vaccine was "safe, effective, and potent"—that it would prevent paralytic polio. The date was carefully chosen; the findings were announced on the tenth anniversary of the death of Franklin D. Roosevelt.

The vaccine was licensed for general use. Despite the failure to make preparations for a mass inoculation program, for the first few years it looked as if a miracle had come to pass. In one year the death rate from polio was cut in half, from more than 1,000 deaths in 1955 to 566 in 1956.

But recently, particularly in the past year, as President Eisenhower puts it, "not enough Americans have had the full course of injections needed for the maximum protection afforded by the vaccine against polio." More than 90 million still should be vaccinated. Children under five years of age particularly need this safeguard. Plenty of vaccine is available—a record 26.4 million doses.

The "disease year" began April 1. We could be learning in a tragically few months—from the first reports on the new death toll—that we have only temporized with the miracle, being too busy or lazy to allow it to work its full good.

Kokomo Tribune
April 14, 1960

Worse Than Forand Bill

Budget-balancing Republicans have come up with a real budget buster as their answer to the Forand bill to provide hospitalization for the aged.

The Forand bill proposes self-financing, at least in theory. It would require a hike in social security payroll deductions, setting up a fund to pay hospital and nursing home bills of those over 65.

The new plan, put forward by a group of Republicans, in contrast, would be pure handout.

The elderly would buy hospital insurance from private companies at a sliding scale of rates, depending on income. These fees, apparently, would pay about a fourth of the cost.

Federal and state governments would pay the rest, out of general revenues. This annual subsidy would amount to around $480 million for the federal government, $640 million for the states.

The Republican group is said to be distressed at the political appeal of the Forand bill which largely bears a Democratic trademark. The Republicans think it is incumbent on their party to present a "positive program" as substitute.

They ought to try again.

The Indianapolis Times
April 14, 1960

Continued



Dianabol: new, low-cost anabolic agent

By promoting protein anabolism, Dianabol builds lean tissue and restores vigor in underweight, debilitated, and dispirited patients. In patients with osteoporosis Dianabol often relieves pain and increases mobility.

As an anabolic agent, Dianabol has been proved 10 times as effective as methyltestosterone. Yet it has far less androgenicity than testosterone propionate, methyltestosterone, or norethandrolone.

Because Dianabol is an oral preparation, it spares patients the inconvenience and discomfort of parenteral drugs.

And because Dianabol is low in cost, it is particularly suitable for the aged or chronically ill patient who may require long-term anabolic therapy.

Supplied: *Tablets,* 5 mg. (pink, scored); bottles of 100.

Complete information sent on request.

Dianabol®
(methandrostenolone CIBA)

converts protein to working weight in wasting or debilitated patients

CIBA
SUMMIT, NEW JERSEY

2/2829MB

The Helpless And The Good Society

When anyone—a Congressman, let us say—sees people old, sick, helpless and without the means for either medicines or care, he would be very inhuman indeed not to be moved and to cast about for a way to relieve the distress.

For unnecessary suffering is not only a personal tragedy. To men of compassion it seems also a reproach to society, and from the earliest days of civilization society has groped for ways to care for its old and its helpless. Ancient emperors tried with largess; the feudal system tried to create an orderly place of security for every man; for centuries the Church, as the one encompassing agent of society, made efforts to take on the burden of the unfortunate.

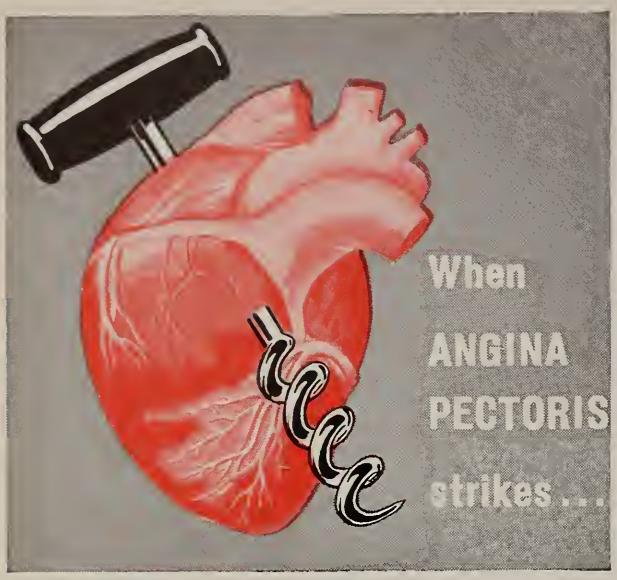
So the impulse in Congress behind such measures as the Forand bill which seeks to put medical care for the aged under social security is an impulse of good will. And anyone who says the remedy is not as wise as it is charitable, which President Eisenhower has just done by opposing such compulsory measures, risks being branded as bereft of compassion.

Yet a little reflection ought to show that these measures are not merely ineffectual remedies but can defeat the very purposes intended, the proper care of the aged. If the problem were so simply solved, it would have been solved long ago.

To begin with, the proposal to put every old person under a blanket of government paternalism overlooks the profound progress that the American society has made already in dealing with this problem. It's not smugness for Americans to recognize that, despite the individual cases of hardship, old people here today have better medical treatment and better care than ever before in history or than they do currently in countries where socialism reigns.

So the problem, for America, is first of all the problem of exceptions. Even one case is a matter of concern, but the way to attack the problem of exceptions is not with a remedy that treats all old people as wards of the State.

To do so is not only disproportionate; it is also self-defeating. The smallest calculation would show that if the government is to undertake to pay the medical expenses for all old peo-



prescribe

NIPHYLLINE

the unique specific

This exclusive development is neutral in action, and ***specific in prophylaxis and treatment of angina pectoris.*** It is effective orally in about thirty minutes, for periods of 7 to 8 hours . . . and, even when given routinely, does not cause nausea or gastric upset. Niphylline is an efficient vasodilator and diuretic combining the effectiveness of Neothylline (soluble, neutral, stable derivative of theophylline) and pentaerythritol tetranitrate, substantially more effective than mannitol hexanitrate. Thus, the patient receives the benefits of both drugs without any annoying side effects.

Niphylline is safe, and well tolerated . . . exerts strengthening effect on heart muscles, and acts synergistically, remarkably reducing severity and frequency of cardiac attacks.

Indications: Relief and control of angina pectoris, cardiovascular symptoms, asthenia, coronary spasm with myocardial pain, prophylaxis and treatment of left ventricular insufficiency, cardiac dyspnea and oliguresis.

Dosage: One or two tablets, 3 or 4 times daily, or as directed by physician.

Supplied: Bottles of 100 and 1000 tablets.

Each tablet contains: Pentaerythritol tetranitrate, 10 mg., and Neothylline (dihydroxypropyl theophylline), 100 mg.

PM **PAUL MANEY**
LABORATORIES, INC.
Cedar Rapids, Iowa

Fourth Estate

Continued

ple in the country, the amount which can be allocated to each will be small indeed. On the one hand we will have the ridiculous situation of the government taxing the poor to make medical payments to those able and willing to care for themselves. On the other hand, the truly helpless can receive only a pittance.

To some extent we have already got ourselves in this situation with social security anyway. A Nelson Rockefeller has no need of what the government will pay him when he is 65, while for others the total allowance will barely keep body and soul together. It is not very intelligent, however well-intentioned, to attack the problem of a relatively few indigent old people by this kind of blanket program.

But this is only a part of the difficulty. A graver matter is that the effort to blanket everyone in this paternalism—the cost of it, if one may speak of bookkeeping—diminishes the chances of the vast majority of the people to meet this problem themselves.

Here the government has already done great injury to all the old people of this country. Reflect, for a moment, on what the deliberate, or recklessly thoughtless, policies of heavy taxation and inflation have done to those who ten or fifteen years ago set aside a substance just to meet this personal problem. If they now find their savings or pensions or their insurance inadequate to today's cost, the blame lies not with themselves but with a government which has, by those policies, robbed them of part of their substance.

Consider, then, the millions who today are counting on the savings or the private pension plans which have proliferated out of the richness of America.

Twenty or 40 years from now they too will be old, and if the government is honest with their money they will have no need for charity or paternalism. They will need the pittance the government can give them only if in the meantime that same government has robbed them further by inflation and taxes to support a costly program started to give them that pittance.

So we are brought to this. There are, and will be, individual cases of misfortune for which society must provide. That our society in many



for the acute asthmatic attack elixir synophylate®

(Theophylline Sodium Glycinate)

RAPID ORAL CONTROL WITHOUT G.I. IRRITATION

ELIXIR SYNOPHYLATE relieves wheezing and dyspnea in 5 to 10 minutes after a single dose. Significant blood levels are achieved in 15 minutes, persisting for at least 4 hours.

Because of its built-in buffer, theophylline sodium glycinate [SYNOPHYLATE] is "tolerated in larger doses than are possible with other theophylline preparations,"[1] including aminophylline.[1-3]

the most potent theophylline elixir available . . . may avoid need for I.V. injection

1. A.M.A. Council on Drugs: New and Nonofficial Drugs 1959, Philadelphia, Lippincott, 1959, p. 389. 2. United States Dispensatory (Osol-Farrar), ed. 25, Philadelphia, Lippincott, 1955, p. 1412. 3. Grollman, A.: Pharmacology and Therapeutics, ed. 3, Philadelphia, Lea & Febiger, 1958, p. 208.

Each tablespoonful (15 ml.) contains 0.33 Gm. (5 gr.) equivalent to 0.16 Gm. (2½ gr.) Theophylline U.S.P. Supplied: Bottles of 1 pint and 1 gallon.

Literature on request.

. . . particularly useful for children

Products Born of Continuous Research

THE CENTRAL PHARMACAL COMPANY Seymour, Indiana

Fourth Estate

Continued

forms already does much for these cases is no argument against further efforts by private citizens, local and state governments or even if need be the Federal government. And we are sure it is not this which President Eisenhower argues against. The good society will always grope for better ways to take care of those who cannot take care of themselves.

But the wise society will not confuse intentions with intelligence. It will not so order itself with vast and costly programs that in trying to relieve the hardships of the few it does injury to the efforts of the many to prepare against them.

To do that, to heap heavier burdens upon all the citizens in the name of freeing them from burdens, is not humane. And, as the world around us shows, making all the people the wards of the State is not the wise way to the good society.

Wall Street Journal
March 24, 1960

Controlling Drug Addiction

A special interdepartmental Presidential committee is holding hearings on the narcotics problem in New York City. This city is an appropriate place to study the long-standing evil of drug addiction for its police say 40% of the nation's addicts live there.

The committee may present a forum for renewal of the old controversy between medical (and legal) authorities and federal enforcement officers. In a report issued a year ago, U. S. Narcotics Commisisoner Harry Anslinger said addiction is declining and attributed this to heavier jail sentences made possible by the federal Narcotics Control Act of 1956.

But a committee representing the American Medical Association and the American Bar Association last June reported that "experience has not demonstrated that the laws and enforcement policies urged by the U. S. Narcotics Bureau provide the full answer to the problem." The committee recommended again that an experimental clinic be set up to treat addicts on a walk-in basis.

Continued

...MALNUTRITION OR
LEG CRAMPS DURING PREGNANCY?

OUTMODED AS GODEY'S FASHIONS!

℞ NEW

PRENALIN-O®

PRENATAL SUPPLEMENT

1. Oyster Shell Calcium - Phosphorus Free!
2. New Form of Iron!
3. Dry Filled Capsule - Sure, Quick Absorption!
4. Economical Once-A-Day Dosage!
5. Wider Range Nutritional Support!
6. Relieves Troublesome Leg Cramps!



EACH dry filled capsule (lavender and white) provides:

Ferrous Fumarate (Iron)	150 mg.	Vitamin B-12 (Cobalamin conc. NF)	2 mcg.
Deep sea oyster shell (Calcium)	600 mg.	Folic Acid	0.25 mg.
Vitamin C	50 mg.	Niacinamide	10 mg.
Vitamin A	4000 USP Units	Vitamin K (Menadione)	0.25 mg.
Vitamin D	400 USP Units	Rutin	10 mg.
Vitamin B-1	2 mg.	Sodium Molybdate	3 mg.
Vitamin B-2	2 mg.	Fluorine (Calcium Fluoride)	0.25 mg.
Vitamin B-6	0.8 mg.	Iodine (Potassium Iodide)	0.15 mg.

SAMPLES ON REQUEST

TUTAG

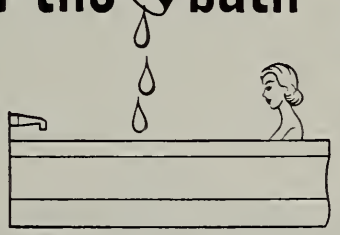
S. J. TUTAG & CO.
DETROIT 34, MICHIGAN



for **dryness** and **itching,** prickly heat and rash
intertrigo, insect bites, other summer skin discomforts

Sardo®

in the bath





1. Spoor, H. J.: N. Y. State J. Med., Oct. 15, 1958

SARDO acts promptly to help restore needed natural oil and moisture[1] to dry, itchy skin, by helping to re-establish the normal lipid-aqueous balance. Thus SARDO eases irritation, soothes, softens, brings sustained comfort.

USED IN THE BATH, SARDO releases millions of microfine water-dispersible globules* to provide an emollient suspension which enhances your other therapy . . . in prickly heat, intertrigo, insect bites, skin dryness and itch of atopic dermatitis, eczematoid dermatitis, senile pruritus, soap dermatitis, etc.[1]

Patients appreciate pleasant, convenient, easy-to-use SARDO. Non-sensitizing. Most economical. Bottles of 4, 8 and 16 oz.

Write for *Samples* and literature . . .

Sardeau, Inc. 75 East 55th Street New York 22, New York

© 1959 *Patent Pending, T. M.

Fourth Estate

Continued

Opponents of the punitive approach to addiction concede, as did the AMA-ABA committee. that "zealous law-enforcement efforts have unquestionably played a part in reducing drug addiction and will indisputably continue to be required in curbing the illicit drug traffic." But they advocate taking a new look at national policy on control of addiction. Their basic proposal is to make drugs available to known addicts, under medical supervision, to save them the pangs of denial.

The British system is often brought up as an example of succesful narcotics control. Britain regulates the drug traffic much as we do, but there are fewer restrictions on the use of narcotics in medical practice, and in certain prescribed circumstances drugs may be administered to known addicts. Of a population of 50 million, only 359 cases of addiction were known to the British Home Office in 1957.

The most cogent argument for treating addicts like sick persons rather than criminals is of course that thereby the profits may be taken out of the illegal drug traffic. That would mean drying up a major source of revenue for the Mafia and other underworld syndicates.

Kokomo Tribune
May 24, 1960

End These Death Traps

Forethought is one of the strongest of our safeguards against accident and death.

Sheriff O'Neal is to be complimented for his action in ordering the owners of water-filled basement excavations to fill them at once or face prosecution.

Spring weather provides enough in the way of natural hazards for children without adding artificial and man-made dangers.

Released from winter's inhibiting grime and cold weather, children yield to the same explorative instincts that sent Magellan, Columbus, Cortez, Ponce de Leon and others into "strange new worlds" of mystery and adventure.

Continued on page 1290

Reliable
PROFESSIONAL LIABILITY
INDIVIDUAL INSURANCE
with proficient defense
that cuts the cost
Unparalleled Experience • Specialized Service • Saving in Cost
THE
MEDICAL PROTECTIVE COMPANY
FORT WAYNE, INDIANA
Professional Protection Exclusively since 1899
INDIANAPOLIS OFFICE: Kenneth W. Moeller, Rep.
5950 Indianola Avenue Tel. CLifford 5-6525



when that early Monday morning telephone call is from a weekend do-it-yourselfer

"...and this morning, Doctor, my back is so stiff and sore I can hardly move."

now...there is a way to prompt, dependable relief of back distress

the pain goes while *the muscle relaxes*

POTENT — **rapid relief in acute conditions**

SAFE — **for prolonged use in chronic conditions**

notable safety — extremely low toxicity; no known contraindications; side effects are rare; drowsiness may occur, usually at higher dosages

rapid action, sustained effect — starts to act quickly, relief lasts up to 6 hours

easy to use — usual adult dosage is one 350 mg. tablet 3 times daily and at bedtime

supplied — as 350 mg., white, coated tablets, bottles of 50; *also available for pediatric use:* 250 mg., orange capsules, bottles of 50

WALLACE LABORATORIES, New Brunswick, New Jersey

SOMA™

(CARISOPRODOL WALLACE)

Fourth Estate

Continued on page 1284

Water-filled excavations hold a tragedy potential too grave to overlook.

O'Neal recognizes this potential. So do parents. So do the owners of the excavations.

Children don't.

So, please, let's see that these holes are filled—at once.

The Indianapolis Times
April 14, 1960

Medics and Labor Confab

The problem of medical care for the aged has bubbled up as a major issue, for discussion at least, in this session of Congress. It's a thorny one; on one hand there is the admitted need of assistance by many of the dependent aged, and on the other the question of socialized medicine.

The issue may have to be settled finally by Congress, but only in accord with the desires and best interests of the American people. It is a favorable development that leaders of two private groups that, in the past, have been particularly involved as antagonists in the debate should have arranged to sit down together in a friendly discussion.

The groups are the American Medical Association and the AFL-CIO. At the request of the AMA, President George Meany of the labor federation is naming a panel of five to meet with a similar group from the medical association in Chicago on May 13 and 14. They will seek areas of agreement and improved understanding on matters of health insurance and care for the aged.

This will mark the first meeting between the AMA and the AFL-CIO to explore methods of financing medical care, the area in which they have had their greatest differences in the past. If they can achieve some measure of agreement at the Chicago meeting, or in future sessions, they may contribute importantly to a solution of the problem.

It should be noted that an estimated 49 per cent of all Americans past the age of 65 already are protected by some form of health insurance. The extension of insurance coverage in this age group has been going ahead at a much more rapid pace than for the population as a whole in recent years.

In addition to the 49 per cent of the aged who are insured, an additional 15 per cent are classified as indigent and their medical needs already are being met through the federal Old Age Assistance program.

These figures show that the problem has been narrowed. The interest stirred by the Forand bill in Congress is evidence that there still is a problem to be faced, however. But is it necessary that it be answered with a compulsory federal program? Working together in good faith, perhaps the labor and medical group delegates may be able to point to a better answer than one which involves doctors and patients in a bureaucratic machine.

Gary Post Tribune

◄

During the 1958-59 fiscal year, 1,737 persons completed Red Cross classes in Care of the Sick and Injured. These classes were taught at the Red Cross chapter house, in high schools, and in other places throughout the county—to people of all ages and all walks of life.

COOK COUNTY
GRADUATE SCHOOL OF MEDICINE

INTENSIVE POSTGRADUATE COURSES

STARTING DATES — SUMMER-FALL, 1960

Surgical Technic, Two Weeks, August 8, September 26
Surgery of Colon and Rectum, One Week, September 19
Gallbladder Surgery, Three Days, October 17
Surgery of Hernia, Three Days, October 20
Surgery of Hand, One Week, September 26
Pediatric Surgery, One Week, September 19
Internal Medicine, Two Weeks, October 17
Diagnostic Radiology, Two Weeks, October 17
Board of Surgery Review, Part II, Two Weeks, August 8
Gynecology, Office and Operative, Two Weeks, September 12
Vaginal Approach to Pelvic Surgery, One Week, September 26
Obstetrics, General and Surgical, Two Weeks, October 3
Fractures and Traumatic Surgery, Two Weeks, October 24

Numerous other courses will be offered by the Divisions of Internal Medicine, Surgery, Gynecology, Obstetrics, Urology, Radiology and Dermatology. Circulars available upon request.

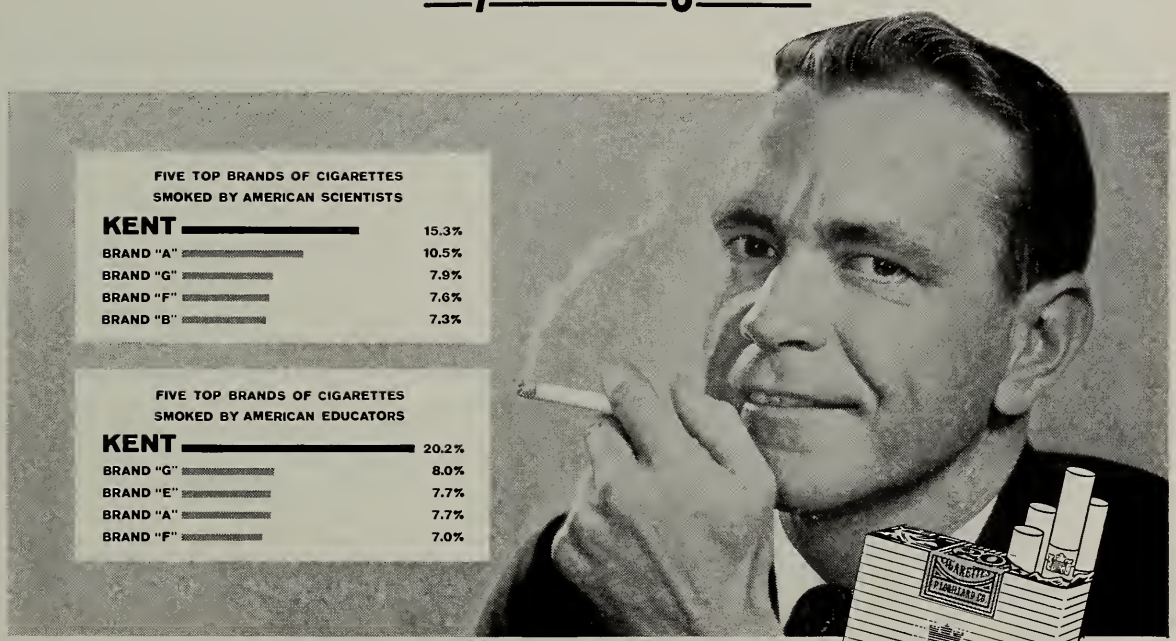
TEACHING FACULTY—ATTENDING STAFF OF COOK COUNTY HOSPITAL

Address:
REGISTRAR, 707 South Wood Street, Chicago 12, Illinois

ALL OVER AMERICA!

KENT with the MICRONITE FILTER IS SMOKED BY MORE SCIENTISTS and EDUCATORS

than any other cigarette!*



THIS does not constitute a professional endorsement of Kent. But these men, like millions of other Kent smokers, smoke for pleasure, and choose their cigarette accordingly.

The rich pleasure of smoking Kent comes from the flavor of the world's finest natural tobaccos, and the free and easy draw of Kent's famous Micronite Filter.



KING-SIZE, REGULAR-SIZE OR CRUSH-PROOF BOX

If you would like the booklet, "The Story of Kent", for your own use, write to: P. Lorillard Company—Research Department, 200 East 42nd Street, New York 17, New York.

For good smoking taste, it makes good sense to smoke KENT

* Results of a continuing study of cigarette preferences, conducted by O'Brien-Sherwood Associates, N.Y., N.Y.

A PRODUCT OF P. LORILLARD COMPANY · FIRST WITH THE FINEST CIGARETTES · THROUGH LORILLARD RESEARCH

© 1960, P. LORILLARD CO.

Letters
to the Editor

Dear Sir: June 6, 1960

Mention of repository therapy in the lay literature has been scant over the past two years. However, a popular monthly magazine plans to have an article on this subject in July. This will certainly be followed by questions and demands on physicians, with which they may not be able to cope. This letter is written to give the physicians of Indiana a succinct review of the subject.

The technic is not new. In 1928, Feinberg attempted mixing extracts in almond oil. In 1932, Sutton used olive oil as an emulsifying agent. Many workers since have used various agents to allow administration of large doses of extracts because of slow release. Tannates, alum, gelatin and, recently, various oils have been used as adjuvants. This type of therapy is not peculiar to allergic disease. Adjuvants have been used in poliomyelitis vaccine, influenza vaccine, alum precipitated vaccine, protamine insulin, and various penicillin preparations, to name a few.

The "one shot" (an unfortunate name) treatment is a more refined manner of immunizing against inhalant allergic disease. The advantages are:

1. Convenience to the patient. Multiple office visits are reduced or eliminated. The patient sensitive to only one allergen, such as ragweed, is the exception. Nearly all have multiple sensitivities and will require 3-10 repository injections per year.

2. Workers feel that results are as good and probably better than with the conventional multiple injection therapy. Time and a further compilation of results should help to prove the validity of this statement.

3. From a theoretical point of view, a higher titer of immunity will be obtained. In 1926, Coca, in the *Journal of Immunology,* demonstrated that 90% of injected pollen extract is excreted in the urine within twenty-four hours —10% remains available for anti-body production. With emulsions, excretion is negligible, so that dose for dose, emulsion therapy should have ten-fold the immunizing potentiality possessed by saline extracts.

4. Radioactive studies indicate that saline extracts are dissipated within weeks. Emulsions remain for months, continually stimulating the production of immunity by slow absorption.

The disadvantages are:

1. Each injection must be individually prepared for each patient. Dosage is determined by scratch tests, intra-dermal tests, conjunctival tests, and by the patient's previous tolerance to saline extracts. Unfortunately, mucous membrane sensitivity does not necessarily correlate quantitatively and qualitatively with skin or conjunctival sensitivity.

2. Preparation of each emulsion takes more than an hour, and may take several. The emulsion must be examined (microscopically), using a hydrophilic dye to detect unemulsified antigen, which may produce constitutional reactions. The particles should be less than .5 micron in diameter.

3. The injection must be given within 1-2 hours of preparation, as many emulsions separate on standing.

4. A report at the American College of Allergy Convention in 1960, on results to date, indicates an overall constitutional reaction rate of 6%. It is felt that with newer techniques and a better understanding of emulsions and emulsion therapy, this will and has been minimized. It is common practice among many men to use an antihistamine and epinephrine prophylactically. The reactions are the same as with saline extracts and are due to an immediate release of unemulsified extract. Reactions a day or days later do not occur. Apparently any and all unemulsified extract is immediately (within hours) absorbed. That which is emulsified remains in this state Each globule of oil with the extract trapped in its center remains as one microscopic "ball bearing" in a homogenous mass. Each droplet is engulfed by a white cell, so that slowly, over a period of months, the repository is dissipated and small amounts of extract transferred probably to plasma cells to produce immunity.

Continued

in arthritis and allied disorders

Butazolidin®

brand of phenylbutazone

Geigy

Proved by a Decade of Experience
Confirmed by 1700 Published Reports
Attested by World-Wide Usage

Since its anti-inflammatory properties were first noted in Geigy laboratories 10 years ago, time and experience have steadily fortified the position of Butazolidin as a leading nonhormonal anti-arthritic agent. Indicated in both chronic and acute forms of arthritis, Butazolidin is noted for its striking effectiveness in relieving pain, increasing mobility and halting inflammatory change.



Butazolidin®, brand of phenylbutazone: Red, sugar-coated tablets of 100 mg. Butazolidin® Alka: Orange and white capsules containing Butazolidin 100 mg.; dried aluminum hydroxide gel 100 mg.; magnesium trisilicate 150 mg.; homatropine methylbromide 1.25 mg.

Geigy, Ardsley, New York

162-60

Letters

Continued

5. In the past, when the oil, Falba, was used as the emulsifying agent, local abscesses with resultant ulceration were reported. Since Drakeol (a brand of mineral oil) and Arlacel (an emulsifying agent) have been used as the adjuvant, no ulcers, to my knowledge, have been reported.

6. Extreme local soreness and swelling occurs infrequently. Swelling sometimes persists for several weeks. Apparently some patients react violently to the adjuvant as a foreign body, and swelling even into the forearm from an injection in the arm is seen. Fortunately, with time, and cold packs, this disappears.

7. The question of the adjuvant's being carcinogenic has been raised, but with the tens of thousands of such treatments given, the first report of such a case is yet to be made.

8. A great deal of new equipment is necessary for proper emulsification of extracts. New techniques must be learned. As an example, a drop of alcohol in the emulsion or on the skin will break down the emulsion.

9. More help is required, as it becomes a full-time job for one or more to prepare emulsions.

In summary, it can be stated:

1. Repository therapy is valid and will no doubt gradually replace conventional therapy.

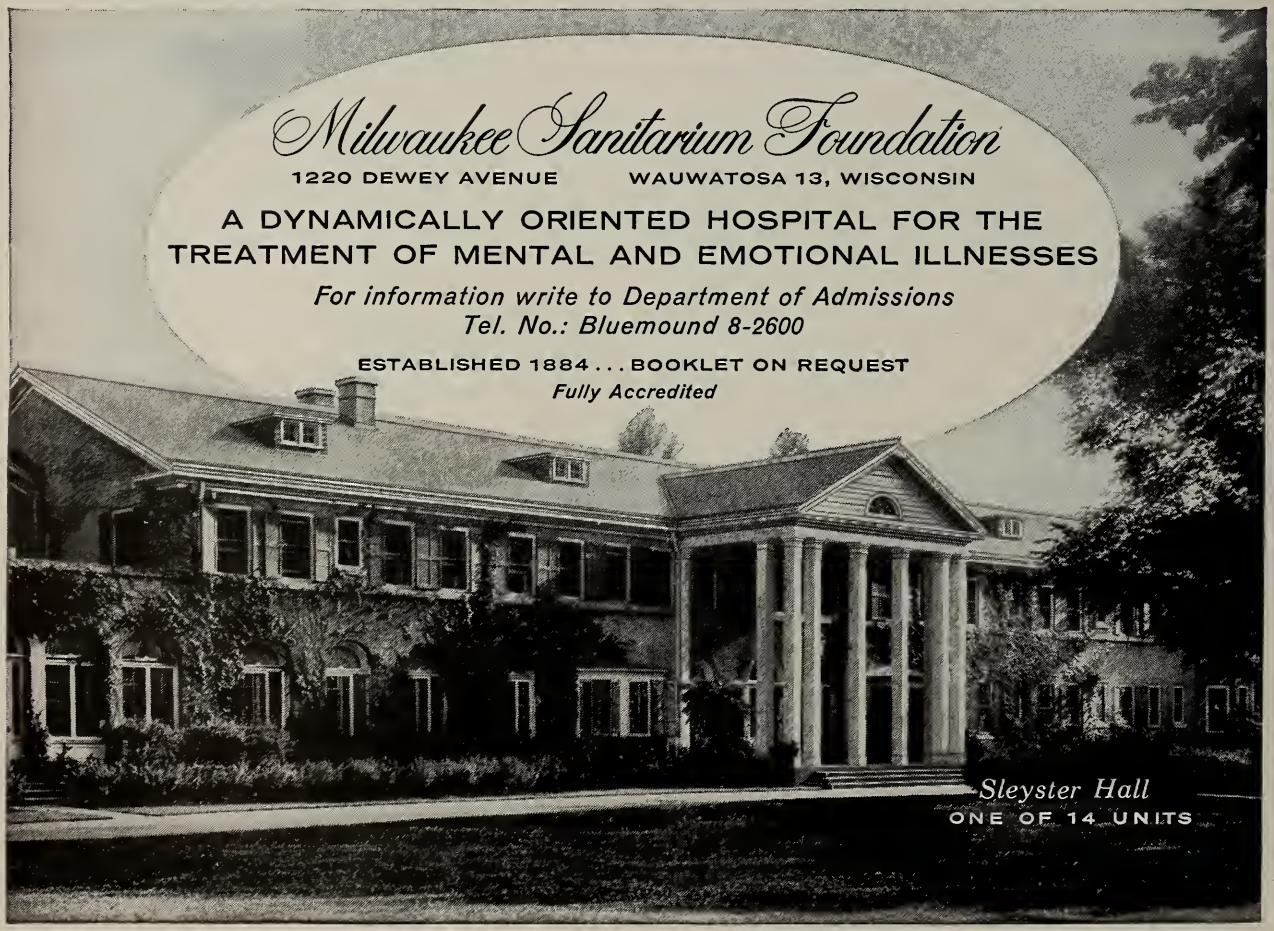
2. With time, reactions will be reduced by improvement in emulsions, adjuvants, better judging of dosage, and possibly by preparing questionable patients with several injections of saline extract or smaller doses of emulsion prior to administering the "one shot treatment."

3. Results seem to be better than with conventional therapy.

4. As it stands today, repository therapy of inhalant allergic disease remains on an investigational basis. Repository therapy is now in the hands of those allergists who have availed themselves of the necessary added training and qualified as investigators.

Very truly yours,
Irvin Caplin, M.D.
Indianapolis, Ind.

Continued



IN CONTRACEPTION...



WHY IS SPEEDIER SPERMICIDAL ACTION IMPORTANT?

Because a swift-acting spermicide best meets the variables of spermatozoan activity.

Lanesta Gel, "...found to immobilize human spermatozoa in one-third to one-eighth the time required by five of the leading contraceptive products currently available . . ."* thus provides the *extra* margin of assurance in conception control. The accelerated action of Lanesta Gel — it kills sperm in minutes instead of hours — may well mean the difference between success and failure.

**Berberian, D. A., and Slighter, R. G.: J.A.M.A.* 168:2257 *(Dec. 27) 1958.*

In Lanesta Gel *7-chloro-4-indanol,* a new, effective, nonirritating, nonallergenic spermicide produces immediate immobilization of spermatozoa in dilution of up to 1:4,000. Spermicidal action is greatly accelerated by the addition of 10% NaCl in ionic form. Ricinoleic acid facilitates the rapid inactivation and immobilization of spermatozoa and sodium lauryl sulfate acts as a dispersing agent and spermicidal detergent.

Lanesta Gel with a diaphragm provides one of the most effective means of conception control. However, whether used with or without a diaphragm, the patient and you, doctor, can be certain that Lanesta Gel provides faster spermicidal action — plus essential diffusion and retention of the spermicidal agents in a position where they can act upon the spermatozoa.



new Lanesta® Gel

Supplied: Lanesta Exquiset . . . with diaphragm of prescribed size and type; universal introducer; Lanesta Gel, 3 oz. tube, with easy clean applicator, in an attractive purse. Lanesta Gel, 3 oz. tube with applicator; 3 oz. refill tube — available at all pharmacies.

Manufactured by Esta Medical Laboratories, Inc., Alliance, Ohio Distributed by GEORGE A. BREON & Co., New York 18, N. Y.

A product of Lanteen® research.

Letters

Continued

Dear Mr. Waggener:

Eli Lilly and Company is pleased to announce that a new cancer detection film is now available for showing to qualified professional groups.

Entitled *The Cancer Detection Examination,* the film was produced from a video tape of a closed-circuit telecast in co-operation with the American Cancer Society, New Jersey Division, Inc. It presents Emerson Day, M.D., Director of the Strang Clinic, Memorial Center for Cancer and Allied Diseases, New York City, demonstrating the presymptomatic detection of cancer through simple office procedures. The black-and-white, 16-mm. motion picture requires a showing time of 46 minutes.

Although it is not suitable for nonprofessional groups, the film may be of considerable interest to the members of your association. May we suggest that you or your program chairman consult the enclosed brochure for additional details, including the mechanics of borrowing the film.

Please note that requests for booking should be made at least thirty days before your meeting date, and an estimate of attendance should be given. This allows us to send you an adequate quantity of illustrated handbooks, which outline in detail the procedures discussed in the film.

The film and the materials are offered as a service to the medical profession by Eli Lilly and Company.

We hope you will find them useful.

Very truly yours,
Eli Lilly and Company

Britain's Health Service Bill

Britain's National Health Service bill for 1958 totaled $1,752,800,000. The British government had to pay $1,344,000,000—more than 75% of the total—of the bill to make up the difference between the total and contributions from patients, personal charges, national insurance fund, and local taxes.—*Insurance Economics Surveys* reprinted in *Wichita Kansas Medical Bulletin* June 1960.



PROTECTION AGAINST LOSS OF INCOME FROM ACCIDENT & SICKNESS AS WELL AS HOSPITAL EXPENSE BENEFITS FOR YOU AND ALL YOUR ELIGIBLE DEPENDENTS

ALL PREMIUMS COME FROM

PHYSICIANS SURGEONS DENTISTS

ALL BENEFITS GO TO

PHYSICIANS CASUALTY & HEALTH ASSOCIATIONS
OMAHA 31, NEBRASKA
Since 1902
Handsome Professional Appointment Book Sent to you FREE upon request.



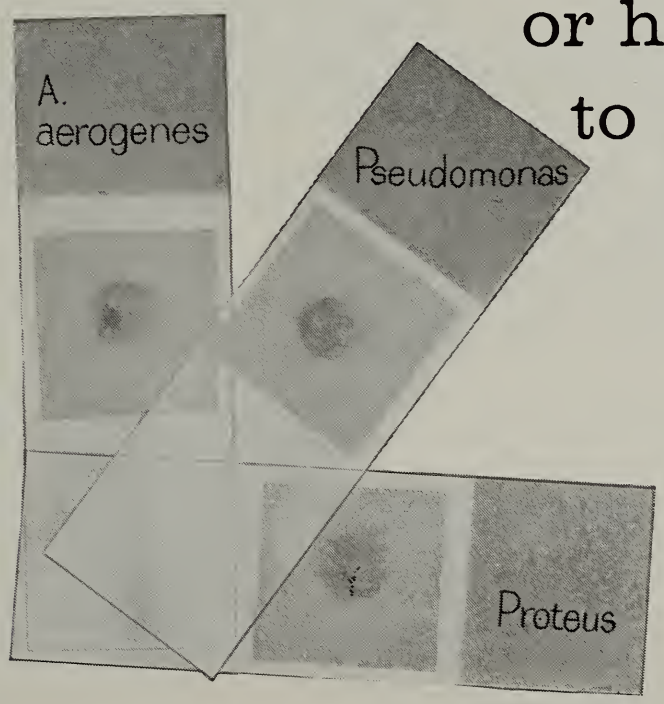
WABASH VALLEY SANITARIUM—HOSPITAL
Lafayette, Indiana
Telephone Riverside 3-1679
A hospital for the treatment of neuro-psychiatric disorders.
Custodial cases are accepted in limited numbers.
— OPEN STAFF —
DONALD R. KINZER
Manager

DECLOMYCIN® NOTES:

Demethylchlortetracycline Lederle

pathogen
sensitivity

In addition to the expected broad-spectrum range of effectiveness, DECLOMYCIN has demonstrated activity against strains of Pseudomonas, Proteus and A. aerogenes[1-4] unresponsive or highly refractory to other antibiotics.



1. Finland, M.; Hirsch, H. A., and Kunin, C. M.: Read at Seventh Annual Antibiotics Symposium, Washington, D. C., November 5, 1959. 2. Hirsch, H. A.; Kunin, C. M., and Finland, M.: **München. med. Wchnschr.** To be published. 3. Roberts, M. S.; Seneca, H., and Lattimer, J. K.: Read at Seventh Annual Antibiotics Symposium, Washington, D. C., November 5, 1959. 4. Vineyard, J. P.; Hogan, J., and Sanford, J. P.: **Ibid.**

Capsules, 150 mg. — Pediatric Drops, 60 mg./cc. — New Syrup, cherry-flavored, 75 mg./5 cc. tsp., in 2 fl. oz. bottle — 3-6 mg. per lb. daily in four divided doses.

GREATER ACTIVITY... FAR LESS ANTIBIOTIC... SUSTAINED-PEAK CONTROL... "EXTRA-DAY" PROTECTION AGAINST RELAPSE

LEDERLE LABORATORIES, a Division of AMERICAN CYANAMID COMPANY, Pearl River, New York

ABSTRACTS

BOOK REVIEWS

HANDBOOK OF POISONING: DIAGNOSIS AND TREATMENT, 2nd ED.

Robt. H. Dreisbach M.D., Ph.D., Professor of Pharmacology, Standford Univ., Lange. Med. Publ., Palo Alto, Calif. Price $3.50.

This is a compact pocket-size book which is concise, complete and, best of all, up to-date; in keeping with the ceaseless advent of the many new commercial chemicals—which are potentially poisonous—into industry, agriculture and the household.

The book is singularized by the grouping of the chemically and pharmacologically related drugs together with their "brand names." There are also separate categories for the poisons of industry, agriculture, the household and natural hazards.

Because of its conciseness and "cross-index," this handbook fills an important nook in the emergency armamentarium and I take the liberty of paraphrasing "brevity is the soul of it."

Franklin F. Premuda, M.D.
Hammond



VISION REQUIRES VISION

Vision for planning man's future largely originates in the mind's eye — but it must be translated to the visual medium for understanding by those who follow the lead. White-Haines follows the professional man's lead in augmenting or correcting visual defects through fine quality ophthalmic craftsmanship, and has been a dependable source for more than half a century.

THE White-Haines OPTICAL COMPANY
34 Modern Laboratories
OHIO • PENNSYLVANIA • MARYLAND
KENTUCKY • W. VIRGINIA • INDIANA
MICHIGAN • ILLINOIS

HYPOTENSION ASSOCIATED WITH ANESTHESIA

Crandell, D. L., Whitcher, C. E.: N. Car. Med. J., Vol. 20:416-422, 1959.

This timely article reviews the contribution of drugs and physical measures to the problem of maintaining adequate blood pressure during anesthesia. The most important group of drugs in this regard are the adrenal steroids and corticotropin. The latter substance following prolonged use inhibits the pituitary's response to stress causing relative adrenal-cortical insufficiency even though the adrenal cortex itself is responsive. It is estimated that at least a week's vacation from cortiocotropin should precede surgery, this time representing the lag phase in recovery of the system of the pituitary-adrenal-cortex system. Therapy with cortisone or related adrenal cortex material, on the other hand, results in suppression of adrenal cortical function of great persistence.

These authors feel that if these substances have been given for even a few weeks, the lag phase in in adrenal response following their withdrawal may last for from six weeks to a year. They recommend that any patient who has had therapeutic amounts of cortisone for more than one week within the six months period preceding surgery should have supplemental cortisone the day before, the day of, and immediately following the operation.

The rauwolfia group of drugs are also implicated in a hypotension and brady-cardia associated with withdrawal, a hypotension which the authors find rather resistant to vasopressor drugs but somewhat responsive to vagal blocking agents. The phenothiazine drugs such as chlorpromazine are implicated because of their ability to depress or abolish reflex circulatory control, and the authors recommended that they not be used within eight hours before anesthesia.

Apropos of preoperative sedation I would like to quote the authors directly: "Drugs are often used to obtain the tranquil state which was not achieved through psychologic preparation by the physician. Drugs are often a poor substitute for the establishment of rapport between patient and physician." In contrast to the narcotics they find little circulatory or respiratory effect from the barbituates.

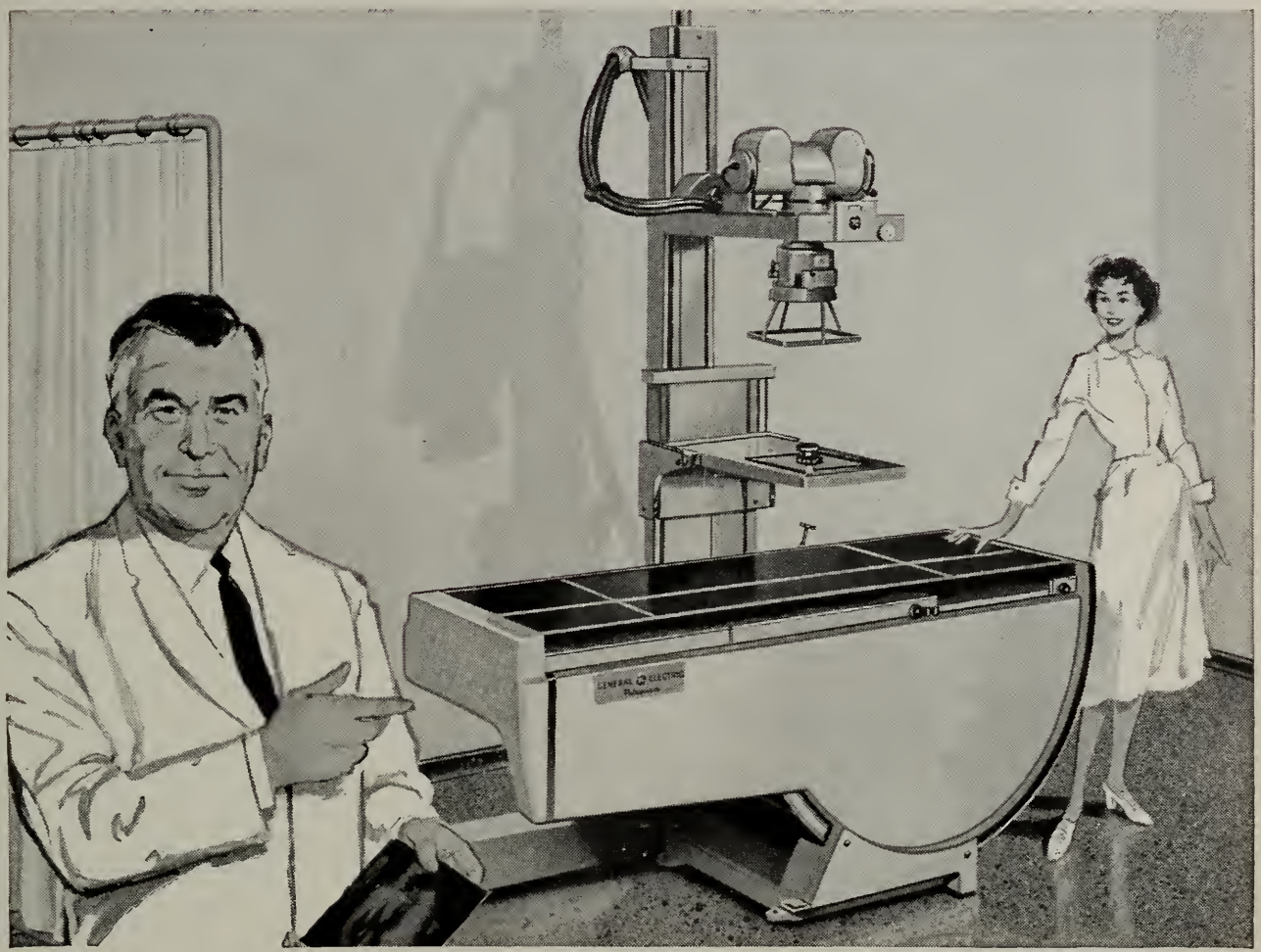
Space forbids the abstracting of the rest of this excellent article except for mention of the complications which may accompany the use of mechanical aids to breathing, all of which are unphysiologic in their effects on right heart filling and accordingly on circulation, especially to the brain.

One final important caution in this review is the effect of the citrate in massive transfusions on the ionized blood calcium, the depression of which should probably be corrected by the administration of calcium gluconate intravenously following every fourth or fifth transfusion.

Stephen L. Johnson, M.D.
Evansville

Continued

The choice of confidence...



diagnostic x-ray equipment planned for private practice!

Few who purchase x-ray equipment have time to thoroughly test the quality of materials, workmanship and technical performance offered by all the makes of x-ray units. And happily this is not necessary.

The manufacturer's *reputation* is worth more than anything else to you in choosing x-ray equipment, one of the most complex professional investments you will ever face.

General Electric has created "just what the doctor ordered" in the 200-ma Patrician, in terms of both reasonable cost and operating qualities. Here diagnostic x-ray is ideally tailored to *private practice.* Patrician provides everything you need for radiography and fluoroscopy — and with consistent end results, since precise radiographic calibration is as much a part of the Patrician combination as it is of our most elaborate installations. For complete details contact your G-E x-ray representative listed below.

Progress Is Our Most Important Product

GENERAL ELECTRIC

DIRECT FACTORY BRANCHES

CHICAGO
1061 W. Jackson Blvd. • SEeley 3-0700
CINCINNATI
3056 W. McMicken Ave. • MUlberry 1-7230—31
INDIANAPOLIS
1845 W. 18th St. • MElrose 5-4576
LOUISVILLE
501 W. Oak St. • JUniper 3-9562

RESIDENT REPRESENTATIVES

FORT WAYNE
H. J. Wallace • 918 Oakdale • Kenmore 9749

Wanted: Locations Physicians

Following is a list of physicians who have made inquiry at our office during the latter part of April, and May 1960 concerning openings in our state for practice.

General Practice

Norman T. Townley, 2834 Alisdale, Toledo, O.
Herbert Parks, 2412 E. 16th Street, Indianapolis, Ind.
John R. Culver, 150 N. Main Street, Oconto Falls, Wis.
James R. Tosetti, 103 S. Vine Street, Nokomis, Ill.

Specialists

William H. Ellswood, 920 Fairchild Street, Lackland AFB, San Antonio, Tex., *Radiology*.

Emmanuel Samouhos, 518 N. Shore Drive, Crystal Lake, Ill., *Radiology*.

Richard H. Schneider, 1105 Pomona Road, Ann Arbor, Mich., *Orthopedics*.

Emmet J. Thorpe, 6811 Stockton Drive, Knoxville, Tenn., *Orthopedics*.

Rolland E. Greenburg, U. S. Naval Hospital, Portsmouth, N. H., *Obstetrics and Gynecology*.

Thomas R. Skaggs, 4866 N. Anita Avenue, Milwaukee, Wis., *Pediatrics*.

Locations

Adams County—BERNE—population 2500. Prosperous agricultural and industrial town. One physician in area recently died; one physician left because of health of wife. Contact Robert L. Boze, M.D., 265 W. Water Street, Berne, for details.

Carroll County—FLORA—population around 1,800 with a large surrounding area. Two new companies located in the town. Contact Max Adams, M.D., or Mr. Frank Fox, both of Flora.

DeKalb County—BUTLER—population 2,000. One physician in the community. Chamber of Commerce interested in securing a physician for the community. Contact Mr. D. C. Mayer, Butler Chamber of Commerce, Butler, Indiana, for details.
WATERLOO—population 1,800. Equipped office available for one or two doctors. Hospital 5 miles away. Dr. F. B. Coleman leaving late summer for medical mission work abroad. Contact Dr. Coleman at Waterloo.

Fountain County—COVINGTON—population around 3,000. Located near three hospitals. County seat town. Olin-Mathison plant located two miles from town. Physicians in community interested in having another physician for the community. Contact Mrs. Margaret B. Ooley, Business and Professional Women's Club, Covington.

Hendricks County—DANVILLE—population 3,500. County seat town. New hospital to be built within the very near future. Located 18 miles from Indianapolis on U.S. 36 (west). Office available. Dr. Kermit Hibner is leaving Danville and wants someone to take over his practice. Contact Dr. Hibner, 25 W. Marion Street, Danville.

Henry County—MIDDLETOWN — population 2,000. Dr. Ralph Reynolds is leaving for a residency and wants someone to take over his practice. Office building and equipment available. Also a home. Contact Dr. Reynolds for details. One other physician in the town.

Jay County—DUNKIRK—population 3,050. Located 14 miles from two hospitals. One physician leaving for a residency—two physicians in the community. Contact Dr. Elizabeth Tate, 317 S. Main Street, Dunkirk, Indiana.

Kosciusko County—CLAYPOOL—located in the lake region of the state. A new 30 x 50 air conditioned clinic building is available with new equipment, including laboratory, x-ray, drug room, etc. Also a large supply of drugs of the late Dr. H. O. Murphy available. Contact Mr. Walter Bouse, Secy., Claypool Clinic Trustees, Claypool, Indiana.

La Porte County—LA CROSSE—Dr. David D. Oak, who has practiced in this community many years, is retiring. His office and equipment are available. No other physician in the community. Contact Dr. Oak for details.

Madison County—CHESTERFIELD — population around 2,500. Located near Anderson, Indiana, where hospital facilities are available. No physician in the community. Contact Mrs. Harry Clendenen, 21 West Plum Street, Chesterfield.

Noble County—LIGONIER—population 3,000. Located in the lake region in northern Indiana. Office and equipment available. Doctor giving up practice for health reasons. Two physicians in the community. Contact Mrs. James A. Chase, R. R. #3, Ligonier, for more details.

Abstracts, Reviews

Continued

SILO-FILLER'S DISEASE

Evans Jr., E. G., McDonald, L. B., Porter, R. A.: N. Car. Med. J., Vol. 21:59-64, 1960.

"Silo-filler's disease—report of two cases." Silo-filler's disease has been identified only since 1956 as an acute broncho-pulmonary disease coming on abruptly after inhaling gas evolved from fresh silage. The noxious inhalant is nitrogen dioxide which develops in the early fermentation of silage. The pulmonary symptomatology varies with the intensity of the exposure from acute fatal pulmonary edema to bronchitis and broncho-pneumonia. The hazard of this exposure is increasing with mechanized farming and shortening of the period from harvesting crop to ensilage. It may also be increased by heavy use of nitrate fertilizers. The disease is reported to respond dramatically to the adrenal steroids but the authors caution that this disease must be definitely identified and infectious pulmonary diseases eliminated.

Stephen L. Johnson, M.D.
Evansville

The Journal of the INDIANA STATE MEDICAL ASSOCIATION

Supervised by THE COUNCIL

Volume 53 — July 1960 — Number 7

Preservation of joint function is the most important element in fracture treatment.

Early Active Motion In Joint Pain and Stiffness

E. B. MUMFORD, M.D.

Indianapolis

A FRACTURE has been defined as a loss of continuity in a bone. To the laity the treatment is not difficult, consisting of the reduction of the fracture and a type of splintage to maintain this reduction during the period required for healing. However, the physician knows that the reduction and splintage are only too often minor factors in the end result and that the degree of permanent impairment may be determined entirely by the pain and the stiffness in the joint or joints adjacent to the fracture line.

Malalignment with faulty weight bearing and a non-union associated with tenderness and pain will cause impairment of a varying degree, but these conditions may be corrected through surgery. It is the pain and stiffness in the joints adjacent to the fracture line which is the more important, which can be prevented to a large degree and can be corrected through treatment based upon a thorough understanding of the tissue changes which cause the pain and a loss of motion in the joint.

Joint, as used in this discussion, is a skeletal articulation which permits motion. It is composed of *intra*-articular tissues, articular cartilage and synovia, *extra*-articular tissues, capsule, ligaments, tendons and other soft tissues.

In order to formulate a satisfactory form of treatment of any fracture which is associated with pain and stiffness in the joint, one must accept a concept of two basic changes in the joint tissues, both soft and bony, as the result of trauma. First, in fractures into or adjacent to joints, the soft tissues soon become infiltrated with a fluid which is of a plastic or adhesive type. Secondly, in order for two adjacent bones to



FIGURE 1 (left)

FIGURE 2 (right)

become united by bony tissue, complete or incomplete, the adjacent bone surfaces must be free of cartilage or any fibrous tissue and raw bone surfaces must be in contact. Contact must be maintained for a sufficient time to permit solid bone healing, this being the basic and essential factor in any arthrodesis operation.

Exact composition of the fluid which infiltrates the soft tissue adjacent to the joint is unknown. However, clinical evidence shows that it is non-inflammatory and that unless absorbed or dissipated it will create adhesions in the soft extra-articular tissues, limiting the motion in the joint and becoming a source of pain when the joint is mobilized. This fluid infiltration appears soon after the fracture occurs. It is also shown clinically that this adhesive fluid will be dissipated by early *active* joint motion and the adjunct of heat and light massage.

If one accepts these changes in the extra- and intra-articular joint tissues the plan of treatment will be directed to the earliest active mobilization of the joint which is consistent with maintaining the reduction of the bone fragments through complete immobilization in the fracture line. Active motion is that degree of motion made by the patient which does not cause pain.

Reaction Within Joint

The term "traumatic arthritis" has often been used to explain the condition in and about the joints which results in joint pain and loss of joint motion. The term indicates an inflammatory reaction *within* the joint, and with some degree of destruction of the articulating cartilage of adjacent bones of the joint—this inflammatory reaction being the result of trauma to the intra-articular tissue. However, it is recognized that pain and stiffness in a joint can result from a fracture even when the joint surface is not involved in the fracture line. This will be seen in fractures of the shaft of the femur in which pain and stiffness in the knee joint result. Also it will be observed in fractures of the surgical neck of the humerus. Furthermore, it is only in rare comminuted joint fractures that the articulating cartilage of two adjacent joint bones are so disturbed as to create a condition to permit any degree of arthrodesis. One must question the existence of traumatic arthritis.

Accepting the premise that stiffness and pain in joints are due to extra-articular changes and that intra-articular conditions are not factors in the impairment, the treatment of a fracture is to so immobilize the fracture, that early mobilization of the joint becomes possible. The radical procedure of an arthrodesis to relieve the pain in stiff joints associated with fractures is contraindicated until consistent physiotherapy has been followed over a long period of time without adequate relief. The arthrodesis may relieve the pain but does not restore motion in the joint.



FIGURE 3

Immobilization of Fracture Line

After reduction of a fracture, immobilization in the fracture line should be maintained for a period of one week to ten days before any active motion in the joint is begun. In this time the early reparative bone changes which are so important for bone healing will produce the early precallus tissue. This tissue will glue together the bone fragments to a certain degree, perhaps sufficiently to maintain reduction unless undue stress or strain is thrown against the fracture line. In the lower extremities weight-bearing is contraindicated until healing is well advanced. During this period any reaction of the plastic elements of the fluid will be of a mild degree and may be corrected by early active mobilization of the joint.

It is a surgical axiom that passive forcible mobilization of joints is contraindicated when adhesions of the extra-articular tissues cause a loss of joint function. Such adhesions should be stretched or lengthened by either continuous (rubber bands) or repeated gentle, active resistant exercises of the joint over a period of weeks or months. Work done in rehabilitation centers is most important and of great value. To tear or lacerate strong fibrous adhesive bands under anesthesia or by forcible passive motion will only result in a period of increased pain and create adhesions of greater density and thus more loss of motion.

The motion you gain through early mobilization of the joint you do not lose. The motion you lose through long fixation of the joint may be permanent.

Case Reports

Case 1. A comminuted fracture of the humerus, supracondylar, with fracture lines involving the elbow joint. The extremity was placed in balanced traction with the elbow extended to 45 degrees. Without anesthesia the fragments were molded through gentle lateral pressure. This moulding was repeated for several days until the x-rays showed satisfactory, although not complete, reduction of the fracture. Active motion of the elbow was begun on the third day with the extremity remaining in balanced traction.

Figure 1 shows the end result of the bone healing at the end of 15 years. The patient reports that she has almost complete function in the elbow without pain.

Case 2. A severe comminuted supracondylar fracture of the humerus involving the elbow joint. It was not possible to obtain a satisfactory reduction with the extremity in balanced traction. The fracture lines were exposed through a posterior approach (Van Gordon type) and the fragments were approximated and position maintained by wire sutures. The extremity was placed in balanced traction and active motion started the second day.

Figure 2 shows the final bone healing after 13 years. The patient writes that he has but little, if any, loss of function and no pain in the elbow joint.

Case 3. A fracture of the lower portion of the tibia at a level of the epiphyseal line. When first seen by me there was a most satisfactory reduction of the fracture line. (Figure 3) The leg had been in a plaster splint extending from above the knee to the toes for 11 weeks. Upon removal of the splint the ankle and the foot were found to be swollen to an extreme degree and the entire foot was of a dark beefy red color. Very little motion was possible in the ankle joint. There was a large decubitus beneath the head of the first metatarsal due to cast pressure.

After 30 weeks of daily and persistent treatment in the psysiotherapy rehabilitation center with active motion the foot regained almost normal size and 90% of function had returned. At the end of this period weight-bearing was without pain. There has, however, persisted some swelling of the entire leg to a mild degree.

This case illustrates that the pain and loss of function was not due to an intra-articular change in the tissues, but to extra-articular tissue changes and that return of function and loss of pain can follow active motions and other forms of physiotherapy, although the period of convalescence may be long.

Case 4. Fracture-dislocation of the ankle. In this case there was a fracture of each malleolus with a lateral and posterior dislocation of the ankle joint; although the wound was not compounded there was considerable damage to the soft tissues. Reduction under anesthesia gave a satisfactory restitution to the ankle joint. Immobilization was maintained by plaster of paris for one week. At the end of this period active mobilization of the ankle was begun. Partial weight-bearing was permitted after one month. The end result was full function in the ankle. Some discomfort was present for two months. At present he is walking without a cane or crutch and has played golf and the end result is 90% of function in the ankle and foot.

Case 5. This was a complete posterior dislocation of the elbow with an associated fracture of the coronoid process and of the olecranon. Open reduction to stabilize the fracture did not prevent the recurrence of the dislocation. The arm was placed in balanced traction. Active motion maintained the motion in the elbow joint during the period of healing of the fractures and of the extensive lacerations of the *extra*-articular tissues. The end result was 75% motion, without pain, in the elbow joint. ◄

320 N. Meridian St.
Indianapolis 4, Indiana

Hospital Automation

Automation in Surgery.—Automation may soon be introduced into surgical operations to lessen the risk of infection rather than to increase the number of patients treated. Mechanical lifting and conveyor belts will replace the handling of instruments and thus reduce the number of personnel required in the operating room. Instruments will enter on a conveyor belt passing through a hatch. The first operating room of the new type will be at the Plastic and Oral Surgery Center, Odstock, Salisbury, England. All the instruments and appliances for the whole hospital will be sterilized in one unit and delivered automatically. Conveyor belts will also remove them for cleaning and resterilization. This is part of the answer to the increasing incidence of infection in hospitals. The contact of possible carriers with instruments and equipment will be reduced to a minimum. The new method will also reduce the chances of inadequate sterilization, as this will be done on a large scale with adequate precautions.

J.A.M.A., Vol. 173, No. 4, May 1960

Duck embryo rabies vaccine prepared from 'fixed virus' carries little or no risk of encephalitis, yet confers immunity to 'street virus' in laboratory animals.

Tests of Duck Embryo (DE) Rabies Vaccine Against Street Virus in Rabbits and Guinea Pigs

H. M. POWELL, Sc.D.
C. G. CULBERTSON, M.D.
F. B. PECK, JR., M.D.
*Indianapolis**

THIS REPORT CONCERNS the immunizing action of inactivated duck embryo (DE) rabies vaccine against street virus.**

The vaccine used was a variety of this product prepared from first passage fixed virus† grown in embryonated duck eggs.[1,2] Vaccine prepared on such a substrate is largely devoid of encephalomyelitis-producing qualities inherent in vaccine derived from the brain.[3]

Immunizing action of rabies vaccine for use in the United States is assayed by tests in white mice against fixed virus. In work done by several independent investigators[4,5,6,7] as well as our associates and ourselves,[8,9,10,11] a good many studies have been made in both animals and man concerning antibody titers against fixed virus produced by DE vaccine, and the results have been uniformly good.

Little information is at hand concerning effectiveness of DE rabies vaccine in laboratory animals in which street virus has been used for challenge. We are aware of only one series of such tests, and this was done by one of our former associates using one or two large doses of vaccine, as in veterinary practice, in 90 dogs and several different times of challenge. While this work was fairly successful, it has not as yet been published.[12] In view of this, it appeared of interest to report on some experiments which we have been able to do in rabbits and guinea pigs, these species being challenged with street virus intracerebrally and intramuscularly, respectively. Results of four tests are herewith reported although experiment number one has been currently reported upon separately.[13] It may be mentioned that successful results might be assumed from routine data on potency tests against fixed virus in mice; however, direct laboratory proof against street virus should be useful.

Experiments

In experiment number one, eight rabbits were immunized according to Semple's original methods in experimenting with street virus.[14] De-

* From Indiana University Medical Center, and Lilly Research Laboratories.

** "Street virus" is rabies virus as transmitted in nature by biting animals such as rabid dogs, foxes, skunks, etc. This form of the virus is invasive and peripherally virulent for man following bites of such animals.

† "Fixed virus" was first developed by Pasteur by repeated intracerebral injection of street virus from one rabbit to another in a long series of passages. "Fixed virus," as "fixed" or adapted to the rabbit, has lost its former peripheral virulence for man, and constitutes a much safer virus for human antirabies vaccination.

Rabbits immunized with DE rabies vaccine and challenged intracerebrally with street virus one week after last dose. (first series)

Intracerebral Challenge Dose of 0.25 ml of Street Virus Diluted:	Rabbits Immunized with DE Rabies Vaccine			Normal Rabbits	
	Number	Antibody Titer	Result	Number	Result
1:200	4124	85	Rabies, day 17	4132	Rabies, day 15
	4125	48	S	4133	Rabies, day 15
1:400	4126	25	S	4138	Rabies, day 17
	4127	35	S	4139	Rabies, day 15
1:800	4128	14	Rabies, day 19	4134	Rabies, day 15
	4129	26	S	4135	Rabies, day 15
1:1600	4130	6	S	4136	Rabies, day 12
	4131	27	S	4137	Rabies, day 13
1:3200	—	—	—	4140	Rabies, day 15
				4141	Rabies, day 15
1:6400	—	—	—	4142	Rabies, day 15
				4143	S

TABLE I

IMMUNIZED RABBITS received 24 daily doses of 1.5 ml of vaccine diluted to two percent concentration, i.e., the regularly dehydrated vaccine was diluted further 1:5. Antibody titers are reciprocals of serum dilutions computed by Reed and Muench to save 50% of mice from 100 LD_{50} of fixed virus. Challenge virus was mouse passage three of "California 1958" street virus. "S" indicates rabbits that were normal at 30 days. Vaccine RV1639, described previously,[13] was at the time of use more than one year of age.

tails of this test are shown in Table I. Virus-neutralizing antibody titers of the sera of vaccinated rabbits were measured by standard methods utilizing white mice. A week after the last dose of vaccine, vaccinated rabbits were bled for the antibody tests and both vaccinated and control rabbits were then injected intracerebrally with a series of doubling dilutions of street virus.

The results indicate that the vaccine produces fairly good antibody titers and protects rabbits against several otherwise fatal doses of street virus given intracerebrally. Rabies incubation periods (i.e., time from challenge to first paralyses) of 12 to 17 days were noted in control rabbits, and periods of 17 and 19 days in the two vaccinated rabbits that did not survive. Duration of illness, from first paralysis to time of death and not shown in the table, was generally two to three days.

In experiment number two similar groups of rabbits were dealt with for verification and added information. Table II shows the results obtained in these animals. Seemingly, antibody titers observed in these vaccinated rabbits were a little higher than in the first test. While successful immunization against street virus was quite evident in experiment two, it is not apparent whether or not it was any better than in experiment one, since the virulence of the challenge virus possibly was not quite as high. Also, the somewhat longer incubation periods in affected animals in experiment two seems compatible with this.

Tests Show Definite Immunization

These two rabbit tests considered together indicate definite immunization against street virus injected directly into the brain. Such tests as these have been considered very rigorous by Semple and most rabies experimenters who have followed him. Bites by rabid animals were regarded by Semple as a much less rigorous hurdle for vaccine to pass.

In experiment number three, a group of guinea pigs received 14 daily subcutaneous doses of 0.1 ml of DE vaccine. A week after the last dose these animals, along with normal controls, received a series of doubling dilutions of street virus intramuscularly as indicated in Table III. It may be noted that all the vaccinated guinea pigs survived and most of the controls died. Incubation periods of the disease varied from 13

Rabbits immunized with DE rabies vaccine and challenged intracerebrally with street virus one week after last dose. (second series)

Intracerebral Challenge Dose of 0.25 ml of Street Virus Diluted:	Rabbits Immunized with DE Rabies Vaccine			Normal Rabbits	
	Number	Antibody Titer	Result	Number	Result
1:200	4946	99	Rabies, day 21	4148	Rabies, day 15
	4947	91	S	4149	Rabies, day 13
1:400	4949	58	S	4150	Rabies, day 18
	4950	100	S	4151	Rabies, day 16
1:800	4948	106	S	4152	Rabies, day 24
	4951	36	S	4153	Rabies, day 16
1:1600	4952	53	S	4154	S
	4953	84	S	4155	Rabies, day 18
1:3200	—	—	—	4156	S
				4157	S
1:6400	—	—	—	4158	Rabies, day 17
				4159	S

TABLE II

IMMUNIZED RABBITS received 24 daily doses of 1.5 ml of vaccine diluted to two percent concentration, i.e., the regularly dehydrated vaccine was diluted further 1:5. Antibody titers are reciprocals of serum dilutions computed by Reed and Muench to save 50% of mice from 100 LD_{50} of fixed virus. Challenge virus was mouse passage three of "California 1958" street virus. "S" indicates rabbits that were normal at 30 days. Vaccine RV1639, described previously,[13] was at the time of use more than one year of age.

to 30 days. Longest incubation period, 30 days, happened to be in a guinea pig receiving the largest amount of virus. Duration of illness of these guinea pigs was generally from two to six days.

Survivors in this group of guinea pigs were kept under observation for 52 days, that is 22 days after the last paralysis. Although no further cases appeared in this period, a few more cases might have appeared had we kept these animals six months or more, since extraordinarily long incubation periods have sometimes been reported for guinea pigs given street virus intramuscularly. This might possibly have been true of three controls for example which were surviving at 52 days after having received intermediate dilutions of 1:80 and 1:160 of street virus. The experiment, as conducted and terminated in a reasonable time, shows a good degree of immunity in guinea pigs against street virus given intramuscularly.

In experiment number four, a second group of guinea pigs was immunized somewhat as before; however, these differed from those in experiment three in that only 10 doses of vaccine were given. Challenge with street virus was done intramuscularly on the afternoon of day 10, the tenth dose of vaccine having been given in the morning.

This experiment was planned to parallel somewhat the usual 14-dose human treatment in the course of which elevation in antibody titer has been noted in approximately three-fourths of persons at the time of the tenth dose of vaccine. The results of this test are indicated in Table IV. It may be noted that of 23 guinea pigs immunized with this short course of 10 daily doses of vaccine, seven died of rabies. As contrasted to this, of 23 normal guinea pigs challenged with the same series of dilutions of street virus, 17 died of rabies.

Parallels in Immunity and Antibodies

To be sure, there are indeed skips in both columns of results; that is, there is no precise point in virus dilutions above which all animals succumb and below which all survive. Part of such irregularity may, as mentioned above, be related to exceedingly long incubation periods in guinea pigs injected intramuscularly with street virus. A few of our tabulated "S" results may be cases like this. However this test, conducted as described and terminated after a reasonable

Guina pigs immunized with DE rabies vaccine and challenged intramuscularly with street virus one week after last dose.

Intramuscular Challenge Dose of 0.1 ml Street Virus Diluted:	Immunized Guinea Pigs		Normal Control Guinea Pigs	
	Number	Result	Number	Result
1:20	1005	S	3475	Rabies, day 30
	1006	S	3471	Rabies, day 13
1:40	1007	S	3468	Rabies, day 21
	1002	S	3474	Rabies, day 15
	1008	S		
1:80	1009	S	3472	Rabies, day 15
	1003	S	3473	Rabies, day 15
	1028	S	3467	S
1:160	1010	S	3470	S
	1001	S	3476	Rabies, day 13
	1004	S	3469	S
1:320	1013	S	3461	Rabies, day 18
	1014	S	3460	Rabies, day 20
	1015	S	3464	Rabies, day 12
1:640	1016	S	3458	S
	1017	S	3459	Rabies, day 14
	1018	S	3465	Rabies, day 14
1:1280	1019	S	3462	Rabies, day 13
	1020	S	3455	Rabies, day 18
1:2560	1021	S	3466	Rabies, day 20
	1026	S	3457	Rabies, day 18
1:5120	1023	S	3463	Rabies, day 18
	1024	S	3456	S

TABLE III

IMMUNIZED GUINEA PIGS received 14 daily subcutaneous doses of 0.1 ml of regularly reconstituted rabies vaccine and one week after the last dose, along with normal controls, were given 0.1 ml of doubling dilutions of street virus "California 1958" mouse passage three, into the hind leg. "S" indicates guinea pig normal at 52 days.

period of 52 days observation, shows less than half as many rabies cases among the immunized guinea pigs, as among the controls, i.e., seven as compared to 17.

It is suggested that these results are compatible with the idea that in guinea pigs and man, an elevation in immunity against street virus in the one species and an elevation of virus neutralizing antibody in the other have some degree of parallelism, and indeed show quite early responses to the vaccine. The data are not sufficiently precise to show whether or not three-fourths of the human cases showing antibody on day 10 may be matched by three-fourths of guinea pigs exhibiting immunity to street virus on day 10. The guinea pig response seems to be a little less than this; however, the experiment might be modified to answer this question better by challenging immunized and control groups with a single dose of possibly five or 10 LD_{50} of virus. This we did not do.

Discussion and Conclusions

The foregoing experiments have been done to learn something specific about the immunizing action of DE rabies vaccine against street virus in the laboratory. We were somewhat limited to rabbits and smaller animals, and could not include dogs. Two experiments using rabbits have been described and the results of these appeared quite similar and showed, about as Semple noted for phenolyzed vaccine, reasonable immunity against street virus given directly into the brain.

Both of the guinea pig tests showed that demonstrable immunity was produced in this species against street virus given intramuscularly. The first guinea pig test (of longer duration) showed more massive immunity as would be expected. The second guinea pig test gave results compatible with the idea that immunity as well as antibody becomes elevated on day 10.

Guinea pigs immunized with DE rabies vaccine and challenged intramuscularly with street virus on day 10.

Intramuscular Challenge Dose of 0.1 ml Street Virus Diluted:	Immunized Guinea Pigs		Normal Control Guinea Pigs	
	Number	Result	Number	Result
1:20	2883	S	1260	Rabies, day 13
	2880	S	2551	S
1:40	2882	S	9341	Rabies, day 12
	2877	Rabies, day 33	2585	Rabies, day 15
1:80	2879	S	2588	Rabies, day 13
	2875	Rabies, day 30	1299	S
	2884	S	2596	Rabies, day 19
1:160	2873	S	1253	Rabies, day 12
	2878	Rabies, day 26	2594	Rabies, day 20
	2874	Rabies, day 26	2590	S
1:320	2876	Rabies, day 26	2595	Rabies, day 12
	2894	Rabies, day 27	1289	Rabies, day 15
	2885	S	2586	Rabies, day 17
1:640	2891	S	2591	Rabies, day 49
	2896	S	2592	Rabies, day 12
	2888	S	2597	Rabies, day 11
1:1280	2889	Rabies, day 26	2584	S
	2893	S	2587	Rabies, day 21
	2895	S	2582	Rabies, day 14
1:2560	2890	S	2583	Rabies, day 13
	2892	S	2581	S
1:5120	2887	S	2579	Rabies, day 22
	2886	S	2544	S

TABLE IV

IMMUNIZED GUINEA PIGS received 10 daily subcutaneous doses of 0.1 ml of regularly reconstituted rabies vaccine, and on day 10 (following the tenth dose of vaccine), along with normal controls were given 0.1 ml of doubling dilutions of street virus "California 1958," mouse passage three, into the hind leg. "S" indicates guinea pig normal at 52 days.

These showings amplify, and are in agreement with, previous antibody studies involving mice, dogs and human subjects and fixed virus. Although it might well have been assumed from previous results using fixed virus that the present results using street virus could have been anticipated, we believe this direct laboratory proof is of some interest, particularly to those persons concerned with antirabies prophylaxis.

It may be concluded that DE rabies vaccine:

1. Showed demonstrable immunity in rabbits against street virus injected into the brain.

2. Shows rather early demonstrable immunity in guinea pigs against street virus injected intramuscularly.

REFERENCES

1. Powell, H. M., Culbertson, C. G.: Cultivation of fixed rabies virus in embryonated duck eggs. *Pub. Health Repts.* 65:400-401, 1950.

2. Culbertson, C. G.: Background and development of duck embryo rabies vaccine. *J. Ind. S. M. A.* 52:1452-1454, 1959.

3. MacFarlane, J. O., Culbertson, C. G.: Attempted production of allergic encephalomyelitis with duck embryo suspensions and vaccines. *Can. J. Pub. Health,* 45:28-29, 1954.

4. Schwab, M. P., Fox, J. P., Conwell, D. P., Robinson, T. A.: Avianized rabies virus vaccination in man. *Bull. World Health Org.* 10:823-825, 1954.

5. Fox, J. P.: Prophylaxis against rabies in humans. *Ann. N. Y. Acad. Sci.* 70:480-494, 1958.

6. Greenberg, M.: Vaccination against rabies with duck embryo and Semple vaccines. *J. A. M. A.* 173:333-337, 1960.

7. Anderson, G. R., Schnurrenberger, Paul R., Masterson, Ralph A., Wentworth, Frederick H.: Avian embryo rabies immunization. I. Duck embryo vaccine administered intradermally in man. *Am. J. Hyg.* 71:158-160, 1960.

9. Peck, F. B., Jr., Powell, H. M., Culbertson, C. G.: Duck embryo rabies vaccine. A study of fixed virus vaccine grown in embryonated duck eggs and killed with beta propiolactone (BPL). *J. A. M. A.* 162:1373-1376, 1956.

10. Powell, H. M., Culbertson, C. G.: Inactivation of fixed rabies virus, grown on embryonated duck eggs, by means of beta propiolactone. *Southwest. Vet.,* 12:281-285, 1959.

11. Peck, F. B., Jr.: Rabies vaccine experience during the recent Marion County Epizootic. *J. Ind. S. M. A.* 52:1455-1458, 1959.

8. Peck, F. B., Jr., Powell, H. M., Culbertson, C. G.: A new antirabies vaccine for human use. *J. Lab. and Clin. Med.,* 45:679-683, 1955.

12. Sauter, R. A., Corn States Laboratories, Omaha, personal communication.

13. Powell, H. M., Culbertson, C. G.: Action of rabies vaccine, derived from embryonated duck eggs, against street virus. *Proc. Soc. Exp. Biol. and Med.* 101:801-803, 1959.

14. Semple, D.: The preparation of a safe and efficient antirabic vaccine. *Scien. Memoirs,* New Series No. 44, Gov't. Printing, Calcutta, India, 1911. ◄

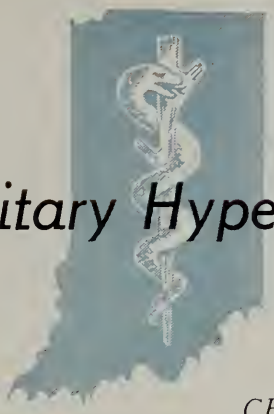
Plan now to attend

111th ANNUAL

ISMA CONVENTION

October 3-5

French Lick Sheraton Hotel



Hereditary Hyperparathyroidism

CHARLES E. JACKSON, M.D.
PIERRE C. TALBERT, M.D.
HAROLD D. CAYLOR, M.D.
*Bluffton**

REPORTS ON hereditary pancreatitis[1,2] stimulated an investigation of the family of two brothers who had been seen at our institution for many years with recurring attacks of pancreatitis. In an effort to prove their mother to have pancreatitis, a serum calcium was obtained at the time of an episode of abdominal pain. We expected this to be low as it often is in acute pancreatitis. However, it was found unexpectedly to be high.

Subsequently the brothers were found to have high serum calcium levels and other chemical abnormalities indicating that their parathyroid glands were overactive. At this time only a few cases of pancreatitis associated with hyperparathyroidism had been reported. Therefore, we did not have a very good basis for convincing these young men to have their necks explored to cure their abdominal pain. Fortunately one consented to surgery and a parathyroid adenoma was found. Later the other brother had a parathyroid adenoma removed. Both have been relieved of their pancreatitis by excision of these parathyroid adenomas.

Others in the family were investigated with the finding of at least six and possibly seven cases of hyperparathyroidism in two generations.[3] (Figure 1)

We feel that the pancreatitis must be secondary to the hyperparathyroidism because of the relief of symptoms by excision of parathyroid adenomas in our cases and in some of the others in the literature. Of these patients with hyperparathyroidism in our pedigree only three had pancreatitis. This also suggests that the pancreatitis may be secondary to stone formation in the pancreatic duct system.

Shortly after our initial experience with this group an unrelated young man with a kidney stone was found to have hyperparathyroidism. His father who had recurrent peptic ulcer requiring two operations was found to have a parathyroid adenoma. Subsequent investigation of this family has revealed no other definite cases of hyperparathyroidism.[4] Peptic ulcer was frequent in members of this family, even in those without evidence of hyperparathyroidism.

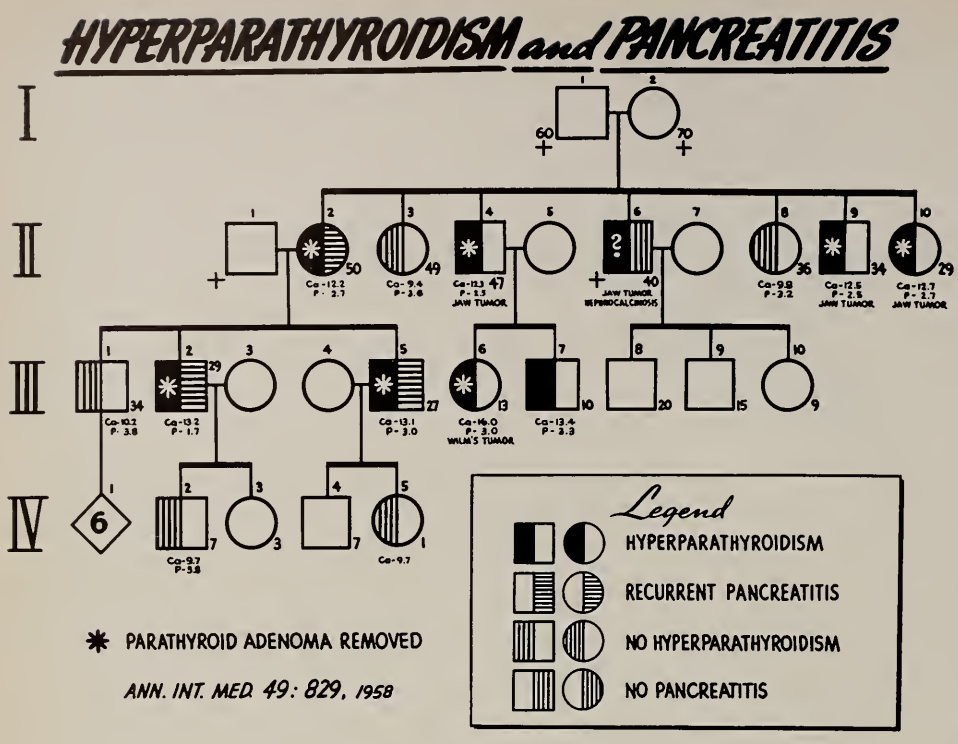
Incidence of Ulcers

Ulcers have been reported to occur in about 15% of the cases of hyperparathyroidism (8-24%). The cause of this association has been a matter of considerable speculation by both endocrinologists and gastroenterologists. On the basis of this family we have suggested[4] that

---

* From the Caylor-Nickel Clinic; sponsored by the Caylor-Nickel Research Foundation.

Presented as a scientific exhibit at the meeting of the Indiana State Medical Association, Ind'pls., Oct. 6-9, 1959.



LEGENDS

FIGURE 1

Pedigree of family[3] showing the association of hyperparathyrodism with recurrent pancreatitis. Calcium and phosphorus values are in milligrams percent. The squares indicate males, the circles indicate females and the diamond enclosing the figure 6 indicates six children of both sexes. The ages are given in the lower right area of each figure. The crosses indicate that the individual is dead. The blank spaces indicate that definite information was not available regarding hyperparathyroidism or pancreatitis in those individuals. (Diagram modified from *Ann. Int. Med.* 49:830, 1958, to include the subsequent finding of definite pancreatitis and the removal of a parathyroid adenoma from II_2).

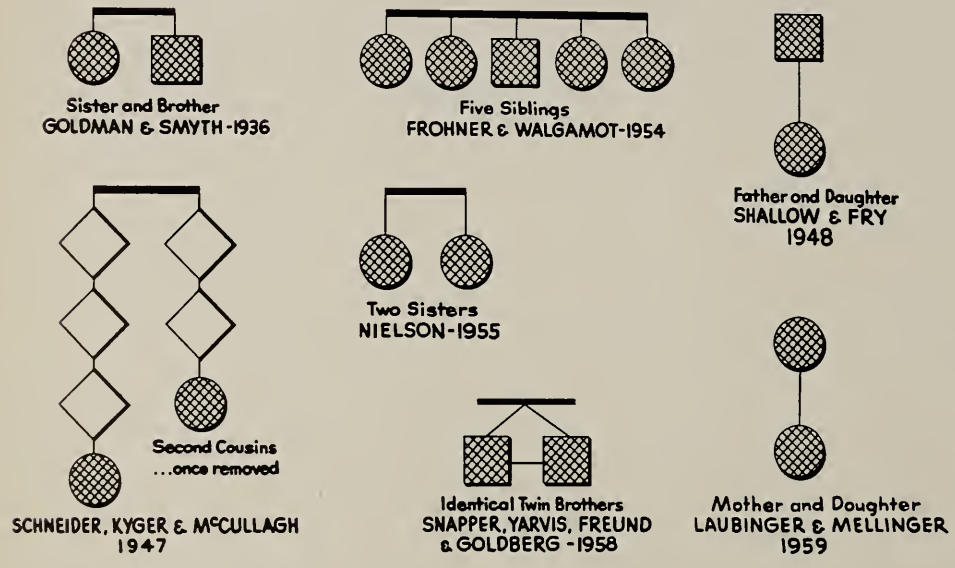


FIGURE 2

Pedigrees of the seven other reported famiiles with hyperparathyroidism from the literature.[6-12]

the cause of the high incidence of ulcer in hyperparathyroidism is simply that in some way the hyperparathyroid state causes the underlying inherited ulcer tendency to be completely or almost completely manifest. The 15% coincidence of ulcer with hyperparathyroidism is perhaps simply indicative of the incidence of the ulcer tendency in the general population.

Another theory which may explain the high incidence of ulcer with hyperparathyroidism is that proposed by Wermer[5] that in some instances peptic ulcer might be a part of a syndrome which includes parathyroid adenomas and other endocrine adenomas.

A review of other cases of hereditary hyperparathyroidism in the medical literature[6-12] has revealed the families illustrated in Figure 2. Our two families and these from the literature suggest that parathyroid adenomas, at least in some instances, are inherited as an autosomal dominant condition. Careful family studies of a large series of cases would be necessary to de-

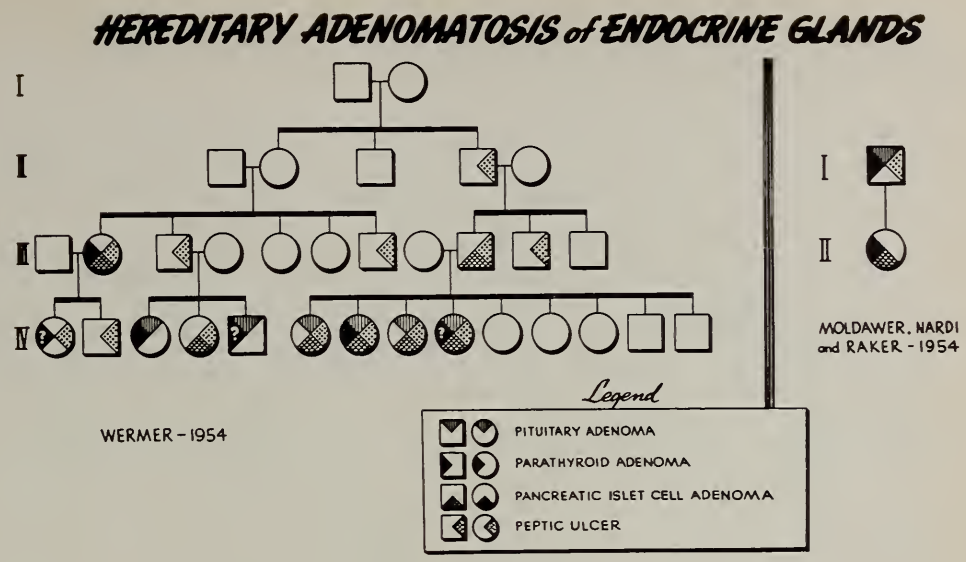


FIGURE 3

Pedigrees of families with hereditary adenomatosis of endocrine glands reported by Wermer[5] (1954 as revised in 1959) and Moldawer, Nardi and Raker.[13]

termine the true importance of heredity as a cause of hyperparathyroidism.

In our families there was no evidence of other endocrine tumors although parathyroid adenomas were multiple in two instances and one individual had had hyperthyroidism treated by excision of a thyroid adenoma. We feel, however, that this is most likely a part of the same disease as that described as hereditary adenomatosis of the endocrine glands by Wermer[5] and by Moldawer, Nardi and Raker.[13] (Figure 3)

Carl Witkop[14] has mentioned that Goliath is probably the earliest recorded case of this syndrome. It is recorded[15] that Goliath and three giant brothers were born to a giant—perhaps

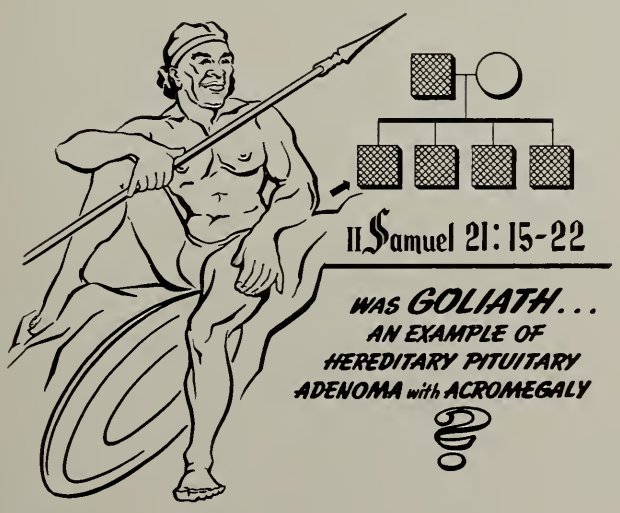


FIGURE 4

Representation of a possible early recorded case of hereditary endocrineadenoma.

they had pituitary adenomas causing acromegaly and their gigantism? (Figure 4)

Summary

Two families of patients with hyperparathyroidism are reported with six and possibly seven cases in two generations of one family and a father and son in another. The occurrence of pancreatitis is one family and peptic ulcer in the other family is discussed. Our two families and the seven other reported families of patients with parathyroid adenomas have suggested that this disease may be inherited as an autosomal dominant condition. It is felt that hereditary hyperparathyroidism is related to a condition described as hereditary adenomatosis of the endocrine glands.

Addendum

Since this paper was submitted additional information has been obtained that individuals III 6 and III 7 (Figure 1) have hyperparathyroidism so that there are now eight and possibly nine affected in this family. Individual II 2 has been found at necropsy to have adenomas in both adrenals and adenomas in the thyroid gland, providing evidence that the disease in this family is related to the condition of multiple endocrine adenomas.

A third family has been encountered in which a 78-year-old woman and her 16-year-old great-nephew have had parathyroid adenomas removed. (Figure 5)

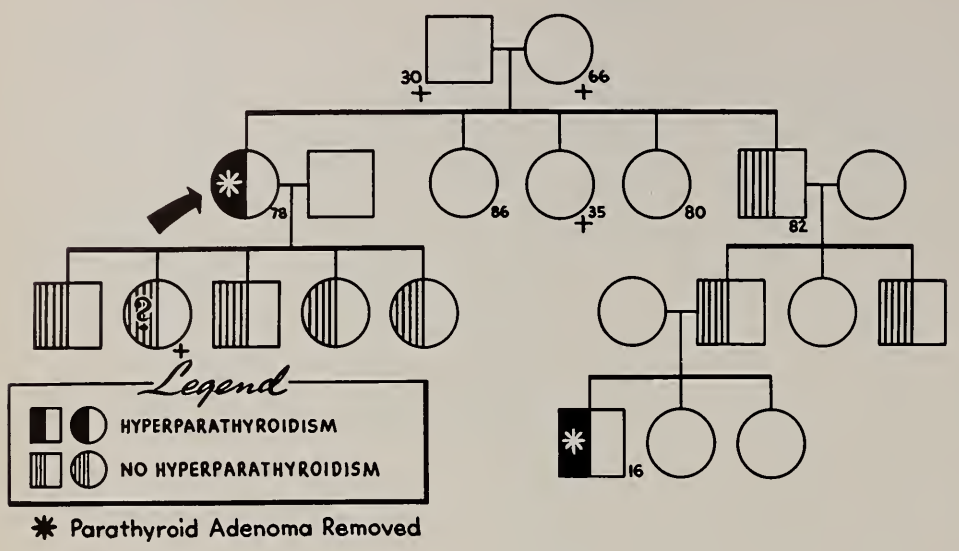


FIGURE 5

REFERENCES

1. Gross, J. B., Comfort, M. W.: Hereditary pancreatitis: report on two additional families. *Gastroent.* 32:829, 1957.
2. Comfort, M. W., Steinberg, A. G.: Pedigree of family with hereditary chronic relapsing pancreatitis, *Gastroent.* 21:54, 1952.
3. Jackson, C. E.: Hereditary hyperparathyroidism associated with recurrent pancreatitis, *Ann. Int. Med.,* 49:829, 1958.
4. Jackson, C. E.: The association of peptic ulcer with hereditary hyperparathyroidism, *Gastroent.* 37:35, 1959.
5. Wermer, P.: Genetic aspects of adenomatosis of endocrine glands, *Am. J. M.* 16:363, 1954.
6. Goldman, L., Smyth, F. S.: Hyperparathyroidism in siblings, *Ann. Surg.* 104:971, 1936.
7. Schneider, R. W., Kyger, E. R., Jr., McCullagh, E. P.: Primary hyperparathyroidism: report of 10 cases, *Cleveland Clin. Quart.* 14:246, 1947.
8. Shallow, T. A., Fry, K. E.: Parathyroid adenoma: occurrence in father and daughter, *Surg.* 24:1020, 1948.
9. Frohner, R. N., Wolgamot, J. C.: Primary hyperparathyroidism: five cases in one family, *Ann. Int. Med.* 40:765, 1954.
10. Nielson, H.: Familial occurrence, gastrointestinal symptoms and mental disturbances in hyperparathyroidism, *Acta med. Scandinav.* 151:359, 1955.
11. Snapper, I. Yarvis, J. J., Freund, H. R., Goldberg, A. F.: Hyperparathyroidism in identical twins, one of whom suffered concomitantly of Boeck's Sarcoidosis, *Metab.* 7:671, 1958.
12. Laubinger, G., Mellinger, R. C.: Uber das familiare Auftreten des hyperparathyroidismus; Beschreibung eines weiteren Falles. (Familiar incidence of hyperparathyroidism; description of an additional case.) *Deut. med. Wschr.* 84:264, 1959.
13. Moldawer, M. P., Nardi, G. L., Raker, J. W.: Concomitance of multiple adenomas of the parathyroids and pancreatic islets with tumor of the pituitary: a syndrome of familial incidence, *Am. J. M. Sc.* 228:190, 1954.
14. Witkop, C. J., Jr., Bethesda, Md., personal communication.
15. *Holy Bible,* King James Version, II Samuel 21:15-22. ◄

Chronic ulcers of the leg require every possible advantage for healing; powdered Gelfoam is useful . . .

Gelfoam in the Treatment of Stasis Ulcers

M. MURRAY NIERMAN, M.D.

Calumet City, Illinois

TREATMENT of leg ulcers, particularly stasis ulcers, challenges the ability of the dermatologist. Although the basic problem is vascular, often a dermatologist is consulted by the patient. This paper will not consider the various peripheral vascular lesions which can cause leg ulcers, but it should be emphasized that treatment is not complete without efforts to correct the primary problem. When surgical or medical correction is not possible, bed rest with elevation of the extremities is a valuable adjunct to treatment.

Powdered gelatin foam (Gelfoam), as reported by Milberg and Tolmach,[1] Barefoot[2] and Feldman, et al.,[3] is effective in augmenting the re-epithelization of chronic ulcers. The purpose of this paper is to reaffirm the usefulness of Gelfoam and to describe the procedure which for me has been the most successful method of treating uncomplicated leg ulcers.

Previously I have used the following local treatments to stimulate epithelization: (1) powdered erythrocytes with sponge rubber and pressure dressings; (2) "Unna's boot" type dressing, especially those available commercially; (3) enzyme therapy systemically and locally. In many cases treated with these methods, successful healing of the ulcer was accomplished; but often there was treatment failure. Local sensitization with the development of dermatitis venenata at the site of application was frequent, especially when topical enzymes were used. Application of dried erythrocytes frequently resulted in intense pain at the site of the ulcer and secondary infection was prone to occur. The procedure now used and herein reported results in less pain, sensitization and infection than the previously-used methods.

From the Department of Dermatology, Chicago Medical School.

Materials and Methods

One hundred forty-two patients with stasis ulcers of the leg were seen over a period of three years. Three were uncooperative and are excluded from this study. The patients' ages ranged from 32 to 81 years, average 60 years. The duration of the ulcer varied from two months to 20 years, with a mean duration of 6½ years. The time of treatment was two weeks to seven months with a mean of two months.

In treatment of uninfected ulcers the following technic was employed: hydrocortisone with neomycin ointment was applied to the eczema which usually surrounded the rim of the ulcer, Gelfoam powder (a sterile, purified, specially processed gelatin) was packed into the ulcer as suggested by Milberg and Tolmach[1] and a sterile pressure dressing was applied. Dressings were changed twice weekly until improvement occurred and then once weekly until healed or until treatment was discontinued. At the time of dressing changes, the Gelfoam was not removed

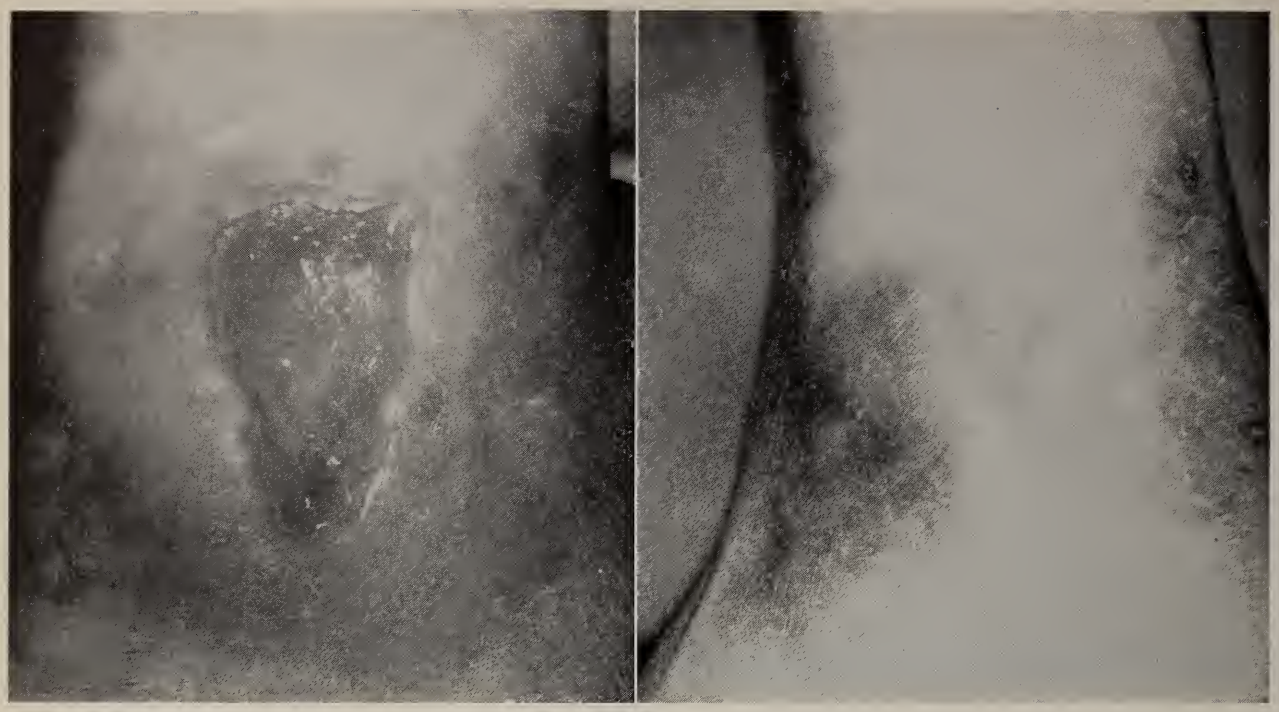


FIGURE 1
A 67-YEAR-OLD MAN with a varicose ulcer of nine years duration treated for three months.

if it was adherent to the ulcer base; it was removed when it was attached only to the margin of the ulcer.

Infected ulcers were treated initially with soothing compresses and systemic antibiotic or chemotherapy, followed by the topical use of antibiotic ointments with a low sensitizing index. After the infection was controlled, the above-described regimen was initiated.

Calculations of means and percentages were made with a slide rule.

Results

The results are summarized in Table I. Of the 13 patients characterized as "not healed," four had not completed treatment, two were diabetic, one had Hodgkin's disease, and three had extremely poor circulation.

It is apparent from the table that the prospect of good results is not markedly diminished by the chronicity of the ulcer, although a longer period of treatment may be required.

In addition to the tabulated data, the following should be mentioned: (1) Gelfoam powder seemed to afford positive relief of pain in the ulcer area. (2) In no case did dermatitis venenata or secondary infection occur as a result of the use of Gelfoam.

Discussion

In treating stasis ulcers with Gelfoam and positive pressure, it will be noted that if the

Results of Treatment of Stasis Ulcers with Gelfoam and Pressure Dressings

Duration of Ulcer	Number of Patients	Duration of Treatment	Results	
			Healed	Not Healed
2-11 mos.	25	2-7 wks.	23 (92%)	2 (8%)
1-4 yrs.	39	2½ wks.-4 mos.	36 (92%)	3 (8%)
5-9 yrs.	33	4 wks.-6 mos.	32 (97%)	1 (3%)
10-14 yrs.	27	2-7 mos.	23 (85%)	4 (15%)
15-20 yrs.	15	7 wks.-7 mos.	12 (80%)	3 (20%)
TOTALS	139	2-wks.-7 mos.	126 (91%)	13 (9%)

TABLE I



FIGURE 2

A 35-YEAR-OLD WOMAN with a deep-seated, infected ulcer complicating acute thrombophlebitis treated for a period of three months.



FIGURE 3

AN ELDERLY WOMAN, probably much older than her stated age of 57 years, with diabetic ulcers of 15-20 years duration treated for five months.

ulcer produces a large volume of exudate, the Gelfoam tends to dissolve readily. However, as treatment progresses and epithelization is stimulated the powder dries and remains attached to the ulcer base. It is beneath this attached dried Gelfoam powder that healing of the ulcer rapidly takes place. When the Gelfoam powder is firmly attached to the entire ulcer base it is best not to remove it but to leave it attached until it separates spontaneously. This may require several weeks. In larger ulcers the Gelfoam will remain attached to the margin of the ulcer but will dissolve in the central areas. In these cases the Gelfoam should be removed, leaving skin buds at the margin. With each new application of Gelfoam there will be further attachment to the margin with subsequent healing proceeding centrally until the epithelization of the ulcer is complete.

The treatment of stasis ulcers is a most chal-

lenging problem. No local treatment can be altogether successful unless surgical correction or non-specific measures such as rest and elevation of the part are made to improve the circulation. Assuming that the underlying circulatory disease is adequately treated and that acute inflammatory complications are corrected, sterile Gelfoam powder is considered to be the treatment of choice for this resistant disease. The patients have less pain than with other local treatment, the treatment does not aggravate the disease and usually the epithelization is complete.

Summary

Treatment of stasis ulcers with Gelfoam powder in 139 patients was followed by healing of the ulcer in 91%. Chronicity of the ulcer did not much diminish the likelihood of cure, but it did bear a direct relationship to the duration of treatment.

The technic of treatment is described and details of management are discussed.

It is concluded that sterile Gelfoam powder and pressure dressing constitute effective treatment for this condition.

BIBLIOGRAPHY

1. Milberg, I. L., Tolmach, J. A.: Treatment of Chronic Leg Ulcers With Absorbable Gelatin Sponge (Gelfoam) Powder, *J.A.M.A.* 155:1219-21, July 31, 1954.
2. Barefoot, S. W.: A Method of Treating Chronic Leg Ulcers, *N. C. Med. J.* 16:101-102, March, 1955.
3. Feldman, S., Mahl, M. M., Goodgold, Joseph: The Use of Powdered Gelatin Foam in the Treatment of Vascular Ulcers, *Angiology* 8:4, pp. 345-347, Aug., 1957. ◄

Tell ya what I'm gonna do

Suppose a flashy character walked into your office and said, "Doc, I've got just the investment you've been waiting for. You won't get any certificate to show that you own it and you'll have to keep paying on it every year or you'll go to jail. This year it'll only cost you about 500 iron men, but we'll see that you get a price rise regularly; and there's no limit to how high it can go. You'll have to retire at 65 to get anything out of it, but the majority of doctors don't quit that young, so you'll probably only get $250 to bury you instead of the thousands that you paid in. Don't let that discourage you, though, old man, because the owners have been dipping into the till and the whole darn thing's liable to go bankrupt unless you stockholders bail it out. It's a mutual company, you know."

Don't throw the fellow out! He isn't crazy and he isn't a crook. He's just an unusually honest salesman trying to sell you Social Security. If you don't interrupt him, he may tell you that the boss of Social Security, Administrator Charles Schottland, is an honest man, too, and in 1958 told interviewers that SOCIAL SECURITY IS A TAX AND NOT AN INSURANCE CONTRIBUTION, as the guardians of the Welfare State would prefer to have you believe . . . .

Rocky Mountain Journal
Vol. 57, No. 2, Feb., 1960

A case report with photographs, showing the value of vaccinia immune globulin in the treatment of eyelid vaccinia.

Vaccinia Immune Globulin Used for Vaccinia of Eyelids

ROBERT WILLIAM HARGER, M.D.
Indianapolis

LUCIAN A. ARATA, M.D.
Shelbyville



FIGURE 1

MARCH 26, 1960—Cornea was not seen and patient was unable to open her right eye. Swelling increased enough so that the tarsal surface of the upper lid was overriding the matching lesions of the lower lid.

THE USE OF convalescent serum and especially the gamma globulin fraction has been widely accepted. Field studies from Madras India,[1] laboratory tests and clinical reports from this country[2] and Europe[3,4,5] indicate the real usefulness of *vaccinia immune globulin* in the treatment of early cases of generalized vaccinia, eczema vaccinatum, progressive vaccinia, vaccinia necrosum and the other serious complications, especially dermal, of smallpox vaccination. In smallpox, this material provides passive immunity, which is especially significant if it can be given before the secondary viremia. This occurs 12 days after inoculation or exposure.

In recent years great strides have been made in the development and use of hyperimmune vaccinal gamma globulin. Volunteers of recently vaccinated recruits from the armed services donate one pint of blood between the third and eighth week following inoculation. One pint of blood provides the equivalent of five cc gamma globulin (1.69 mgm per cc). Gamma globulin is prepared in the usual way by commercial blood processing laboratories, using the Cohn fraction II. After routine testing at the National Institutes of Health, the material is packaged in five cc ampules for distribution. The collection by the armed forces of the U. S. and the preparation, testing and distribution of this material, at no cost to the patient, is now a regular service of the blood program of the American National Red Cross. Previously it had been distributed through Dr. C. Henry Kempe, Colorado University Medical Center, Denver, Colo.; Dr. James H. Pert, Research Director, Blood Program, American National Red Cross, Washington, D. C. and Col. A. S. Benenson, Immunology



FIGURE 2

UPPER ROW, left to right, March 27 (2 photographs) and March 29.
LOWER ROW, left to right, April 2, April 9, May 21.

Department, Walter Reed Army Institute of Research, Washington, D. C.

Recently added points of distribution include Dr. Heinz F. Eichenwald, Cornell Medical Center, N. Y. 21, N. Y.; Dr. Moses Grossman, San Francisco General Hospital, San Francisco 10, Calif.; Dr. Ralph V. Platou, 1430 Tulane Ave., New Orleans 12, La., and Dr. Irving Schulman, 107 Fullerton Ave., Chicago 14, Ill.[6]

Case Report: Vaccinia of Eyelids

On March 3, 1960 a smallpox vaccination was applied to a 5-year-old white female and one sibling on the upper outer aspect of left arm, with the usual instructions to the parent, including "when pustule forms put long-sleeved shirts on the children to prevent scratching and re-inoculation elsewhere, such as the face and eyes." Also, precautions were noted should scratching occur.

By March 23, there was history of scratching the primary lesion and the right eyelids with formation of three small papules on the margin of the right upper eyelid and matching lesions on the lower lid, slight edema of the lid, and no ocular signs or symptoms.

Additional edema of the lid was present on March 24, and the patient was started on Aureomycin topical ointment and 1% Atropine topical ointment; two cc commercial gamma globulin was given intramuscularly.

Temperature elevation, exudative pharyngitis and cervical adenitis were noted on March 25, and the patient was started on Tetracycline pediatric syrup. The cornea could still be seen on this date and it was clear. There was no involvement deeper than the eyelid margins.

Rectal temperature on March 26 was 102°-103°. The cornea was not seen and the patient was unable to open her right eye. The eyelid swelling increased enough so that the tarsal surface of the upper lid was overriding the matching lesions of the lower lid. After telephone conversation with Dr. Dwayne Walcher, of the Indiana University Medical Center, Department of Pediatrics, a call was placed to the American National Red Cross in Washington, D. C. Dr. Sam T. Gibson was able to release

10 cc of vaccinia immune globulin (0.3 cc per lb.), which was dispatched to Indianapolis by air express through the prompt courtesy of Col. A. S. Benenson, of the Walter Reed Army Institute of Research. The material arrived by midnight of the same day and was given to the patient in five sites of injection (two cc each) the next morning.

On March 27 the rectal temperature was 101°-104°. This was the day of injection; the lesions had changed from papule to pustular stage, providing copious material which could have easily inoculated the right eye, since the eyelid margins were overriding and tightly swollen.

March 28th rectal temperature dropped to 99°-100°. Twenty-four hours after the injection the lesions were obviously beginning to clear.

Forty-eight hours after injection, on March 29, there was almost no exudate present and the rectal temperature did not rise above 99°. The right eyelids rapidly cleared and there was no sign of involvement of the right eye.

At her most recent visit, May 21, 1960, the eyelids had returned to normal, except for two small tarsal glands, which were slightly enlarged and easily treated by simple expression. A few of the cilia along the lateral margin of the upper lid had not grown out fully, but the roots were not destroyed. Visual acuity: 20/20 each eye. The eye muscles, media and fundi were normal.

From the clinician's standpoint, it is especially thrilling to be studying a critical problem on Saturday noon (with the office already two or three hours behind schedule), get telephone consultation at the Indiana University Medical Center, call the Director of Blood Program for American National Red Cross in Washington, D. C. (he had just returned from Haiti late the night before), have someone at Walter Reed Army Institute of Research package the material for air express late the same afternoon and then go to the Indianapolis airport to receive the package (at no cost to the patient) within 12 hours of the consultant's suggestion. This is certainly a tribute to all medical center "telephone consultants," and especially to the American National Red Cross Research Program.

804 Hume Mansur Building
Indianapolis, Indiana

BIBLIOGRAPHY

1. Kempe, C. H., Berge, T. O., England, B.: *Pediatrics,* Vol. 18:177-188, 1956.
2. Kempe, C. H., Benenson, A. S.: Vaccinia Passive Immunity in Newborn Infants. *J. Pediatrics,* 42:5, pp. 525-531, May, 1953.
3. Pierce, E. R., Melville, F. S., Downie, A. W., Duckworth, M. J.: Antivaccinial Gamma Globulin in Smallpox Prophylaxis, *Lancet,* No. 2, pp. 635-638, 1958.
4. Hogben, G. H., McKendrick, G. D. W., Nicol, C. G.: Smallpox in Tottenham, 1957, *Lancet,* 1:1061-1064, 1958.
5. Semple, A. B., Parry, W. H., Hobday, T. L.: Antivaccinial Gamma Gloublin, *Lancet,* II:7089, 1959.
6. Pert, James H., personal communication. ◄

Overconscientious Anonymity

To refer to an article of my own . . . may I suggest I am immodest. That is a risk of using the first person. Yet avoiding "I" by impersonality and circumlocution leads to dullness, and I would rather be thought conceited than dull. Articles are written to interest the reader, not to make him admire the author. Overconscientious anonymity can be overdone, as in the article by two authors which had a footnote, "Since this article was written, unfortunately one of us has died."

Richard Asher, M.D., in *Brit. Med. J.*, p. 503,
Aug. 23, 1958; reprinted in *U. S. Armed Forces Med. J.*

The Case of Hypothyroid Constipation

*ARNOLD LIEBERMAN, M.D.**
New York, N. Y.

AS LONG AS I could remember her Mrs. Henriot has been an extraordinarily obese, very industrious and amazing voluble little woman, always bustling around our little neighborhood drug store. Her husband was the pharmacist while she tended behind the counter. Not over five feet in height, she had a bust one would guess at over fifty inches, with a waist and hips in proportion. Extremely intelligent, her bright eyes twinkled in a face always ready to crinkle in a smile. The voice was quite musical and had just the faintest suggestion of her French ancestry.

She knew everyone and had a pleasant quip on tap for the grandfather as well as his kindergarten grandchild. Her husband, while not nearly so fat, was also very short, rolypoly and equally industrious and pleasant. They had owned their drug store for the quarter of a century they had been married. With the true thrifty instincts of the French petit bourgeoisie they had saved and scrimped to buy the building in which they had their store and above which they lived; they had also set aside a modest but comfortable competence.

Their life had but one real void: after all their married years, they were still childless. They had been to many specialists over the decades; none had been of help, and so they were reconciled to this one major flaw in their lives.

Their drug store was a short block away from my home. Over the years, it had become an ingrained habit to wander over to the store for the usual necessities or just a soda and have a bit of chit-chat with the Henriots. Several years after I had opened my downtown office, the couple dropped in on me—informally and unannounced. They had known me since my grammar school days; I was secretly pleased to think that in their eyes I had "arrived."

They wanted me to check them both; also, they had decided to adopt a boy. There was nothing wrong with Mr. Henriot that less food would not remedy. As he was a real French gourmet, I knew that all my sage remarks as to diet would not be followed. I did tell him that

* The fifth of an intermittent series of case reports. Dr. Lieberman formerly practiced in Lake County, Ind.

Art by Miki Wilson, San Francisco.



loss of weight would be beneficial. He had been told all that before. Also, he was told that he produced sperm in normal amounts, quite motile, and satisfactorily normal in appearance. This pleased his masculinity no end.

With her the problem was far more complex. There was a whole briefcase full of reports from the Mayos, the Cleveland, Lahey and Chicago clinics plus assorted top notch internists and endocrinologists. Her menarche had not begun until she was nearly 17 and then her periods had been irregular, painful and scanty. She was grossly fat but it was a hard, almost brawny adiposity rather than the usual pudgy, flabby blubber.

The sella turcica and other x-rays revealed only normal structures. There was a slightly elevated glucose tolerance curve in the blood and a trace of sugar in the urine. The hair was dry and coarse as was the skin all over. The finger nails had a tendency to split and the fingers were short, stubby and almost square. All the reflexes were physiological.

She was still having periods even if she confessed to occasional "hot flashes." The heart rate was quite slow, the blood pressure was normal, the lungs and abdomen showed nothing exciting, and the pelvic examination confirmed the fact of small, almost infantile, internal organs.

She volunteered the information that she rarely perspired and that she liked warm weather. Repeated basal metabolic tests in the past had fluctuated around only a minus 10. However, the electrocardiogram showed very low voltages and the blood cholesterol was just at the upper limits of normal. Her intelligence certainly was superior; she had been a very fine, alert student when in high school and there was nothing dull or sluggish about her mind or movements now.

Thyroid Medication Worth a Trial

In spite of the equivocal tangible data, the puffy look on her face decided me to be bolder than my ever so much more famous predecessors had been with Mrs. Henriot: it occurred to me that a course of thyroid medication was worth a therapeutic trial. First, however, we set in motion the wheels so that the Henriots would be placed in line for foster parenthood. Second, Mrs. Henriot was put on small doses of thyroid and told to return weekly for dosage adjustments.

The response to the medication was little short of miraculous. The basal metabolism rose only to a plus 10 but, over the winter, Mrs. Henriot became a different woman: from a hefty 198 pounds she came down to a trim 125 in spite of not observing her diet too faithfully!! Her periods regularized and became painless; she seemed to shed a decade and be again a sprightly 30-odd.

In the spring, also, the Henriots adopted a healthy new-born baby boy. Their happiness was complete and I was unabashedly proud of having had a small part in helping it come to pass. That summer I was going abroad to study and travel. A week or so before leaving, I had a phone call from Mrs. Henriot.

"Arnold! I don't want to bother you but I have begun to gain weight again; also, I have missed a couple periods—you think it could be the change?"

"Are you taking your thyroid regularly?"

"Well, no; I have felt so well that I just take it now and then."

"In that case, Mrs. Henriot, why not take it again as prescribed originally and see what happens. I'll be back in October; if you have any problems in the meantime, either see Dr. Katz, who is covering for me, or maybe your nephew, Manny, in Chicago or just anybody else you may wish."

And so it was arranged. I had a happy summer abroad. On my return, the appointments came in close succession so that, in a few days, the trip was only a lovely memory. And then, late in the afternoon, there came a call from from Mrs. Henriot. There was distress and genuine alarm in her voice.

Funny Gas Pains . . .

"Doctor, I know you are dreadfully busy but I'm afraid I'm in real trouble. For the last couple of months I have been getting a lot of funny gas pains, off and on. Yes, I've been taking my thyroid regularly. No, I've not lost any weight to speak of. No, I've not had any periods; no, I've had no hot flashes again. Then, these last couple weeks, I've been very constipated. Two nights ago, I had some terrible cramping abdominal pains; Bill helped me with an enema; I felt a little better but I still have the same pains, off and on. When I go to the bathroom, nothing happens—but nothing at all. I think I have an obstructed bowel or something. It cannot be an appendix as I lost it many years ago."

"Have you seen a doctor in my absence?"

"Well, no! I have gotten awfully bloated but I've not been dieting so I had not worried, that is, until this week. This terrible constipation really has me in a tizzy. Did you know Mrs. Wyborn down the street a ways? Well, she got



"Very quietly, her husband collapsed into a convenient chair. . . ."

a locked bowel, waited too long and died just last week. You MUST see me immediately; please wait for me; Bill will drive me right down."

Within 10 minutes she hobbled in accompanied by her solicitous husband. Just as she was entering, she paused and grimaced with her pains, "They are getting worse, doctor, and they last so long!"

The abdomen bulged and her breasts were again quite large. The nurse helped Mrs. Henriot to the examining table. I took a closer look and gaped: very obviously, Mrs. Henriot was pregnant, at term, and in labor. . . . Abdominal palpation confirmed the fact of a single fetus, head down. A rectal examination showed a thinned cervix being pushed away, only a rim being outlined by the gloved finger:

"Why, Mrs. Henriot! You are going to have a baby; you cannot move your bowels because the baby's head is right there; and the pains you are having are just plain, old-fashioned labor pains."

That Just Cannot Be!

"I'm WHAT?" Mrs. Henriot almost fell off the examining table in her startled amazement. Very quietly, her husband collapsed into a convenient chair. "Why—why that just cannot be. We've been married these many years and they've all told me I could not get that way."

"Well, folks, there is no arguing away the fact, but tell me, Mrs. Henriot, didn't you feel the baby kicking around?"

"Why, I just thought I had gas pains."

"Well, this just proves once again that, when the thyroid straightened out your metabolism, you could—and did—become fertile. And there you are."

There was still time to take Mrs. Henriot to the hospital. An episiotomy and a low forceps delivered my unexpected, elderly primipara of a perfectly normal robust eight-pound boy. The puerperium was totally routine and the adopted infant now had a brother.

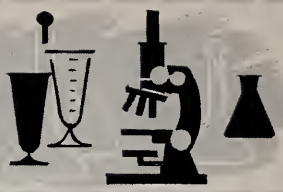


". . . had to endure a lot of good-natured ribbing . . ."

For a while, the Henriots had to endure some good-natured ribbing; they took it in their stride as good sports. Both the boys are grown men now. They live out West and have families of their own. I have not seen the senior Henriots these many years but I can still hear their good-natured chuckle at the joke told on them. ◄

1026 6th Avenue
New York, N. Y.

Path-finder
PUBLISHED UNDER THE AUSPICES OF THE INDIANA ASSOCIATION OF PATHOLOGISTS



The Indiana Association of Pathologists and Indiana Roentgen Society recently sent the following letter to every hospital administrator and board of trustees member in Indiana. The letter is published in the Journal in the belief that it contains information of value to every Indiana physician.

Why a Change in Method of Payment?

THE PURPOSE of this joint letter by pathologists and radiologists of Indiana is to explain why these physicians desire to effect an orderly change in the method of payment for their professional services. To be specific, what is intended at this time is the transfer from Blue Cross to Blue Shield of charges for medical services rendered by pathologists and radiologists.

When Blue Cross was first organized in Indiana, charges for specialists' services were included under the Blue Cross plan only because there was then no Blue Shield. It was expressly understood, however, that whenever practical, charges for their services would be so transferred. Over the years there has been continuous dissatisfaction on the part of pathologists and radiologists with this program so that in 1959 a concerted effort was finally made to effect a change.

The president of the Indiana State Medical Association, Dr. Kenneth Olson, appointed a committee, with Dr. Wallace Buchanan as chairman, to explore the matter and submit recommendations. This committee, composed of pathologists and radiologists, met several times and conducted a lengthy correspondence. Conversations were held with administrative officials of Blue Cross-Blue Shield to learn how the mechanics of the transfer could be arranged. Cost figures were obtained from Blue Cross-Blue Shield in Iowa and based on their experience, interpretive analyses were made to reflect the Indiana experience. A subcommittee then met with representatives of the Indiana Hospital Association. At this meeting a frank exchange of viewpoints resulted in a better mutual understanding.

From the very beginning certain principles were adopted which affected our thinking and planning. These principles are as follows:

1. The plan should not result in a decrease in the pathologic and radiologic services rendered at the present time under the Blue Cross plan.

2. The plan should not result in an increased cost to the subscriber for the same services rendered under Blue Cross.

3. The plan should not complicate the problem of collections unnecessarily.

4. There should be a guarantee by the state pathological and radiological societies that the plan should not be used as a lever by the pathologists or radiologists to improve their financial relationships with the hospitals.

5. A service plan would be mandatory so that broad coverage would be provided, as at present.

Why a Change—What Gain?

The question must arise in your minds as to just why we desire this change. What have we or the patients or the hospitals to gain? The answers are as follows:

1. Whatever physicians do in the course of their duties in the care of the sick is the practice of medicine. That this is no less true in the case of those physicians who perform most of their duties within an institution is widely recognized, not only by public opinion but also by the various statutes. Physicians practicing mainly within a hospital are obligated to adhere to the same legal and ethical requirements as other physicians. Physicians cannot permit the sale of their services by any nonmedical organization. Therefore, the professional services of pathologists and radiologists should be provided in a medical and not hospital service contract.

2. We desire the transfer for ethical reasons only. Physicians, pathologists and radiologists concern themselves first with the welfare of the patient. We desire to render the highest quality service at the lowest possible cost and want to be paid for our services in the same manner as other physicians are reimbursed for their professional services. The present arrangement creates a distinction between ourselves and other physicians, and permits obstacles to the attainment of the highest quality of service.

3. The proposed change would secure for pathologists and radiologists a broader recognition of their professional positions in the hospital, by their colleagues, by the public, by administrators and boards of trustees. This would result in a clearer definition of the practice of pathology and radiology as the practice of medicine. This is most important in that it will mean more medical graduates will elect to enter these specialties, thus relieving the chronic shortage. We cannot expect our specialties to attract outstanding physicians unless they can be assured of proper professional status. The public thus will be assured of increasing numbers of desirable specialists.

4. An established principle of medical ethics which has been repeatedly affirmed by the American Medical Association is as follows:

> "A physician should not dispose of his professional attainments or services to any hospital, corporation or lay body by whatever name called or however organized under terms or conditions which permit the sale of the services of that physician by such agency for a fee."

5. We feel that the present system of Blue Cross coverage for specialists' services is illegal because the payment of a professional fee to a corporation or hospital, however organized, implies the practice of medicine.

6. If this proposed transfer is effected, the patient's "hospital" bill will be less, since charges for pathologic and radiologic services will not be included but will be rendered as part of the medical services. This will help the hospitals avoid mounting criticism of "spiraling hospital costs."

Not for Monetary Gain

We would like to emphasize that this change is not desired by the specialists with any thought of monetary gain whatsoever. It is contemplated that a grievance committee will be appointed to investigate legitimate complaints. We feel we have a plan which will be acceptable to the insurance carrier, to the hospitals and to the patients. We cordially invite cooperation from the Indiana Hospital Association in effecting this change. We are ready to work with the Hospital Association on a *mutually* satisfactory program.

The details of the plan are presented as an appendix to this letter.

Indiana Association of Pathologists

By: Leon L. Blum, M.D.,
President

Indiana Roentgen Society

By: John R. Lionberger, M.D.,
President

Appendix

The Indiana State Medical Association approved the following plan at its October, 1959 session: (Reference: *Journal of Indiana State Medical Association,* Vol. 52, page 2280, Dec., 1959)

Continued

FROM: THE COMMITTEE FOR STUDY AND PLANNING FOR TRANSFER OF PROFESSIONAL FEES FROM BLUE CROSS TO BLUE SHIELD.

REFERENCE: ACTION OF THE HOUSE OF DELEGATES OF 1958 WITH RESPECT TO RESOLUTION NO. 2, NO. 3 AND NO. 4 (*J.I.S.M.A.*, p., 1769, Dec., 1958)

Pursuant to instruction contained in the action of the House referred to above, a committee of ten members was appointed by the president.

This committee believes that whatever physicians do in the course of their duties in the care of the sick is the practice of medicine. Control, even remotely by non-medical persons, is not in the best interests of the patient or of the public. Physicians, therefore, cannot permit the sale of their services by any non-medical organization. Therefore, sale of the physician's services must not be provided in any hospital service contract.

For the above reasons, the following plan is offered to provide for the orderly transfer of whatever medical services Blue Cross may now be offering to the public from Blue Cross to Blue Shield. Assurance is given that there is no intent to produce or foresee a possibility of monetary gain to physicians or harm to the patient, the public, hospitals or to the insurance plan.

1. Blue Cross will discontinue issuing contracts providing medical coverage on and after March 1, 1960.

2. Blue Shield will offer coverage to fulfill the provisions of Blue Cross contracts now in existence containing these medical services of equal or better provision.

3. Blue Cross will pay to Blue Shield whatever portion of premiums hereafter collected on existing certificates as are ascribable to such coverage.

4. When new or different contracts are issued by Blue Cross no coverage will be offered for physicians' services. Subscribers desiring such coverage will be offered this coverage through either a Blue Shield rider attached to Blue Cross policies or by separate Blue Shield policy.

5. Blue Shield will provide benefits for transferred medical services on the basis of fee schedules in effect with Blue Cross participating hospitals as of March 1, 1960. Changes in fee schedules, if any, will be arranged with Blue Shield in the same manner as they have been arranged with Blue Cross.

6. Participating hospitals will submit charges for medical services in which they have an interest (radiology, pathology, possibly electrocardiography) in the same Blue Cross claim form currently in use. Blue Cross will transmit these charges to Blue Shield where checks will be written to the appropriate physicians.

7. All checks for medical services will be drawn in the name of the appropriate physician. Blue Shield will transmit these checks along with appropriate accounting information to the physician with duplicate accounting information to the hospital involved. It is assumed that the hospital information will accompany the Blue Cross check drawn to the hospital covering hospital services, thereby precluding the necessity for multiple posting procedures.

8. All parties conversant with the problem recognize that unforeseen questions will arise from time to time. It is expected that these will be arbitrated in a sincerely cooperative manner not injurious to the public good.

The committee calls attention to the fact that the plan submitted is, for all practical purposes, identical with the mechanics of a similar transfer currently in operation in Iowa. It is further expected that all parties involved will draw heavily on the experience of the Iowa group. In this manner the program can be expedited, and perhaps unnecessary mistakes avoided. ◄

Condensed Cardiology



Presented as a regular feature of The JOURNAL, Condensed Cardiology is a series of short talks on cardio-vascular diagnosis and treatment, edited by the staff of the Robert M. Moore Heart Clinic of the Marion County General Hospital, Indianapolis.

Transient Nature of Depression Of Arrhythmias by Potassium

CHARLES FISCH, M.D.

Indianapolis

IN 1918, DR. LOEWI first showed that arrhythmia due to digitalis can be abolished with K. Since the extensive clinical studies of Sampson,[1] Enselberg[2] and Lown,[3] potassium has been used widely for the treatment of arrhythmias accompanying or due to digitalis therapy. Although mentioned by Sampson that the effect is transient, this has not been widely recognized by the practicing physician. Our studies both in humans and animals suggest that the short-lived effect is due to a transient rise of plasma potassium after administration of the cation. As soon as the plasma potassium drops, the arrhythmia tends to reappear.

It is the purpose of this brief report to emphasize: (1) the transient nature of the beneficial effect of potassium and (2) to suggest that when treating serious cardiac arrhythmias with potassium the latter should be administered at reasonably frequent intervals.

Cases Show Potassium Effect

The transient effect of potassium and its relation to the plasma level is illustrated by the accompanying two cases.

Case 1—This patient with hypertension and arteriosclerotic heart disease in failure was given what was considered to be excessive doses of digitoxin. On admission (Fig. 1) the EKG demonstrated repetitive ventricular tachycardia with 1st degree A-V block. The diagnosis of ventricular tachycardia was made on the basis of accurate coupling of each bout of tachycardia to the preceeding normal QRS, the presence of

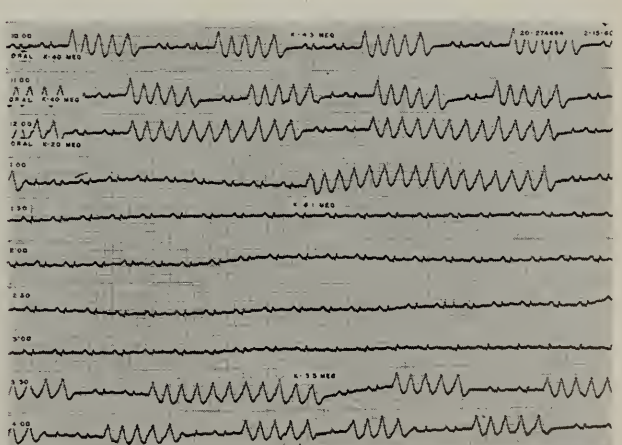


FIGURE 1

THIS FIGURE SHOWS the repetitive ventricular tachycardia abolished by potassium and recurrence of the arrhythmia when the level dropped. For details see text.

compensatory pause and of aberrant rapid intraventricular conduction. Plasma K on control determination was 4.3 mEq. After administration of a total of 100 mEq of K triplex (Lilly) the plasma potassium was elevated to 6.1 mEq/L at which time the arrhythmia disappeared. Two hours later, however, with the plasma potassium dropping to 5.5 mEq/L the arrhythmia reappeared and persisted for a number of days.

Case 2—This patient, a hypertensive and anteriosclerotic male in congestive heart failure, was treated with what was considered to be excessive doses of digitoxin. The control tracing taken at 8:30 a.m. with the plasma K level at 4.2 mEq/L showed a first degree heart block and ventricular beats arising from one focus. After administration of 80 mEq of potassium triplex, the plasma potassium gradually rose to 6.2 mEq/L, at which time the arrhythmia disappeared and U waves became prominent. Approximately two hours later the plasma level dropped and the arrhythmia reappeared.

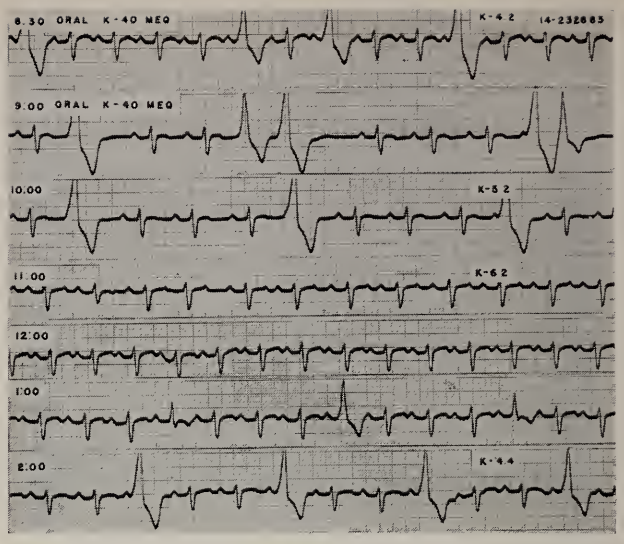


FIGURE 2

THIS TRACING SHOWS a 1st degree block with many ventricular premature beats which disappeared with elevation of plasma potassium to 6.2 and reappeared when the plasma potassium dropped. For details see text.

BIBLIOGRAPHY

1. Sampson, J. J., Albertson, E. C., Kondo, B.: The effect on man of potassium administration in relation to digitalis glycosides, with special reference to blood serum potassium, the electrocardiogram and ectopic beats. *Am. Heart J.* 26:164, 1943.
2. Enselberg, C. D., Simmons, H. G., Muntz, A. A.: The effect of potassium upon the heart, with special reference to the possibility of treatment of toxic arrhythmias due to digitalis. *Am. Heart J.* 39:713, 1950.
3. Lown, B., Levine, H. D.: *Atrial Arrhythmias, Digitalis and Potassium.* Landsberger Medical Books, Inc., New York, 1950.
4. Fisch, C., Shields, J. B., Ridolfo, A. S. and Feigenbaum, H.: Effect of potassium on conduction and ectopic rhythms in atrial filbrillation treated with digitalis. *Circ.,* 18:98, 1958.
5. Fisch, C., Steinmetz, E. F., Fasola, A. F., Martz, B. L.: Effect of potassium and "toxic" doses of digitalis on the myocardium. *Circ. Res.,* 7:424, 1959. ◄

National Safety Council

The AMA Council on Medical Service has announced the availability of four leaflets produced for sale by the National Safety Council. The leaflets were reviewed by the AMA Council and have been reproduced in large numbers as a part of an educational campaign to help reduce accidents among older persons. They are suitable for distribution by doctors and public spirited organizations to elderly citizens. A single set of four is priced at 12 cents. Quantity discounts are available (1000 sets of four at .084 per set). Write the National Safety Council, 425 N. Michigan Ave., Chicago 11, Ill.

The Journal of the Indiana State Medical

Association

MEDICAL ESSAY CONTEST

for

Interns and Residents of Indiana Hospitals

During the intern and resident year

1960-1961

$100.00 First Prize

75.00 Second Prize

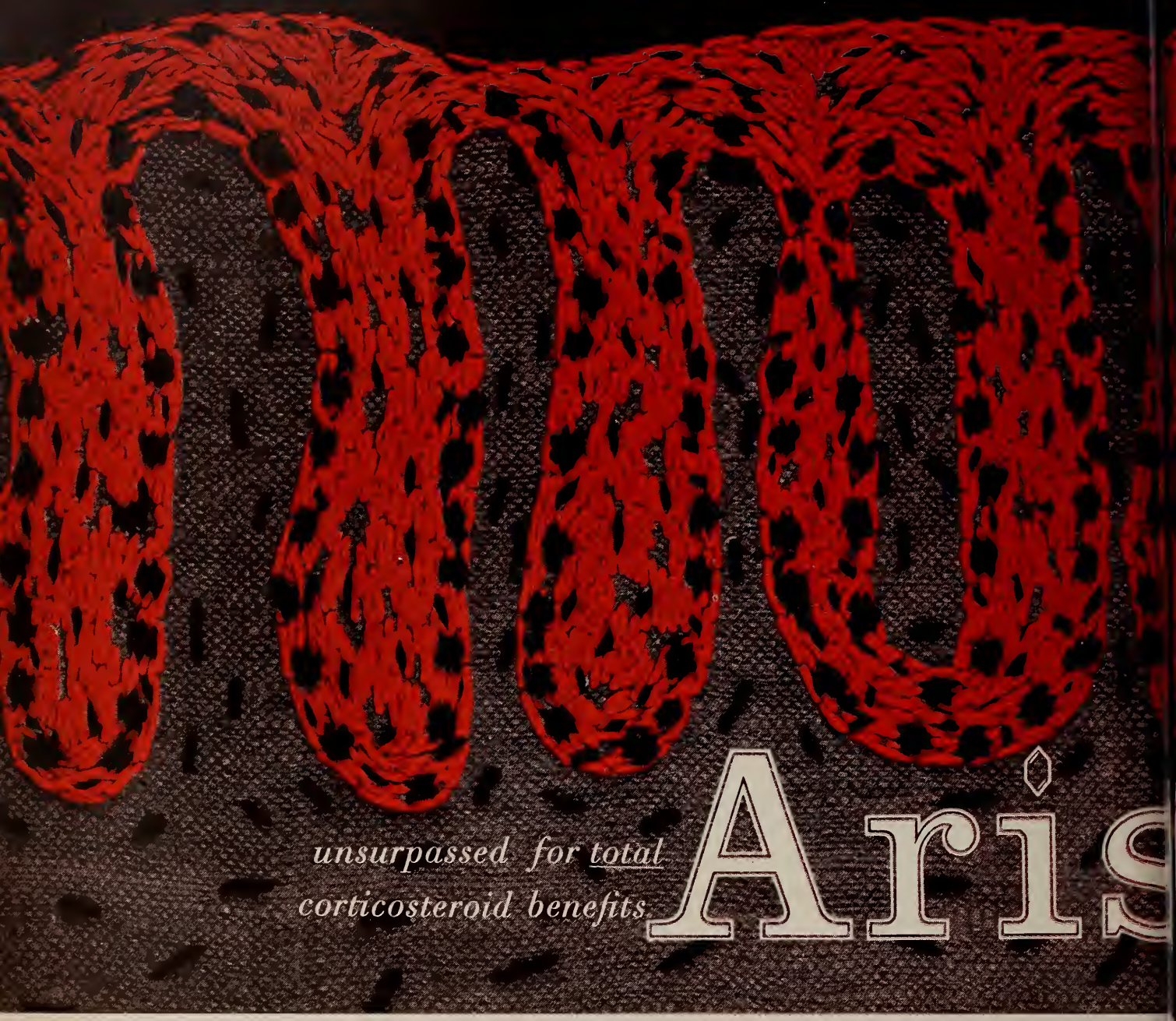
50.00 Third Prize

Watch subsequent issues of the

Journal

for detailed information

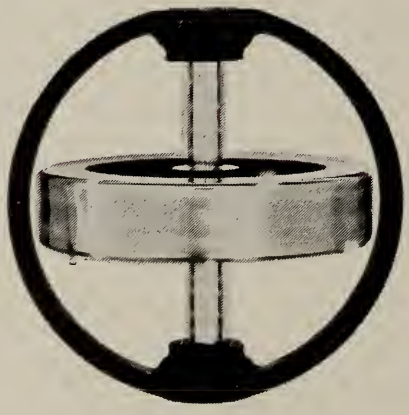
in allergic and inflammatory skin disorders (including psoriasi



unsurpassed for total corticosteroid benefits

Aris

Substantiated by published reports of leading clinicians





At the recommended antiallergic and anti-inflammatory dosage levels, ARISTOCORT means:

- **freedom from salt and water retention**
- **virtual freedom from potassium depletion**
- **negligible calcium depletion**
- **euphoria and depression rare**
- **no voracious appetite — no excessive weight gain**
- **low incidence of peptic ulcer**
- **low incidence of osteoporosis with compression fracture**

Precautions: With ARISTOCORT all traditional precautions to corticosteroid therapy should be observed. Dosage should always be carefully adjusted to the smallest amount which will suppress symptoms.
After patients have been on steroids for prolonged periods, discontinuance must be carried out gradually over a period of as much as several weeks.
Supplied: 1 mg. scored tablets (yellow); 2 mg. scored tablets (pink); 4 mg. scored tablets (white); 16 mg. scored tablets (white).
Diacetate Parenteral (for intra-articular and intrasynovial injection). Vials of 5 cc. (25 mg./cc.).

References: 1. Feinberg, S. M.; Feinberg, A. R., and Fisherman, E. W.: *J.A.M.A.* 167:58 (May 3) 1958. 2. Epstein, J. I., and Sherwood, H.: *Conn. Med.* 22:822 (Dec.) 1958. 3. Friedlaender, S., and Friedlaender, A. S.: *Antibiotic Med. & Clin. Ther.* 5:315 (May) 1958. 4. Segal, M. S., and Duvenci, J.: *Bull. Tufts N.E. Medical Center* 4:71 (April-June) 1958. 5. Segal, M. S.: Report to the A.M.A. Council on Drugs, *J.A.M.A.* 169:1063 (March 7) 1958. 6. Hartung, E. F.: *J. Florida Acad. Gen. Practice* 8:18, 1957. 7. Rein, C. R.; Fleischwager, R., and Rosenthal, A. L.: *J.A.M.A.* 165: 1821 (Dec. 7) 1957. 8. McGavack, T. H.: *Clin. Med.* (June) 1959. 9. Freyberg, R. H.; Berntsen, C. A., and Hellman, L.: *Arthritis & Rheumatism* 1:215 (June) 1958. 10. Hartung, E. F.: *J.A.M.A.* 167:973 (June 21) 1958. 11. Zuckner, J.; Ramsey, R. H.; Caciolo, C., and Gantner, G. E.: *Ann. Rheumat. Dis.* 17:398 (Dec.) 1958. 12. Appel, B.; Tye, M. J., and Leibsohn, E.: *Antibiotic Med. & Clin. Ther.* 5:716 (Dec.) 1958. 13. Kalz, F.: *Canad. M.A.J.* 79:400 (Sept.) 1958. 14. Mullins, J. F., and Wilson, C. J.: *Texas J. Med.* 54:648 (Sept.) 1958. 15. Shelley, W. B.; Harun, J. S., and Pillsbury, D. M.: *J.A.M.A.* 167:959 (June 21) 1958. 16. DuBois, E. L.: *J.A.M.A.* 167:1590 (July 26) 1958. 17. McGavack, T. H.; Kao, K. T.; Leake, D. A.; Bauer, H. G., and Berger, H. E.: *Am. J. M. Sc.* 236:720 (Dec.) 1958. 18. Council on Drugs: *J.A.M.A.* 169:257 (January) 1959.

Lederle LEDERLE LABORATORIES, A Division of AMERICAN CYANAMID COMPANY, Pearl River, N. Y.

The Journal

of the INDIANA STATE MEDICAL ASSOCIATION

Devoted to the interests of the medical profession of Indiana

Editor: Frank B. Ramsey, M.D., 1802 North Illinois Street, Indianapolis 2, Indiana

Associate Editors: A. W. Cavins, M.D., 221 South Sixth Street, Terre Haute, Indiana; Lall G. Montgomery, M.D., Ball Memorial Hospital, Muncie, Indiana; David A. Bickel, M.D., 515 Odd Fellows Building, South Bend, Indiana; Stephen L. Johnson, M.D., 521 Sycamore Street, Evansville, Indiana.

Editorial Board: Term Expires

George M. Johnson, M.D., Richmond . . Dec. 31, 1960
Irvin W. Wilkens, M.D., Indianapolis . Dec. 31, 1960
Harold D. Lynch, M.D., Evansville . . Dec. 31, 1961
Jene R. Bennett, South Bend . . . . Dec. 31, 1961
Samuel R. Mercer M.D., Fort Wayne . Dec. 31, 1962
Franklin F. Premuda, M.D., Hammond . Dec. 31, 1962

Necrologist: James B. Maple, M.D., 117 West Washington Street, Sullivan, Indiana.

Assistant Editor: Sara M. Snyder

Business Manager: James A. Waggener

1019 Hume Mansur Building, Indianapolis 4, Indiana

111th Annual Convention

THE PRELIMINARY PROGRAM for the Annual ISMA Convention at French Lick Springs October 2, 3, 4 and 5 promises to be one of the most instructive sessions ever scheduled.

The official, political and business events of the convention will be separated, as has been the custom of recent years, in so far as is possible from the scientific presentations. This will be especially appreciated this year because of the excellence of the medical portion of the meeting.

Sunday, Oct. 2, will be devoted to meetings of the Executive Committee, the Council and the House of Delegates, in that order and starting at noon. The delegates will hold a dinner meeting.

Monday morning, Oct. 3, will open the technical and scientific exhibits, the golf tournament and the trap and skeet shoot. Reference Committees of the House of Delegates will start their hearings at 9:00 a.m. The Instructional Courses, which are approved for Category No. 1 credit with the Indiana Academy of General Practice, meet from 10 to 12.

Monday afternoon from 1:30 to 5:00 will be devoted exclusively to a panel discussion on "Coronary Heart Disease," to be moderated by Dr. John B. Hickam, chairman, Department of Medicine, I. U. School of Medicine. It is expected that five panelists will participate. They will discuss all facets of the disease, including diet, stress, body build, work in management and therapy and anti-coagulant therapy.

After dinner on Monday, a dance and special entertainment is scheduled for all the conventioneers in Convention Hall.

Tuesday morning will also be devoted to a single scientific presentation—a panel of six distinguished clinicians will discuss diseases of the gastro-intestinal tract. In addition to a moderator of national reputation it is expected that a pathologist, a gastro-enterologist, a surgeon, a radiologist and an internist will compose the panel.

Scheduled for Tuesday afternoon are three non-medical or socio-economic subjects: "The Doctor and His Finances," "Medical Politics on a Nationwide Basis" and "Malpractice and How

It Can Be Avoided." Each of these topics will be discussed by a nationally known expert.

Tuesday night is set aside for the President's Reception, the President's Night, and the Annual Dinner.

Wednesday morning will see the final meeting of the policy-making bodies of the association, in reverse order to the opening meetings—the House of Delegates, the Council and the Executive Committee.

Luncheon times throughout the convention will accommodate section meetings, class reunions and specialty group meetings.

A more detailed program will be published in the next issue of *The Journal.*

Increase in Hospital Admittance & of Prepayments

THE INCREASED USE of hospitals, despite the obvious advantages to the health and medical care of the population as a whole, has been criticized by many people and groups of people. Recent increases and requests for increases in Blue Cross premium rates have brought forth a flood of discussion, including carping criticism, all with the general objective of fixing the blame for increased use of hospitals and increased cost of hospitalization upon someone else.

Oftentimes that someone else is the doctor who is accused of recommending hospital admissions for trivial illness, for diagnostic reasons or for nursing that allegedly might better be performed in a nursing home. Doctors have been accused of prolonging a patient's stay beyond the time when he should properly return home. Patients have been accused of "chiseling" on Blue Cross and other insurance companies in order to enjoy a "rest cure" or in order to achieve a diagnostic series of tests which should have been performed on an out-patient basis.

One of the most natural and obvious reasons for the increased use of hospitals has been largely overlooked. Blue Cross and (later) other types of hospital insurance were organized to help people who were not able to take advantage of hospital care because of their inability to pay. Hospital insurance has served to level out the cost and has provided a method of prepayment. As a consequence the people who formerly could not afford hospital care are now able to take advantage of it and have done so. Result: increased use of hospitals.

For several years, those who have been interested in improving prepaid hospital insurance have emphasized that many of the charges against it and some of the answers have been based on a preponderance of surmise and emotion and on a minimum of facts. Everyone has agreed that more knowledge about present utilization is needed in order to produce high-quality and economical services.

Facts and Figures

Now it appears that Indiana Blue Cross has provided a lot of the needed facts. Health Information Foundation in its May 1960 issue of "Progress in Health Services" reviews a 1956 study conducted by our Blue Cross on the utilization data and cost figures on a group of 843,046 subscribers, all of whom were covered by one type of contract.

To quote George Bugbee, President of H. I. F., "The data analyzed here give little support to the criticism that great numbers of patients are unnecessarily admitted to general hospitals or could be treated less expensively elsewhere."

Mr. Bugbee comments further: "This finding has nationwide implications. While the 843,046 Blue Cross subscribers in Indiana are not an exact cross-section of the population in their state or for the country as a whole, the group is large enough to furnish some measure of the diagnoses causing admission to general hospitals, length of stay and costs of care. Furthermore, hospital costs in Indiana appear to be close to national averages."

It is interesting to note that the diagnostic category which accounts for the most hospital days and for the higher hospital bills is that of digestive diseases, a field of medicine in which many patients are treated surgically, and the field also in which recent reductions in mortality have been most striking.

The survey corroborates what has been known by Indiana Blue Cross and also by Indiana Blue Shield for some time—obstetrical care soaks up a considerable portion of the Blue Cross and Blue Shield dollar. Today almost all births occur in hospitals. In 1935 only 37% of obstetrical cases were hospitalized. Here too, the availability of hospital care has been followed by a marked reduction in maternal and infant mortality.

Health Information Foundation lauds the Blue Cross report as an example of how adequate statistics can be helpful in improving services.

Medicolegal Digest

A NEW, HELPFUL and important journal for physicians made its appearance in May. *Medicolegal Digest,* published by the Medicolegal Publishing Association, 430 N. Michigan Ave., Chicago, will appear each month. The subscription price is $13.50 per year.

The aims, purpose and plan for the new magazine are so concisely stated by the editor, Milton Golin, in an editorial in the initial issue, that the editorial is reproduced below, with the permission of Mr. Golin, for the information of physicians:

"Legal aspects have become so entwined in the healing arts that no longer is it possible to regard medicine apart from the law. In these pages each month will be found the essence of trends in the medicolegal field. This journal is designed for the physician in general practice, the specialties, education, research and public health. Our editorial approach will emphasize interpretive reporting.

"One category of *Medicolegal Digest* will present the prudently-condensed version of a significant medicolegal article selected from law reviews and similar journals. In another classification will be the original article tailored for *Medicolegal Digest* readers. For example, some of the digest reports might deal with radiation hazards, privileged communication or liability for blood transfusion injuries. An original article might explore medical hypnosis, unauthorized surgery, or artificial insemination in this country.

"In addition, our recipe for future issues calls for a pinch of spice—perhaps a collection of 'ridiculous' medicolegal rulings, a picture report, or a column for airing the healthy, no-holds-barred controversies which characterize the human side of any profession.

"If you expect elaborate treatises in *Medicolegal Digest* you will be disappointed. If you look for technically-worded reports on obscure cases, you will be disillusioned. Thus, the basic tone of this authoritative journal will be readability, conciseness and pertinence. And if, through it all, you ken the shape of a crystal ball, you won't be far wrong. For our consultants and editors will be keeping your future in mind: Does this describe a trend that may reach my practice or duties? What might I expect next, and how may I prepare for it?

"This is our humble blueprint. Our builders are doctors, lawyers and other professionals. Come visit with us."

Homely—But Helpful

ONE OF THE arguments advanced in favor of conduction of local anesthesia in normal labor is the danger of aspiration of vomitus under general anesthesia. The parturient enters the hospital as a candidate for anesthesia without the precautionary fasting customary in elective procedures. In spite of this, general anesthesia must often be used in obstetrics.

In 1956 appeared an article by J. A. Holmes (*J. Obst. & Gyn. Brit. Emp.* 63:239, 1956) on

"the prevention of inhaled vomit during obstetric anesthesia," in which he advocated the use of apomorphine to cause self-emptying of the stomach, and rapidly, just prior to anesthesia; and he reported 35 cases so handled with complete success.

Since January 1957 apomorphine hydrochloride has been used as a preanesthetic emetic at two universities in this country: University of Colorado and the Johns Hopkins University.

Robert T. White, M.D., reports on 75 cases from the two hospitals. (*Obs. & Gyn.* 14:111, 1959.) Dr. Nicholson J. Eastman considered this work of sufficient importance to include a review of it, abstracted in *Obstetrical & Gynecological Survey,* 15:31, 1960. His editorial remarks are of considerable interest—quoted in part as follows: "Anesthesiologists, I know, look down their noses at this homely procedure. To begin with, it is below their dignity; and if they deign to discuss it at all, they will tell you that any skilled anesthesiologist can handle vomiting under anesthesia with the greatest of ease and safety. This may be true.

"But what proportion of obstetric anesthetics are administered by skilled anesthesiologists? Shamefully few. . . . Many of the patients, I happen to know, were distinctly fussy, hoity-toity young ladies; but they didn't seem to mind it a bit."

The technic used is simple, but there are, of course, precautions to be observed. No fancy apparatus is required. Atropine sulphate 0.4 mg is given intravenously after the effect of apomorphine begins to wear off. After allowing a few minutes for the full effect of the atropine, the anesthetic is administered.

In Dr. White's summary he states: "Intravenous apomorphine hydrochloride has proved to be a very effective and safe preanesthetic emetic in obstetric patients. The average total dosage of apomorphine hydrochloride used in a series of 75 patients was 3.9 mg. The maximum dose should not exceed 6.5 mg. The patients did not regard the induced emesis as objectionable or repulsive. Apomorphine hydrochloride used properly does not depress fetal respirations."

Those interested are urged to read Dr. White's original article which gives specific details of technic and of the precautions employed, in a succinct manner.—A.W.C.

Journal Offers $5 Each for Anecdotes

A new department of *The Journal* is being organized for the publication of accounts of personal experiences of Indiana physicians. The practice of medicine is interwoven and frequently involved with the drama of life. In a lifetime of practice doctors are in contact with many episodes of amusing, thrilling, ridiculous or dramatic import. Members of the association are invited to submit manuscripts for this purpose. Authors' names need not be published, initials may be used. The narrations may be short, but should be limited to 1200 words. *The Journal* will pay $5.00 for each one published.

President's Page

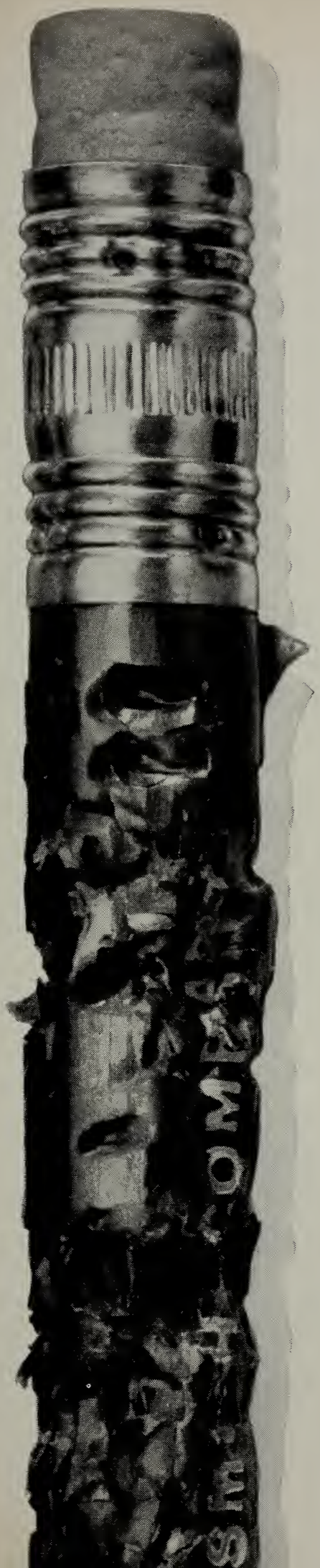
Recently in Washington, D. C., while on State Association business in the Capital city, Don Wood, Okla Sicks, and I went to the social security headquarters' office in Baltimore, Maryland. Our reason for going was that we had information indicating doctors would soon be brought under social security and we thought it would be well if we could learn something about it prior to our being brought under this scheme.

The building is located in northwest Baltimore; it is a massive structure and very modern. We were told by one of the directors that it had been occupied for four months. We were received very cordially and a tour was arranged through this massive structure so that, by observation, we could learn something about the program.



We learned that any man who served in the armed forces in World War II, or in the Korean conflict, has a wage credit to his social security account of $160 per month for each month he served. This was in effect from September 16, 1940, through December 31, 1956. We were told that this would pay to any recipient of social security, or his survivor, $33 per month for life, provided he had the number of quarters needed. This is an unusual situation as the number of quarters needed varies according to the time one reaches retirement age. This is a sliding scale—if one reaches retirement age in 1953, he needs six quarters of pay into social security. This advances by increments of one quarter until one, who reaches retirement age by 1971, will need forty quarters paid into social security to participate in benefits. We were also told by the director that any provision to include doctors in this program would be spelled out by the act that does this. This is based on their past experience; when a new group is brought into social security it requires an act on the part of Congress and any provisions are spelled out in detail.

Social security payments are based on earnings of the person during his productive years and the present system is based on laws passed in 1937 and 1951. There are two ways of calculating the payments that are to be made to an individual. We were informed that if the payment was larger on the '51 calculation than on the '37, the '51 calculation would be used and vice versa. In other words the recipient is paid the highest calculated amount. Maximum benefits are $127 per month and the lowest benefit is $33 per month to any person who qualifies for social security benefits. A person who is receiving social security



when you see signs of **anxiety-tension** specify

Dartal®

dihydrochloride

brand of thiopropazate dihydrochloride

for rapid relief of anxiety manifestations

You will find Dartal outstandingly beneficial in management of the anxiety-tension states so frequent in hypertensive or menopausal patients. And Dartal is particularly useful in the treatment of anxiety associated with cardiovascular or gastrointestinal disease, or the tension experienced by the obese patient on restricted diet. You can expect consistent results with Dartal in general office practice.

with low dosage: Only one 2, 5 or 10 mg. tablet t.i.d. *with relative safety:* Evidence indicates Dartal is not icterogenic.

Clinical reports on Dartal: 1. Edisen, C. B., and Samuels, A. S.: A.M.A. Arch. Neurol. & Psychiat. *80*:481 (Oct.) 1958. 2. Ferrand, P. T.: Minnesota Med. *41*:853 (Dec.) 1958. 3. Mathews, F. P.: Am. J. Psychiat. *114*:1034 (May) 1958.

SEARLE

benefits can be paid for any month in which he does not earn over $100. This is true even though he might earn $100,000 throughout the remainder of the year—if he has one month that he doesn't earn over $100 he will receive his social security benefit for that particular month. At the age 72 benefits are paid regardless of what the person earns if he qualifies for social security at the time. We were told that they feel that actuarially the social security program is quite sound as their present resources are practically 21 trillion dollars.

Needless to say, the three of us, Dr. Sicks, Dr. Wood, and I had our own records checked while there. In my own experience I had four years of pay into social security while employed at Norways Sanitarium; this was from 1936 until 1940. And then, according to their own program, I had approximately five years additional amount due to military service. I was feeling rather good about the whole situation; feeling that I might be able to qualify for social security without much trouble regardless of when my retirement age would be reached because I had 16 quarters plus approximately another 20, making a total of 36 quarters, and the highest demand that is required at present is that there be 40 paid quarters. Consequently I filled out a card with my name, address and social security number on it and returned to Indiana expecting to get the good news. After a delay of about two weeks the following information came, and I feel it should be printed in full as I believe it is the most illuminating aspect of the whole experience I had with social security—

"We are returning your request for information about your old-age and survivors insurance account because no earnings have been recorded for you under the account number you gave us.

"Our records may not show information as to earnings you have had during the last calendar year. This is because of the time it takes to receive and record social security reports.

"If you had earnings prior to the last calendar year which you believe should be on your account, we suggest you take this notice to your nearest Social Security Administration District Office."

It is rather discouraging to have this experience but one should be alert to the fact that bureaucracy is not now, nor has it ever been, able to answer individual problems that arise. I believe this information should temper our decision before asking for social security. Certainly the present Keogh-Simpson bill might be much better for physicians than any social security benefit that is on the books at the present time. We should all remember that government intervention in any phase of our lives is more apt to lead to mediocrity than to elevate the standards to a higher level. This should be a sterling example as to what might happen to medicine in America if government ever gets into control.

Earle W Arnold M.D.



whenever there is inflammation, swelling, pain

VARIDASE®

STREPTOKINASE-STREPTODORNASE LEDERLE

BUCCAL *Tablets*

conditions for a fast comeback . . .



5 days of classic therapy — after 48 hours of VARIDASE

as in cellulitis*

Until VARIDASE stemmed infection, inflammation, swelling and pain, neither medication nor incision and drainage had affected the increasing cellulitis.

VARIDASE mobilizes the natural healing process, by accelerating fibrinolysis, to condition the patient for successful primary therapy. Increases the penetrability of the fibrin wall, for easy access by antibodies and drugs . . . without destroying limiting membrane . . . and limits infiltration. Prescribe VARIDASE Buccal Tablets routinely in infection or injury.

*Innerfield, I.: Clinical report cited with permission.

VARIDASE BUCCAL Tablets contain:
10,000 Units Streptokinase, 2,500 Units Streptodornase.

Supplied: Boxes of 24 and 100 tablets

Lederle

LEDERLE LABORATORIES,
A Division of American Cyanamid Company, Pearl River, N. Y.

The Women's Auxiliary

REPORTS TO ISMA

The past month has been a period of awakening—awakening to the beauties of the state in which we live. Even when viewed through the window of a speeding car, an observer can immediately realize why Indiana has acquired its well deserved reputation for loveliness. Like pieces of a puzzle, it all fits together—the spiraling freshness of a plowed field, the somnolence of a small town in the afternoon sun, the unforgettable smell of new mint, the inexorable process of nature as it slowly shifts into another gear.



May has also been a month of EDUCATION—a period in which we travelled all over the state presenting the auxiliary program at area and district meetings, outlining our plans for the forthcoming year. A period in which a re-evaluation of auxiliary principles and duties has been defined. Most gratifying has been the remarkable interest and enthusiasm shown by auxiliary officers and chairmen, their eagerness to prepare themselves for the responsibility they have assumed.

With the coming of this critical election year it is not surprising to find auxiliary members throughout the state greatly concerned about the legislative program. They are anxious to mobilize forces with the medical societies opposing any legislation that would destroy the continued freedom in the practice of medicine. They wish to help *you* carry out effective legislative action programs.

Legislation, a priority project in auxiliary interest, has received considerable attention during the past 30 days. Your auxiliary has organized a legislative team for action. Our State Legislative Chairman, Mrs. Otis Bowen, of Bremen, has working with her four area chairmen and 60 county chairmen, each with strong legislative committees. You have a big job to do but you have a lot of helpers.

In conjunction with our legislative program we will continue to work for better and more effective medicine. Nothing gives us more pleasure than to work with you as partners, upholding the principles for which you are fighting. This is our response to a tremendous task which is yours and ours together.

Ina. Rigley

NEW

For the "multi-system disease"[2] HYPERTENSION...
an integrated multi-therapeutic antihypertensive...

SALUTENSIN™

Hydroflumethiazide • Reserpine • Protoveratrine A

A multi-system disease such as essential hypertension often requires a multi-therapeutic approach for satisfactory control. SALUTENSIN combines in balanced proportions three clinically proven antihypertensives. These components act through three different physiologic mechanisms to offer greater therapeutic benefits while minimizing the risk of side effects sometimes observed in patients on single drug therapy at maximally effective doses. The components in each SALUTENSIN Tablet:

SALURON (hydroflumethiazide Bristol)—a saluretic-antihypertensive agent postulated to lower elevated blood pressure by affecting vascular reactivity to a still unknown pressor mechanism ..... 50 mg.

Reserpine—a tranquilizing drug with peripheral vasorelaxant effects, which have been described as a "chemical sympathectomy"[3] ..... 0.125 mg.

Protoveratrine A—"a potent hypotensive drug"[4] which is "well tolerated" in combination with rauwolfia;[5] a centrally mediated vasorelaxant that produces "the most physiologic, hemodynamic reversal of hypertension"[1] ..... 0.2 mg.

INDICATIONS: Essential hypertension; hypertensive cardiovascular disease; insufficient response to a single or dual antihypertensive agent; partial or complete replacement of potentially more toxic agents.

SALUTENSIN should be used cautiously in hypertensive patients with renal insufficiency, particularly if such patients are digitalized.

DOSAGE: Usual adult dose 1 tablet twice daily. Detailed information on dosage and precautions in official package circular or available on request.

SUPPLY: Bottles of 60 scored tablets.

A sustained-action foundation drug for an antihypertensive regimen . . .

saluron®

sustained-action hydroflumethiazide 'Bristol'

SALURON is an economical, well-tolerated *salutensive* agent—saluretic and antihypertensive—for use as a foundation drug in the treatment of hypertension. In mild to moderate hypertension, SALURON often is adequate by itself. It has been described as "a distinct advantage in the manifestations of hypertension"[6] and "a marked advancement in the field of diuretic therapy."[7]

DOSAGE: Usually 1 tablet daily. Full information in official package circular.

SUPPLY: Scored 50-mg. tablets, bottles of 50.

Bristol

BRISTOL LABORATORIES, Syracuse, New York

CHILD PSYCHIATRY IN INDIANA

JAMES E. SIMMONS, M.D.

Indianapolis

ALMOST DAILY we receive requests from physicians for help in treating their mentally and emotionally ill child patients. Most of these physicians are very understanding of the fact that treatment facilities are grossly inadequate to meet the needs. At the present time only 12 of the 92 counties in the state have mental health clinics which can treat some of these problems. Almost all of these clinics have long waiting lists and are barely keeping up with the demands in their own counties. It is also immediately apparent that the Medical Center Child Guidance Clinic cannot provide sufficient service for the other 80 counties.

For the hundreds of children who are so emotionally disturbed that they must be hospitalized, the state provides one 25-bed treatment unit in Indianapolis. Many mentally ill children are out of necessity hospitalized in the adult wards of our state hospitals. These children are committed because they are so ill that they cannot be contained in the community. However, under the present appropriations the state has not provided funds for additional psychiatrists, psychologists, social workers, nurses and teachers necessary to establish a treatment program for these children.

Many of our colleagues believe the problem is insolvable because even if there were sufficient funds, we could not find qualified staff to fill the positions. This is only partly true. Recently, the Department of Psychiatry at Indiana University Medical Center extended its program to include two full additional years of training in the subspecialty of child psychiatry. This program has now been fully approved and accredited by the American Board of Psychiatry and Neurology, Inc. We expect that nearly all of the graduates of this program will remain in Indiana, if citizens of the state are really serious about wanting treatment facilities for emotionally ill children.

The following report was written at the request of the Indiana State Legislative Study Commission for Emotionally Disturbed Children by a group of our colleagues in this state who are actively engaged in psychiatric treatment of children. The report is submitted to the *Journal* for review by all the members of the State Medical Association.

We are indebted to the directors and staffs of all the State Mental Health Clinics and especially the resolutions committee who formulated and wrote the following recommendations. The resolutions committee consisted of Jay Bisgyer, M.D., Gary; David Dallal, M.S.W., Indianapolis; Margaret Davidson, M.S.W., Evansville; Marian De Myer, M.D., Indianapolis; Robert Greenlee, M.D., Fort Wayne; M. T. Hegreness, M.S.W., South Bend; Charles Heineman, Ph.D., Fort Wayne. Dr. S. T. Ginsburg and his staff of the Division of Mental Health were extremely helpful with the arrangements for the meeting of this group.

RECOMMENDATIONS FOR IMMEDIATE ACTION

TO: Indiana Legislative Commission on Emotionally Disturbed Children.

Continued

Associate Professor and Coordinator of Child Psychiatry Services, Indiana University Medical Center.



Of course, women like "Premarin"®

THERAPY for the menopause syndrome should relieve not only the psychic instability attendant the condition, but the vasomotor instability of estrogen decline as well. Though they would have a hard time explaining it in such medical terms, this is the reason women like "Premarin."

The patient isn't alone in her devotion to this natural estrogen. Doctors, husbands, and family all like what it does for the patient, the wife, and the homemaker.

When, because of the menopause, the psyche needs nursing—"Premarin" nurses. When hot flushes need suppressing, "Premarin" suppresses. In short, when you want to treat the whole menopause, (and how else is it to be treated?), let your choice be "Premarin," a complete natural estrogen complex.

"Premarin," conjugated estrogens (equine), is available as tablets and liquid, and also in combination with meprobamate or methyltestosterone.

Ayerst Laboratories • New York 16, N. Y. • Montreal, Canada

ayerst®

5854

Child Psychiatry

Continued

Keenly aware that treatment facilities for Indiana's thousands of emotionally disturbed children are wholly inadequate, representatives of the state's 14 community psychiatric clinics met March 17 and 18, 1960, at Indianapolis to study the problem.

Attending the meeting were psychiatrists, psychologists and social workers employed by the clinics, representatives of the state Division of Mental Health, and the Indiana Association for Mental Health.

The group unanimously agreed that immediate steps should be taken to alleviate present treatment inadequacies and meet other urgent, essential needs.

The following facilities are required for the treatment of four general types of emotionally disturbed children:

1. *Children able to live at home or with foster parents.* Type of facility required for treatment: community clinics and private psychiatrists.
2. *Children requiring placement outside their homes but able to attend public school.* Type of facility required for treatment: open institutions cooperating with community clinics or private psychiatrists.
3. *Children requiring placement outside their homes under close supervision unable to attend public school but able to respond to treatment.* Type of facility required for treatment: closed residential units.
4. *Children requiring indefinite supervision and care.* Type of facility required: state hospitals.

The committee calls attention to the report of Dr. Delton Beier of Indiana University, giving actual numbers of emotionally disturbed and mentally ill children currently going without care.

1. Section on Child Mental Health

It is recommended that a Section on Child Mental Health be established within the state Division of Mental Health with enough money to design and carry out its program.

This section would be responsible for all matters related to the various types of treatment facilities, including staffing, professional standards, personnel practices, patient transfers, budgeting and buildings.

2. Existing State Hospital Programs

(Group 4—Children requiring indefinite supervision and care)

On June 30, 1959, Indiana state mental hospitals had a patient population of 422 children 18 years or under. Many of these children require long-term care.

Existing programs for these children are wholly inadequate.

For the most part, no separate facilities are provided, so children are necessarily housed with adults.

It is imperative that these programs be strengthened and expanded *immediately* in order to provide prompt, effective treatment.

This can only be done by expanding state hospital budgets, and the key to improved treatment programs for children is *staff*.

For every 20 children, the following additional staff is urgently recommended:

1. A psychiatrist with training in child psychiatry who could function either full-time, part-time or as a consultant to the staff psychiatrist in charge of the children's program. It is imperative, however, where there are 40 or more children that a full-time psychiatrist be employed.
2. One full-time psychiatric social worker.
3. One full-time clinical psychologist.
4. One full-time educational supervisor, principal or superintendent of the school for children.
5. Two full-time teachers. Since emotionally disturbed and mentally ill children have special learning problems, the ratio of children to teacher should never exceed ten children to one teacher.
6. One full-time registered occupational therapist, with training and experience in work with children.
7. Two full-time recreational therapists, trained and experienced in group work with children.
8. Adequate nursing help to provide 24-hour coverage.

Continued



A Vacation from Hay Fever is a Real Vacation

ANYWHERE – ANYTIME

Just a "poof" of fine **NTZ** *spray brings relief* IN SECONDS, FOR HOURS

NTZ is a potentiated, balanced combination of these well known synergistic compounds:

Neo-Synephrine® HCl, 0.5%
– dependable vasoconstrictor and decongestant.

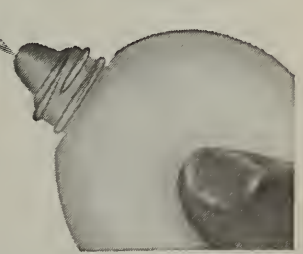
Thenfadil® HCl, 0.1%
– potent topical antihistaminic.

Zephiran® Cl, 1:5000
– antibacterial wetting agent and preservative.

NTZ®

NASAL SPRAY

Supplied in leakproof, pocket size squeeze bottles of 20 cc.



Winthrop LABORATORIES
New York 18, N. Y.

Child Psychiatry

Continued

3. New Residential Treatment Facilities

(Group 3—Children requiring placement outside their homes under close supervision, unable to attend public school but able to respond to treatment.)

Residential treatment facilities are critically needed for seriously disturbed children who require hospitalization. These children are too disturbed to be handled in their own homes or foster homes, but should not be placed in a remote state hospital where they will be cut off from their families.

For all the children in the entire state who need intensive treatment, Indiana has only 25 beds at Larue Carter Memorial Hospital.

At least three new residential treatment centers should be established *immediately.*
These centers should be located in areas where the need is greatest, preferably near to patients' homes, in order to:

1. Give patients the most effective treatment possible.
2. Facilitate the early discharge of patients and return to their homes.
3. Enable parents of patients to participate in treatment and to maintain an active interest in patients.
4. Utilize local schools and official community agencies, thus avoiding the necessity of duplication of services.
5. Permit patients to receive follow-up care at out-patient community psychiatric clinics, thereby shortening their hospital stay.

Each center should consist of at least 36 beds, divided into separate units for children up to 18 years in different age and sex groups.

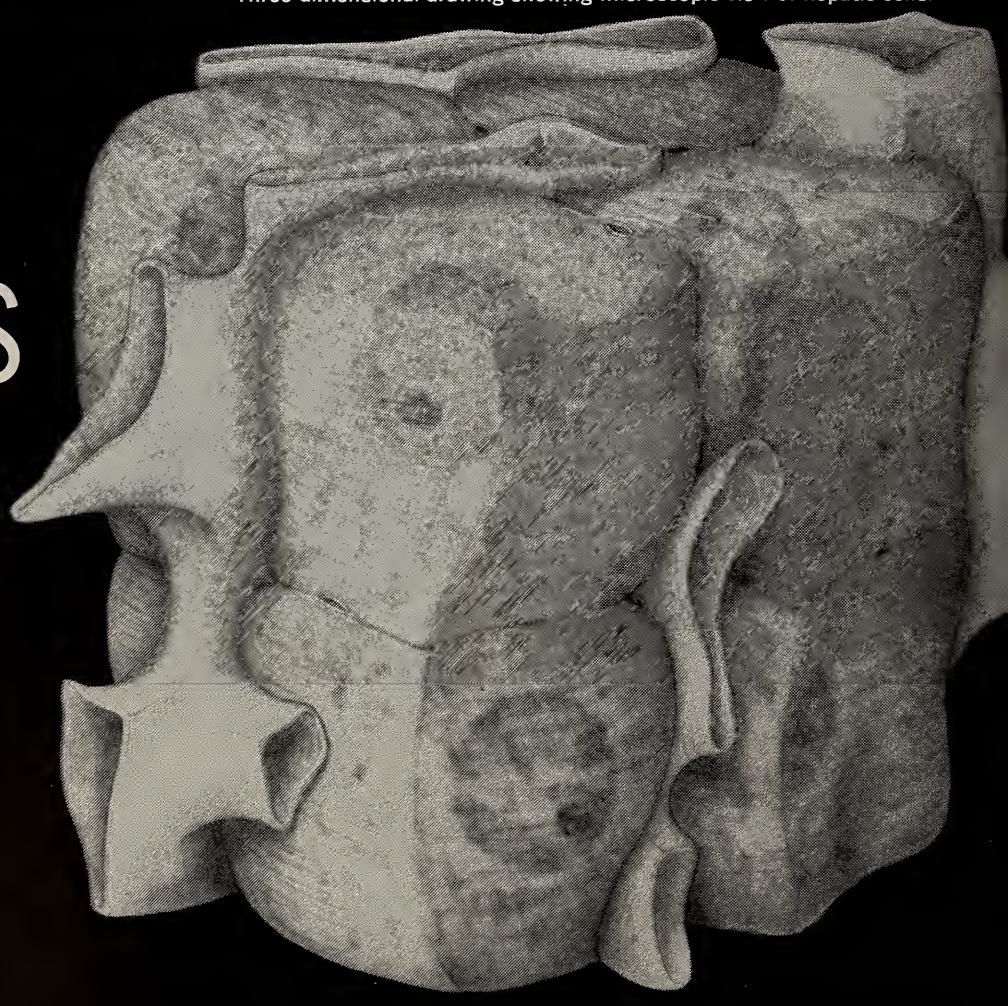
Specifications for these centers should be provided by the Division of Mental Health.

It should be noted these three units will provide a total of only 108 additional beds.
This limited recommendation is made because of the difficulty in obtaining qualified persons to staff such centers.

As rapidly as staff can be trained, at least three additional units should be established.

Three-dimensional drawing showing microscopic view of hepatic cells.

what goes on in the liver?



A multitude of physiological processes . . .

4. Research and Training Unit

This committee recommends that the children's unit at Larue Carter Hospital be retained as a research and training unit with special emphasis on training staff to work in the new centers and in children's units at other state hospitals.

5. Expansion of Community Psychiatric Clinics

(Group 1—Children able to live at home or with foster parents.)

Serious shortages of facilities exist at every level of care for the state's emotionally disturbed children.

Committee studies indicate a particular need for expansion of community clinics for children who need psychiatric care, even though they may be able to live at home or with foster parents.

Many areas of the state have no community clinics. This is extremely serious for two reasons. First, the community clinics provide diagnosis and treatment. They also serve as the focal point for the mental health program of local schools, social agencies and juvenile courts.

The committee strongly urges that the legislature:

1. Provide funds for the establishment of seriously needed new clinics.
2. Provide additional funds for existing clinics in order to:
   (a) Cut down on long waiting lists for diagnosis and treatment; and to
   (b) Encourage existing clinics to provide these services for children in surrounding counties and communities.

6. Other Child Care Institutions

(Group 2—Children requiring placement outside their homes but able to attend public school.)

Though able to attend public school, some emotionally disturbed children—because of family problems—require placement outside their homes.

Under certain conditions, these children may be placed in existing child care institutions which are not exclusively devoted to providing psychiatric care and be given treatment at local community clinics.

It is strongly recommended such institutions

Continued on page 1356

. . . the formation of vitamin A, fibrinogen, heparin, prothrombin; the storage of glycogen, iron, copper; the metabolism of carbohydrates, proteins and lipids, etc. The importance of maintaining normal liver function— and its repair when damaged—is readily apparent.

methischol®

choline, methionine, inositol, vitamin B_{12}, desiccated liver

METHISCHOL:
capsules: 100, 250, 500, 1000;
syrup: 16 oz. and 1 gallon

Samples of METHISCHOL and literature available from

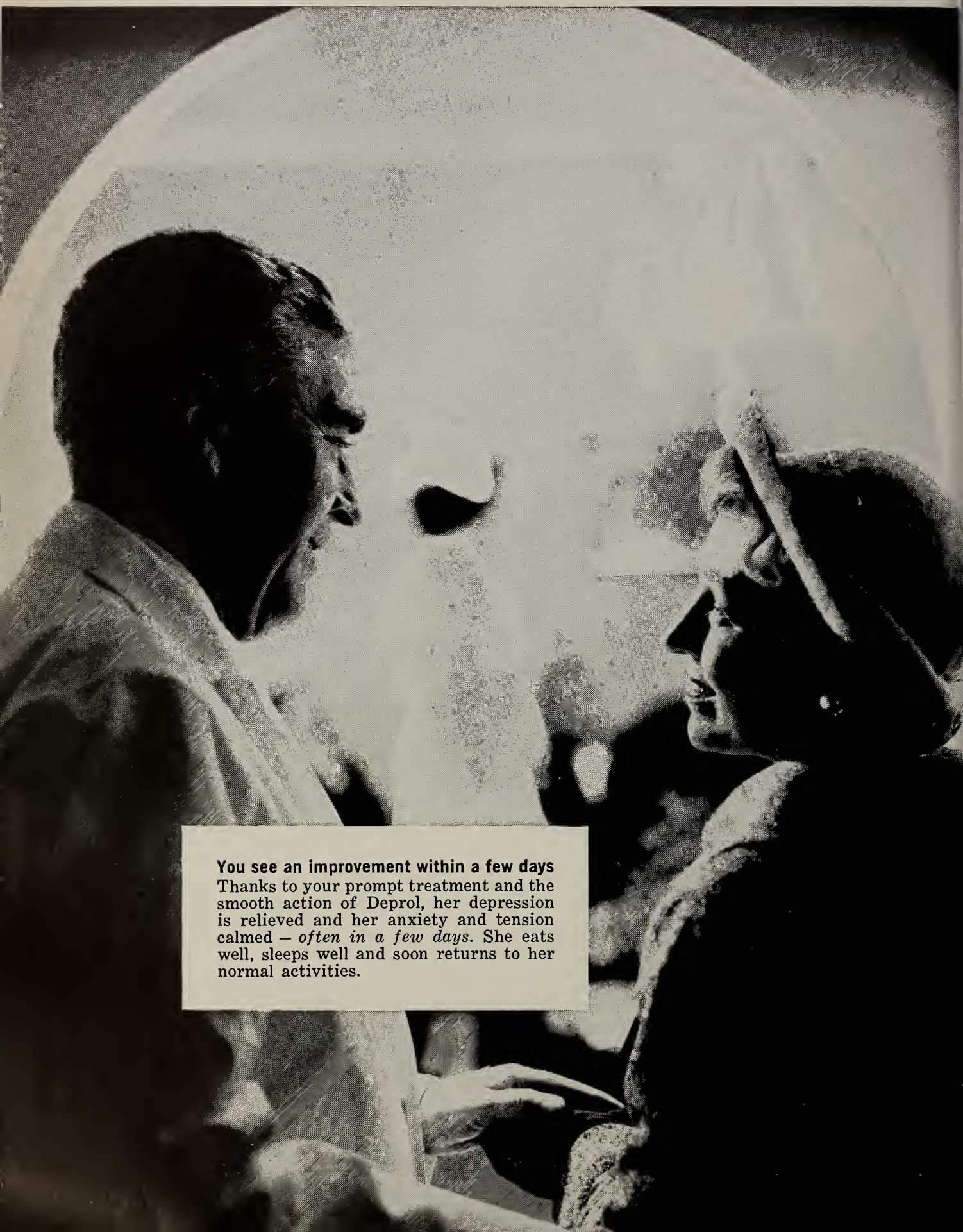
u. s. vitamin & pharmaceutical corporation
Arlington-Funk Laboratories, division
250 East 43rd Street, New York 17, N. Y.

helps restore or maintain liver normality when hepatic damage occurs or threatens in

cirrhosis
alcoholism
hepatitis
obesity
diabetes
atherosclerosis

Methischol acts to remove hepatic fat, stimulate regeneration of new functioning liver cells, and lessen tendency to fibrosis and cirrhosis.

Lifts depression..



You see an improvement within a few days
Thanks to your prompt treatment and the smooth action of Deprol, her depression is relieved and her anxiety and tension calmed – *often in a few days*. She eats well, sleeps well and soon returns to her normal activities.

as it calms anxiety!

Smooth, balanced action lifts depression as it calms anxiety... rapidly and safely

Balances the mood – no "seesaw" effect of amphetamine-barbiturates and energizers. While amphetamines and energizers may stimulate the patient *–they often aggravate anxiety and tension.*

And although amphetamine-barbiturate combinations may counteract excessive stimulation*–they often deepen depression.*

In contrast to such "seesaw" effects, Deprol's smooth, *balanced* action lifts depression as it calms anxiety–both at the same time.

Acts swiftly – the patient often feels better, sleeps better, within a few days. Unlike the delayed action of most other antidepressant drugs, which may take two to six weeks to bring results, Deprol relieves the patient quickly – often within a few days. Thus, the expense to the patient of long-term drug therapy can be avoided.

Acts safely – no danger of liver damage. Deprol does not produce liver damage, hypotension, psychotic reactions or changes in sexual function–frequently reported with other antidepressant drugs.

Bibliography *(13 clinical studies, 858 patients)*: **1.** Alexonder, L. (35 patients): Chemotherapy of depression – Use of meprobamate combined with benactyzine (2-diethylaminoethyl benzilate) hydrochloride. J.A.M.A. *166*:1019, March 1, 1958. **2.** Bateman, J. C. and Carlton, H. N. (50 patients): Meprobamate and benactyzine hydrochloride (Deprol) as adjunctive therapy for patients with advanced cancer. Antibiotic Med. & Clin. Therapy 6:648, Nov. 1959. **3.** Beerman, H. M. (44 patients): The treatment of depression with meprobamate and benactyzine hydrochloride. Western Med. *1*:10, March 1960. **4.** Bell, J. L., Tauber, H., Santy, A. and Pulito, F. (77 patients): Treatment of depressive states in office practice. Dis. Nerv. System 20:263, June 1959. **5.** Breitner, C. (31 patients): On mental depressions. Dis. Nerv. System 20:142, (Section Two), May 1959. **6.** Gordon, P. E. (50 patients): Deprol in the treatment of depression. Dis. Nerv. System 21:215, April 1960. **7.** Landman, M. E. (50 patients): Clinical trial of a new antidepressive agent. J. M. Soc. New Jersey. In press, 1960. **8.** McClure, C. W., Papas, P. N., Speare, G. S., Palmer, E., Slattery, J. J., Konefal, S. H., Henken, B. S., Wood, C. A. and Ceresia, G. B. (128 patients): Treatment of depression – New technics and therapy. Am. Pract. & Digest Treat. *10*:1525, Sept. 1959. **9.** Pennington, V. M. (135 patients): Meprobamate-benactyzine (Deprol) in the treatment of chronic brain syndrome, schizophrenia and senility. J. Am. Geriatrics Soc. 7:656, Aug. 1959. **10.** Rickels, K. and Ewing, J. H. (35 patients): Deprol in depressive conditions. Dis. Nerv. System 20:364, (Section One), Aug. 1959. **11.** Ruchwarger, A. (87 patients): Use of Depral (meprobamate combined with benactyzine hydrochloride) in the office treatment of depression. M. Ann. District of Columbia 28:438, Aug. 1959. **12.** Settel, E. (52 patients): Treatment of depression in the elderly with a meprobamate-benactyzine hydrochloride combination. Antibiotic Med. & Clin. Therapy 7:28, Jan. 1960. **13.** Splitter, S. R. (84 patients): Treatment of the anxious patient in general practice. J. Clin. & Exper. Psychopath. In press, April-June 1960.

Dosage: Usual starting dose is 1 tablet q.i.d. When necessary, this dose may be gradually increased up to 3 tablets q.i.d.

Composition: 1 mg. 2-diethylaminoethyl benzilate hydrochloride (benactyzine HCl) and 400 mg. meprobamate. **Supplied:** Bottles of 50 light-pink, scored tablets. Write for literature and samples.

Deprol®

WALLACE LABORATORIES/*New Brunswick, N. J.*

CD-2128

Child Psychiatry

Continued from page 1353

and clinics be given financial support which would enable them to:

1. Meet standards set by the Division of Mental Health, and to
2. Receive reimbursement under the Division's Family Care Program.

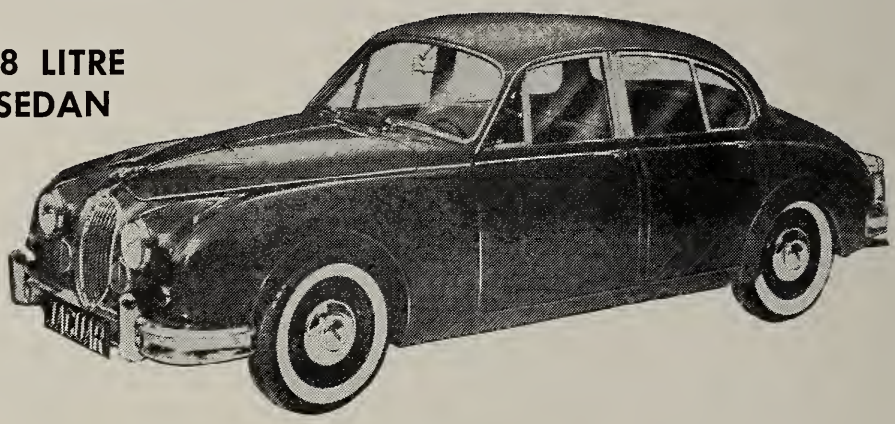
Summary of Recommendations

1. Creation of a special Section on Child Mental Health within the state Division of Mental Health with enough money to design and carry out its programs.
2. Additional funds to strengthen and expand treatment programs for the 422 children 18 years of age and under now being cared for in Indiana state mental hospitals.
3. At least three new residential treatment centers should be established immediately. As rapidly as staff can be trained, at least three more centers should be established, since the first three centers will not begin to meet the needs of emotionally disturbed and mentally ill children requiring intensive treatment.
4. Retain the children's unit at Larue Carter Hospital as a research and training unit, with special emphasis on training staff to work in the new centers and in children's units at other state hospitals.
5. Expansion of community psychiatric clinics and appropriation of additional funds for existing clinics in order to eliminate waiting lists for diagnosis and treatment and to enable these clinics to serve children in surrounding counties and communities.
6. Additional financial support to other existing child care institutions and local community clinics.

Real Cost Falling

It required fewer hours of work in 1958 to buy the same quantity of medical care that could be bought for $10 in 1938. While the actual price was higher in 1958, the real cost was lower, reports AMA's Department of Economic Research. (*AMA News,* Feb. 8, 1960; story on page 9)

NEW JAGUAR 3.8 LITRE FAMILY SPORTS SEDAN



The only car in the world that unites the vitality and spirit of a sports car with the roominess and comfort of a family sedan!

The Jaguar 3.8 sedan is a supreme achievement in performance, comfort and modern, functional styling in the highest Jaguar tradition. Full competition sports car power COMBINED with 5-passenger sedan luxury and comfort. Blazing acceleration and speed, with the famous Jaguar XK engine that has won countless trophies round the globe. Maximum safety with road-race-proved disc brakes. Greater visibility with wrap-around windows, thinner pillars. New high-output heating and defrosting system. Automatic transmission and power steering are optional. Also see the luxurious Mark IX sedan and the classic XK 150 sports models. Convenient terms!

JAGUAR
2330 NORTH MERIDIAN STREET

MIDWEST DISTRIBUTORS, Inc.
• INDIANAPOLIS



because their physician has kept the twins well nourished, healthy, and

free from diaper rash

with

DESITIN®
OINTMENT

Protects against irritation of urine and excrement; markedly inhibits ammonia-producing bacteria; soothes, lubricates, stimulates healing.

For samples of Desitin Ointment, pioneer external cod liver oil therapy, write...

DESITIN CHEMICAL COMPANY
812 Branch Avenue, Providence 4, R. I.

How Something for Nothing Legislation Hurts Those Who Are Supposed to Benefit

THE PART-TIME JOBS at many stores, filling stations and restaurants which have helped high school and college students earn money may soon be part of history. Many full-time jobs of this sort may disappear as well.

These jobs, and many others in "service" companies—like filling stations, taxi companies and laundries—may soon be slated for extinction if new minimum wage proposals in Congress are made law and the predictions of some economists are borne out.

The extinction of these jobs will leave fewer spots for young people to start careers, fewer spots for older people to augment pensions, fewer spots for many people to earn entire livings.

Why should this concern us here in Indiana?

Of course the disappearance of such jobs means more expense for parents and those who help older people. But there's more to it than that.

Historically, whenever the prices have been raised artificially the public has not been able to buy the goods available. When the government raised farm prices to more than the goods were worth it had to find money to buy what farmers couldn't sell. It did this through taxes on incomes and products.

Predicted Results if Law Passes

If prices are raised on certain jobs not now covered by minimum wage laws it is expected by many experts that few businesses will be able to afford those jobs and we may have to solve this problem as we solved the farm surplus problem—with government help.

This will mean more taxes on incomes which will lower buying power and more taxes on products which will increase prices.

The first of a series of articles prepared jointly by the Chamber of Commerce of the United States and members of the International Council of Industrial Editors.

And all this will hurt still other jobs, including ours here in Indiana.

Who will be responsible for all of this woe that some experts foresee?

In one sense, the answer is "All of us!"

For some reason, most of us tend to approve legislation which seems to give people "something for nothing." We vote for people who appear to be trying to give everybody more money just by passing laws. We don't think too seriously about the effect of such laws.

Our lawmakers know this failing of ours, and, since this is an election year, it may explain why there are so many proposals in Congress to increase the national minimum wage and to have the Minimum Wage Law cover more and more occupations.

Most of us never think about the Minimum Wage Law very seriously because the law doesn't seem to concern us. After all, if our pay is higher than the law requires, we don't seem to be affected; and if someone else gets a raise without working for it, because of a higher minimum wage law, isn't that good?

And what about people in occupations not covered by the current law? Wouldn't it be good if they got a raise without working for it?

Well, how about that? Let's see:

If proposals to increase the minimum wage to $1.25 per hour and to make it apply to many uncovered occupations go through, we might hear the following in any small city or town:

"I'm sorry, Charlie. I've got to let you go. I just can't pay you the $1.25 per hour the law requires. It's not you. It's just that the job isn't worth $1.25 per hour. I tried to raise prices to pay you and the others, but you know how our business dropped. Maybe they've got enough volume some places to pay the minimum, but we haven't got it here. I've got to let you and four others go."

Continued

For topical infections, choose a 'B. W. & Co.'® 'SPORIN'...



Each gram contains:
'Aerosporin'® brand Polymyxin B Sulfate 5,000 Units
Zinc Bacitracin ..... 400 Units
Neomycin Sulfate ..... 5 mg.
Hydrocortisone .....(1%) 10 mg.
in a special petrolatum base.



Each gram contains:
'Aerosporin'® brand Polymyxin B Sulfate 5,000 Units
Neomycin Sulfate ..... 5 mg.
Zinc Bacitracin ..... 400 Units
in a special petrolatum base.



Each gram contains:
'Aerosporin'® brand
Polymyxin B Sulfate ..... 10,000 Units
Zinc Bacitracin ..... 500 Units
in a special petrolatum base.

BURROUGHS WELLCOME & CO. (U.S.A.) INC., Tuckahoe, N. Y.

Something for Nothing

Continued

"But the work has to be done, Mr. Jones."

"I know it has to be done. I'll have to do it myself—maybe by cutting the size of the business and letting others go. I don't have a choice. The law tells me what I must pay—and I can't pay it."

And then Charlie asks: "Well, they can't expect you to pay the same wages here that they pay in higher cost places or big business locations, can they? I don't need any more than you paid me before."

Doesn't Consider Economical Climate

"Charlie, it's not between you and me. The law says what I must pay. It doesn't say anything about whether I'm in a city or a small town, or whether you do work that's worth the minimum wage. We're stuck. Both of us. I'm sorry."

Charlie's sorry, too.

But the rest of us should be just as sorry. By allowing "something for nothing" legislation to take place, we have been responsible for all of the sad results and, in the long run, we will pay for these results in taxes, in unemployment and—worse still—more inflation.

The sad fact is: Attempts to legislate higher wages do nothing but hurt—seriously—the very people the law is aimed at helping.

This is not false guessing. When the United States Congress made a law requiring certain employers to pay at least $1.00 an hour, many employees who could not produce a dollar's worth of value in an hour—perhaps because the work just wasn't worth $1.00 an hour—were released. They either found employment elsewhere or went without jobs—earning nothing, living on public benefit.

But then many employers may support jobs worth 90¢ or $1.00 an hour and pay $1.25 per hour for them.

If employers are forced to pay more for their manpower and still hold employees, they will be forced to charge more for what they produce. This applies not only to the business primarily affected by the law. The companies that buy goods from these businesses will have to charge more, too. And then the people who . . . and on it goes.

You may want your representative and senators in Washington to know how you feel about Federal intervention in local wages. To write him address the Senate Office Building and/or the House Office Building, Washington, D. C. ◄

About Our Cover

Our July cover, we feel, conjures up the essence of summer in Indiana. The hedgerows lush with wild roses and flowering vines, green fields of corn appearing to grow still taller before one's very eyes, the sleepy slowmoving creeks inviting one to relax . . . and maybe fish awhile. . . . Over all this lovely countryside dart and flicker some of nature's most beautiful insects, the varicolored butterflies. Strange to reflect that these ephemeral beings should develop from the creeping caterpillars which ravage the garden shrubbery, and against which the gardener wages a constant war.

Nighttime, too, brings its share of fluttering wings—not the brightly irridescent colors of the day, but the softer muted shades of the moths. How pleasant to sit on the porch after a long and exacting day and see, maybe, the large Luna moth circling the garden with its slow, and seemingly lazy, flight; a shame that those delicate wings will soon be tattered and torn from beating fruitlessly against a lighted window.

The breath of summer depicted on our cover was supplied to us through the courtesy of The Champion Paper and Fibre Company, manufacturers of our cover stock, Kromekote® paper.—M.F.

Raise the Pain Threshold

WITH MAXIMUM SAFE ANALGESIA

Phenaphen with Codeine provides intensified codeine effects with control of adverse reactions. It renders unnecessary (or postpones) the use of morphine or addicting synthetic narcotics, even in many cases of late cancer.

Three Strengths —

PHENAPHEN NO. 2
Phenaphen with Codeine Phosphate ¼ gr. (16.2 mg.)

PHENAPHEN NO. 3
Phenaphen with Codeine Phosphate ½ gr. (32.4 mg.)

PHENAPHEN NO. 4
Phenaphen with Codeine Phosphate 1 gr. (64.8 mg.)

Also —

PHENAPHEN **In each capsule**

Acetylsalicylic Acid 2½ gr. . (162 mg.)
Phenacetin 3 gr. . . . . (194 mg.)
Phenobarbital ¼ gr. . . . . (16.2 mg.)
Hyoscyamine sulfate . . . . . (0.031 mg.)

PHENAPHEN® WITH CODEINE

Robins

A. H. ROBINS CO., INC., RICHMOND 20, VIRGINIA

Ethical Pharmaceuticals of Merit since 1878

Excerpts from an address prepared for delivery by a member of the Senate Judiciary Committee, at the Iowa Pharmaceutical Association's annual convention, Cedar Rapids, Iowa, March 8, 1960.

What is a Congressional Investigation? The Drug Industry's Trial—By Publicity

SEN. ALEXANDER WILEY

Wisconsin

I CONSIDER it a privilege to come and visit with the members of the pharmaceutical association. For you are not only the dispensers of medications and the suppliers of numerous sundry items for the American home, you also are the high priests of that original American invention—the corner drugstore.

The British may have their pubs, the central Europeans their coffee houses, the Far-Easterns their tea houses, but the American social center is the drugstore—where youngsters and oldsters alike stop to catch their breath, and refresh themselves over coffee, milk shakes and conversation.

Today, I want to talk to you about Congressional investigations—a topic that may have seemed somewhat remote and abstract to you a few months ago. Yet now that the Senate drug investigation, conducted by the Senate subcommittee of which I am a member, has made national headlines—you are in the middle of the puddle, too, so to speak.

It is true that these hearings are directed to the drug manufacturers—not the retail pharmacists. Indeed, we all know that you—with your long hours and the large and expensive inventories—are far from being fortune makers. Yet in the minds of some, your fortunes are somehow linked with those of the drug manufacturers. Consequently, you—who come in direct contact with the ailing and unhappy buyer—may be unjustly blamed for drug prices over which you have no control.

Moreover, Congressional investigations should be of concern to you not merely because in this particular instance you yourselves are interested parties. The conduct of Congressional business, like the conduct of our courts of justice, is a subject of direct interest to all citizens—for it is our basic liberties that are at stake. Every case in which *justice is miscarried,* every investigation in which the *investigators are carried away*—opens the door for the abuse of your rights and mine.

What Is an Investigation?

In the history of mankind none are more outstanding than the great law givers—Hammurabi, Moses, Buddha, Mohammed. Each nation and race has its own claim to divine law. Moses, the *Bible* tells us, spent 40 days and 40 nights in the utter solitude of Mount Sinai—and when he descended he carried with him the tablets of the law.

But we no longer have Mount Sinai, or the necessary 40 days of solitude or a Moses, for that matter. The process of law making, nowadays, is no longer within the domain of a few inspired law givers.

History has shown us that the best law is the one which is based upon the most widespread human knowledge and proper ascertainment of the facts. A rule made by one man is not nearly



Beating too fast?

Slow it down with SERPASIL®

(reserpine CIBA)

Serpasil has proved effective as a heart-slowing agent in the following conditions: mitral disease; myocardial infarction; cardiac arrhythmias; neurocirculatory asthenia; thyroid toxicosis; excitement and effort syndromes; cardiac neurosis; congestive failure. Serpasil should be used with caution in patients receiving digitalis and quinidine. It is not indicated in cases of aortic insufficiency.

SUPPLIED: Tablets, 0.1 mg., 0.25 mg. (scored) and 1 mg. (scored). Complete information available on request.

CIBA

SUMMIT • NEW JERSEY

2/2819MB

Investigation

Continued

so good as the rule a man would make after consultation with those who are intimately acquainted with the situation.

The making of laws—which is the business of Congress—is not an easy undertaking. Much raw material, a great deal of work, sweat and care are necessary in order to produce what may appear, to the casual observer, as a small quantity of annual legislation.

During the first session of the 86th Congress, a total of 13,837 bills and resolutions were introduced in the House and the Senate. Of these, only 619 were enacted in the first session. Usually only five to 10% of the bills introduced eventually become law.

The major job of screening legislation belongs to the committees and subcommittees of Congress. Early in the history of the Congress, a special *ad hoc* committee was set up to dispose of each bill introduced into the National Legislature. In the third Congress, there were thus 350 select committees. Now Congress operates through standing committees which have specific subject matter jurisdiction. The so-called "Kefauver Committee" conducting the drug investigation is in fact the Antitrust and Monopoly Subcommittee of the Senate Judiciary Committee.

It has been rightly said that ours is a "government by committees." Probably better than 90% of the legislative groundwork—the research, the testimony on bills, the personal interviews, the special investigations, the debating, the weighing of factors, the compromising and redrafting take place not in the Senate or House of Representatives chambers—but in their workshops, the standing and special committees.

In carrying out legislative functions, the investigatory power is a major tool. The power to investigate provides the legislature with eyes, with ears and with a thinking mechanism. The investigations provide Congress with an orderly means for absorbing the knowledge, experience and statistical data necessary for legislation in a complex democratic society.

Nowhere in the Constitution did the founding fathers expressly provide for investigations by Congressional committees. It has been said that like Topsy, the institution of Congressional investigations "just growed." As early as 1792, the House of Representatives called for the first known investigation—to inquire into the failure of a military expedition under Maj. Gen. St. Clair against marauding Indians in Ohio and Indiana. Ever since, the power of investigation has been considered a necessary adjunct of the legislation.

Of all Congresses, the 82nd Congress earned for itself the title of "The Investigatingest Congress." The 82nd alone conducted 236 investigations in two years and spent about four million dollars on them.

But the present Congress need concede nothing to the 82nd Congress when it comes to investigating. During the first session of the 86th Congress, committees were authorized to spend almost nine million dollars for investigations. This year, the Subcommittee on Antitrust and Monopoly alone—conducting the drug hearings—will receive $425,000 for investigations. This is the largest single appropriation for a probe in Congress.

What has the antitrust and monopoly subcommittee done with this appropriation? It has

Continued on page 1370

Yes Doctor

I am happy, thankful and glad you sent me and my family to Heid's for correct shoes—this eliminates one of our handicaps.



HEID'S 50th Year

Shoes for Men, Women, Children

411 N. Illinois, Indianapolis

Phone MElrose 5-4247 Drive-In Parking

when "Pollen Polly" rides the wind...

Triaminic®

...relief from pollen allergies

more complete than antihistamines alone... more thorough than nose drops or sprays

The miseries of respiratory allergy can be relieved so effectively with Triaminic.[1-5] Triaminic contains two antihistamines plus the decongestant, phenylpropanolamine, to help shrink the engorged capillaries, reduce congestion and bring relief from rhinorrhea and sinusitis.[1] Oral administration distributes medication to *all* respiratory membranes without risk of "nose drop addiction" or rebound congestion.[2,3]

Each Triaminic timed-release Tablet provides:

Phenylpropanolamine HCl	50 mg.
Pheniramine maleate	25 mg.
Pyrilamine maleate	25 mg.

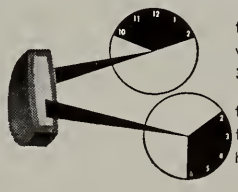
also available:

TRIAMINIC JUVELETS® ½ the formulation of the Triaminic Tablet with timed-release action.

TRIAMINIC SYRUP each teaspoonful (5 ml.) provides ¼ the formulation of the Triaminic Tablet.

References: 1. Fabricant, N. D.: E. E. N. T. Monthly 37:460 (July) 1958. 2. Lhotka, F. M.: Illinois M. J. 112:259 (Dec.) 1957. 3. Farmer, D. F.: Clin. Med. 5:1183 (Sept.) 1958. 4. Fuchs, M.; Bodi, T.; Mallen, S. R.; Hernando, L., and Moyer, J. H.: Antibiotic Med. & Clin. Ther. 7:37 (Jan.) 1960. 5. Halpern, S. R., and Rabinowitz, H.: Ann. Allergy 18:36 (Jan.) 1960.

Relief is prompt and prolonged because of this special timed-release action



first—the outer layer dissolves within minutes to produce 3 to 4 hours of relief

then—the core disintegrates to give 3 to 4 more hours of relief

SMITH-DORSEY • A DIVISION OF THE WANDER COMPANY • LINCOLN, NEBRASKA

Continued

been investigating the insurance business, steel prices, professional sports, the price of bread and—what you are most familiar with—the drug industry.

The Drug Probe

Concluding his testimony before a recent hearing of the antitrust subcommittee, one of the drug company executives thanked the chairman for the opportunity to present his testimony "at this trial." The chairman corrected the witness and called his attention to the fact that this was a "hearing," not a "trial"; to which the latter responded: "I would have had a much easier time before a judge."

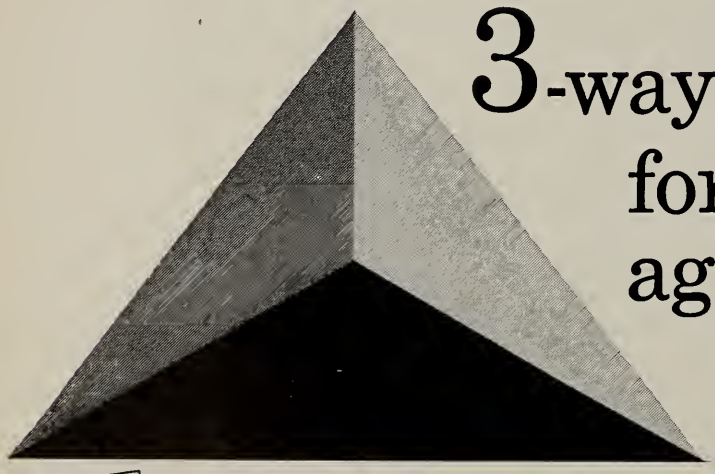
In this exchange lies the essence of my concern for the conduct of these hearings. What is the purpose of these hearings? How far can the subcommittee go? How can we assure that the legitimate interests and legal rights of American citizens and American business not be abused?

The drug hearings were launched after two years of preparation. Ostensibly they are directed to determine whether monopolistic practices exist in the drug industry—and whether new legislation is necessary in order to protect the interest of free enterprise. Commenced on Dec. 7, 1959, the investigation has this far dealt with steroid hormones and with tranquilizers. Antibiotics and vitamins are two of the pharmaceutical products next on the list.

If the purpose of these hearings is to uncover monopolistic practices, the record certainly gives little indication of success. I sat through many of the hearings myself, and I can assure you that I obtained quite an education. Some of the Senators present said they felt that they would be entitled to a medical degree after completing the course. (Interestingly enough, nothing was said about diplomas in pharmacy—so you need not fear any Senators applying to join your professional ranks.)

We found out all about detailmen, patents, medical history and pre-history, quacks, executive salaries, stock appreciation, quality controls, new drug applications, government bids, foreign sales, advertising, merchandising and retailing. By the time the hearing was over we had covered the whole 40-acre lot. What we heard touched

Continued



3-way support for the aging patient...

ASSISTS PROTEIN UPTAKE
IMPROVES MENTAL OUTLOOK
AIDS NUTRITIONAL INTAKE

NEW

1 small capsule every morning

GEVRESTIN®

Geriatric Vitamins-Minerals-Hormones-d-Amphetamine Lederle

Each capsule contains: Ethinyl Estradiol 0.01 mg. • Methyl Testosterone 2.5 mg. • d-Amphetamine Sulfate 2.5 mg. • Vitamin A (Acetate) 5,000 U.S.P. Units • Vitamin D 500 U.S.P. Units • Vitamin B_{12} with AUTRINIC® Intrinsic Factor Concentrate 1/15 U.S.P. Unit (Oral) • Thiamine Mononitrate (B_1) 5 mg. • Riboflavin (B_2) 5 mg. • Niacinamide 15 mg. • Pyridoxine HCl (B_6) 0.5 mg. • Calcium Pantothenate 5 mg. • Folic Acid 0.4 mg. • Choline Bitartrate 25 mg. • Inositol 25 mg. • Ascorbic Acid (C) as Calcium Ascorbate 50 mg. • l-Lysine Monohydrochloride 25 mg. • Vitamin E (Tocopherol Acid Succinate) 10 Int. Units • Rutin 12.5 mg. • Ferrous Fumarate (Elemental iron, 10 mg.) 30.4 mg. • Iodine (as KI) 0.1 mg. • Calcium (as $CaHPO_4$) 35 mg. • Phosphorus (as $CaHPO_4$) 27 mg. • Fluorine (as CaF_2) 0.1 mg. • Copper (as CuO) 1 mg. • Potassium (as K_2SO_4) 5 mg. • Manganese (as MnO_2) 1 mg. • Zinc (as ZnO) 0.5 mg. • Magnesium (MgO) 1 mg. • Boron (as $Na_2B_4O_7.10H_2O$) 0.1 mg. Bottles of 100, 1000.

LEDERLE LABORATORIES, a Division of AMERICAN CYANAMID COMPANY, Pearl River, New York Lederle



"NO ONE'S GOING TO PULL THE WOOL OVER OUR EYES — WE KNOW BLUE SHIELD IS THE BEST DEFENSE AGAINST SOCIALIZED MEDICINE!"



Blue Shield

Mutual Medical Insurance, Inc.
110 N. Illinois St., Indianapolis 9, Ind.
Phone MElrose 5-9411

Sponsored by the Indiana State Medical Association

little on monopoly. It sounded more like a hearing designed to set up price controls.

What we heard, however, made big, damning headlines the country over. The headlines did not reflect the facts—they were produced by one-sided statistical and accounting manipulations. They announced to the unsuspecting reader the evil doings of the drug makers who supposedly collected profits of 1000, 2000 and up to 10,000%.

Called Bluff in Fourth Session

This type of manipulated "fact-finding" went on for three sessions. Only on the fourth session, under my insisting cross-examination, was the bluff called. There were no 1000 or 2000% profits in the industry; there were, instead, profits averaging 13% of sales and dividends to stockholders amounting to five or six percent.

Figures of tremendous profits are easy to manufacture. All you have to do is to select a few isolated examples and present them as proof of the total truth. Yet to judge a total drug operation by profits from one successful product, out of 500, is misleading. And to say that a manufacturer makes an unconscionable profit of several hundred percents because there is a big markup between the cost of the raw material and the final cost of the product to the consumer, is not overly accurate.

I can assure you that accuracy and truthfulness are not easy to come by, especially when the whole battery of subcommittee attorneys, economists and investigators are on the other side. I felt it my duty to insist on facts, but my campaign to bring out the facts was not welcome everywhere. One of the biggest newspapers in my own state of Wisconsin—and I don't mean big in terms of broad-mindedness or responsibility, I am merely referring to its circulation—was so incensed that it devoted an editorial to me. "Senator Wiley," it said, "should represent more the interests of the people" and again, "Senator Wiley sounds like the spokesman of the drug industry."

I am your guest here this afternoon, and you have been very kind hosts. Yet I feel it is my duty to inform you that I do not consider myself a special advocate for you, the drug industry, or any other special interest. What I have done, and shall do again on your behalf, I shall do in any other case where the rights of the American people—their life, liberty and property—are unjustly and improperly interfered with.

Uses and Abuses of Investigations

Let me assure you and my Democratic colleagues on the Subcommittee: I am not against Congressional investigations. Just to prove how non-partisan this address is, I shall even agree with ex-President Truman, who said that "the days are gone forever when Webster, Clay and Calhoun personally could familiarize themselves with all major matters with respect to which they were called upon to legislate." American society and government have become so complex that Congress can perform its function only by resorting to the investigatory process.

Still, the phenomenal growth in the use of the investigating committees cannot be ascribed alone to this greater complexity. I fear there is more than a kernel of truth in the charge that Congressmen have discovered that participation in well publicized investigations of unpopular causes and unpopular peoples is a shortcut to

The Norbury Sanatorium

Established 1901 — Incorporated
Licensed — Jacksonville, Illinois

FRANK GARM NORBURY, A.M., M.D., Medical Director
HENRY A. DOLLEAR, M.D., Superintendent
FRANK B. NORBURY, M.D., Physician

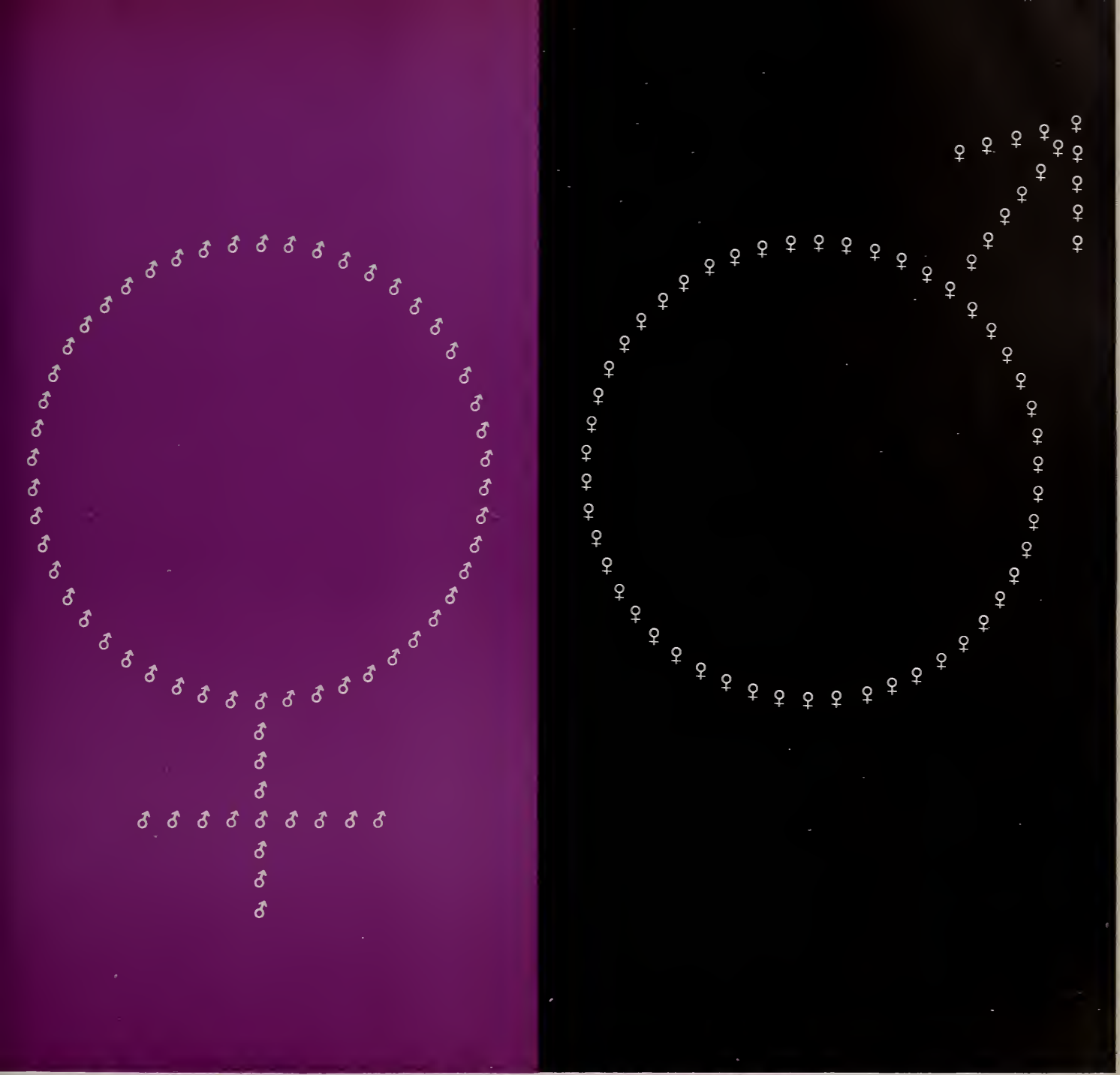
Operating

Maplecrest—

Restful, congenial, homelike surroundings are combined with the most modern diagnostic and therapeutic equipment.

Maplewood—

Most comfortable home for individuals requiring rest, scientific diagnosis and treatment. Fireproof construction.



GONORRHEA IS ON THE MARCH AGAIN...

a new timetable for recovery:

only six capsules of TETREX can cure a male patient with gonorrhea in *just one day

Tetrex®

U.S.PAT.NO.2,791,609

THE ORIGINAL TETRACYCLINE PHOSPHATE COMPLEX

TETREX CAPSULES. 250 mg. Each capsule contains: TETREX (tetracycline phosphate complex equivalent to tetracycline HCl activity) — 250 mg.

DOSAGE: Gonorrhea in the male — Six capsules of TETREX in 3 divided doses, in one day.

* Marmell, M., and Prigot, A.: Tetracycline phosphate complex in the treatment of acute gonococcal urethritis in men. Antibiotic Med. & Clin. Ther. 6:108 (Feb.) 1959.

BRISTOL

BRISTOL LABORATORIES,
SYRACUSE, NEW YORK

Investigation

Continued

fame and political fortune. Even before the advent of television a host of investigators won national acclaim. With television and radio to publicize hearings, Congressional investigators can now win acclaim even more quickly.

One carefully examining the records of many recent Congressional hearings will discover that investigations have not been used merely to secure information for legislative purposes. They have at times been improperly employed to punish individuals without a judicial trial or to perform in an extra-legal way what Congress cannot do legally.

Some investigations have plainly had the purpose of exposing and punishing individuals by public ridicule and embarrassment. And I can assure you that the abuse of the investigatory process has not been a monopoly of conservative or reactionary witch-hunters. In fact, one of my so-called "liberal" colleagues on the drug investigation proudly reported a few years back that during one of his hearings (and I quote my illustrious colleague), "the witness under the relentless questioning of the committee's chief counsel . . . broke down and became an old, beaten man. He grimaced, scowled, showed his teeth, mocked his face and stared at the ceiling in anguish. His grammar failed him and he garbled his words, 'I ask you: is this fact-finding or is this meting out of punishment?'"

That Congress can act as a super Grand Inquisition—in the infamous Spanish tradition—has been demonstrated on several occasions. In 1936 the House of Representatives decided to combat the growing power and influence of the Townsend movement. Yet, it was not within the Congressional power to outlaw the movement. Instead, Congress investigated him and probably dealt his cause a severe blow in the ensuing investigation.

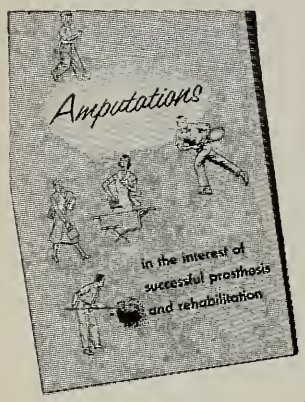
It is against such investigatory excesses that we must constantly keep vigil. We must remember, also, that to the proposition that politicians are too inclined to use investigations for personal political gain, there is a corollary that you as a people have been too willing to let them do so.

Although Congressional investigations have been under vigorous attacks for at least 25 years, the public has generally approved the investigations while they were in progress. For such investigations give the public, unfortunately, the too easy escape of putting the blame for all public and private difficulties and unhappiness on a few selected scapegoats, whether guilty or not.

Much too often, both the public and its politicians have been willing, in their heat of reforming passion, to sacrifice the principles of government by law for the attainment of desired immediate results. Unwittingly we subscribe to the Machiavellian theory that "the end justifies the means." The prices of drugs are too high, some feel, so if the drug industry is harassed some good may come. We become so concerned and emotionally upset over the nefarious activities of communists, munitions makers, racketeers or whomever, that it seems much more important to us to meet present evils than to stoutly defend our liberties.

It is at such times that I must stand up and warn: hold off! Several years ago, in discussing this same topic, I warned: "Let us remember—

Continued



New
AMPUTATION
BOOKLET

A concise reference regarding amputations, prostheses and the rehabilitation of the amputee, is now available. It has been written under the supervision of an eminent orthopedic surgeon and incorporates the experience gained by the Hanger organization from supplying Prostheses for nearly 100 years. Charts and drawings and information about the care and fitting of the amputee, are presented. Write or phone the Hanger office nearest you for your copy of the Amputations Booklet.

AIR-CONDITIONED OFFICES
Hanger PROSTHESES
1529-33 N. ILLINOIS ST., INDIANAPOLIS 2, IND.
3108 BURNET AVENUE, CINCINNATI 29, OHIO
FAIRFIELD AT PONTIAC, FORT WAYNE, IND.
418 N. MAIN ST., EVANSVILLE, IND.



SERENE SURROUNDINGS

ACCREDITED PSYCHIATRIC HOSPITAL FOR PRIVATE DIAGNOSIS AND TREATMENT

Approved by the Joint Commission on Accreditation of Hospitals.

Equipped to provide latest acceptable methods of treatment, including Out-Patient Pavilion.

Ample classification facilities with qualified psychiatric nursing.

Full occupational therapy and recreational activities.

Forty acre estate to assure privacy in a restful setting.

write to the address below for new illustrated brochure

WILLIAM E. HILLARD, M.D.
Medical Director

CHARLES W. MOCKBEE, M.D.
Associate Medical Director

ISABELLE DAULTON, R.N.
Director of Nursing

GRACE SPINDLER, R.N.
Associate Director of Nursing

ELLIOTT OTTE
Business Administrator

CHARLES M. CLIFFE
Associate Business Administrator



THE EMERSON A. NORTH HOSPITAL, Inc.
(Founded 1873)

5642 HAMILTON AVENUE, CINCINNATI 24, OHIO
Telephones: KIrby 1-0135 KIrby 1-0136

Investigation

Continued

today the victims of legislative usurpation are subversives, gamblers and corrupt officials. Tomorrow they may be Republicans or Democrats, corporate executives, and honest public servants trying to do their duty." This, as you can see, has not been an idle warning.

Call for Legislative Due Process

The screaming headlines telling of 10,000% profits in the drug industry created the impression—whether intentionally or not—of an industry run by unconscientious profiteers to whom individual suffering is of no concern. Oftentimes, these hearings constituted, in fact, a public trial of the industry—a trial conducted not in the established traditions of due process, but a trial by publicity—where propaganda counts more than facts.

In undertaking such trials the subcommittee has been doing exactly what the founding fathers sought to prevent by setting forth in the Constitution the specific prohibition against bills of attainder. "A bill of attainder," the Supreme Court said, "is a legislative act, which inflicts punishment without a judicial trial. . . . In these cases the legislative body, in addition to its legitimate functions, exercises the powers and office of a judge; it assumes, in the language of the text book, judicial magistracy, it pronounces the guilt of the party, without any of the forms and safeguards of trial; it determines the sufficiency of the proofs produced whether conformable to the rules of evidence or otherwise."

In this trial by investigation of the drug industry, little attention was paid to the balancing arguments of the defense:

—The public attention was constantly directed to profits on a single product of a single company—without relating these to the many thousands of products produced by the entire industry, or the overall costs of doing business;

—Hardly any reference was made to the high risks of this industry, which in 1958 had to test 114,600 substances before it could produce 40 marketable drugs;

—Little reference was made to the high degree of obsolescence in the drug industry—where one product can have 99% of the market one year, and only three percent two years later;

—No mention was made of the fact that while wages increased 70% between 1948 and 1958, and construction costs 64%—the increase in the wholesale drug prices was three percent only;

—No mention was made of the fact the Soviet Union, in which the profit motive does not exist, produced no single new drug since the Communist revolution;

—And this being a monopoly investigation, it is surprising that nobody bothered to emphasize that more than 1,300 companies are engaged in the manufacturing of prescription drugs—with no one company accounting for as much as 10% of the total sales.

Let me repeat, in concluding, that I believe in Congressional fact-finding. But I am, and shall remain, opposed to trial by investigation. I undertook to guard against abuses of legislative investigatory powers in the drug hearings. I feel it incumbent upon myself to continue doing so—in this or any other investigation. I shall constantly call the attention of my colleagues to the need for legislative responsibility, due process, vigilance and self-restraint. Investigating committees must stay within the boundaries of their jurisdiction, and they must pursue fact, not fancy.

Investigators "Police" Themselves

The Congressional investigator has tremendous powers. The courts have been reluctant to interfere with the exercise of legislative investigations. The Supreme Court has held that "Within the realm of legislative discretion, the exercise of good taste and good judgment in

Postgraduate course in

"Heart Disease—with Emphasis on newer Diagnostic Techniques—Medical and Surgical Management"

September 7-8-9-10, 1960

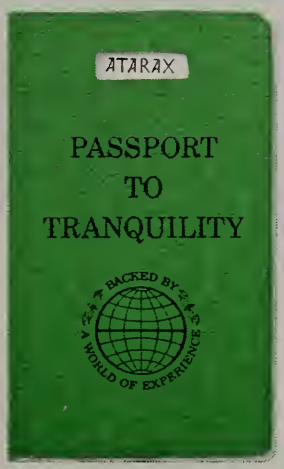
Cardiac Laboratory, Cincinnati General Hospital

Limited to 75

FEE: $75 payable to Cardiac Laboratory
University of Cincinnati

A GUIDE TO

THE REALMS OF THERAPY BEST ATTAINED WITH



ATARAX®

(brand of hydroxyzine)

World-wide record of effectiveness—over 200 laboratory and clinical papers from 14 countries.
Widest latitude of safety and flexibility—no serious adverse clinical reaction ever documented.
Chemically distinct among tranquilizers—not a phenothiazine or a meprobamate.
Added frontiers of usefulness—antihistaminic; mildly antiarrhythmic; does not stimulate gastric secretion.

Special Advantages	Supportive Clinical Observation	...and for additional evidence
IN CHILDREN unusually safe; tasty syrup, 10 mg. tablet	"...Atarax appeared to reduce anxiety and restlessness, improve sleep patterns and make the child more amenable to the development of new patterns of behavior...." Freedman, A. M.: Pediat. Clin. North America **5**:573 (Aug.) 1958.	Bayart, J.: Acta paediat. belg. **10**:164, 1956. Ayd, F. J., Jr.: California Med. **87**:75 (Aug.) 1957. Nathan, L. A., and Andelman, M. B.: Illinois M. J. **112**:171 (Oct.) 1957.
IN ELDERLY PATIENTS well tolerated by debilitated patients	"...seems to be the agent of choice in patients suffering from removal disorientation, confusion, conversion hysteria and other psychoneurotic conditions occurring in old age." Smigel, J. O., et al.: J. Am. Geriatrics Soc. **7**:61 (Jan.) 1959.	Settel, E.: Am. Pract. & Digest Treat. **8**:1584 (Oct.) 1957. Negri, F.: Minerva med. **48**:607 (Feb. 21) 1957. Shalowitz, M.: Geriatrics **11**:312 (July) 1956.
IN ALLERGIC PATIENTS useful adjunctive therapy for asthma and dermatosis; particularly effective in urticaria	"All [asthmatic] patients reported greater calmness and were able to rest and sleep better...and led a more normal life....In chronic and acute urticaria, however, hydroxyzine was effective as the sole medicament." Santos, I. M., and Unger, L.: Presented at 14th Annual Congress, American College of Allergists, Atlantic City, New Jersey, April 23-25, 1958.	Eisenberg, B. C.: J.A.M.A. **169**:14 (Jan. 3) 1959. Coirault, R., et al.: Presse méd. **64**:2239 (Dec. 26) 1956. Robinson, H. M., Jr., et al.: South. M. J. **50**:1282 (Oct.) 1957.
IN HYPEREMOTIVE ADULTS does not impair mental acuity	"...especially well-suited for ambulatory neurotics who must work, drive a car, or operate machinery." Ayd, F. J., Jr.: New York J. Med. **57**:1742 (May 15) 1957.	Garber, R. C., Jr.: J. Florida M. A. **45**:549 (Nov.) 1958. Menger, H. C.: New York J. Med. **58**:1684 (May 15) 1958. Farah, L.: Internat. Rec. Med. **169**:379 (June) 1956.

SUPPLIED: Tablets, 10 mg., 25 mg., 100 mg.; bottles of 100. Syrup (10 mg. per tsp.), pint bottles. Parenteral Solution: 25 mg./cc. in 10 cc. multiple-dose vials; 50 mg./cc. in 2 cc. ampules.

Rx PFERIG

New York 17, N. Y.
Division, Chas. Pfizer & Co., Inc.
Science for the World's Well-Being

INDIANA STATE BOARD OF HEALTH

Monthly Report—May, 1960

Disease	May 1960	Apr. 1960	Mar. 1960	May 1959	May 1958
Animal Bites	667	633	340	648	316
Chickenpox	467	548	885	346	444
Conjunctivitis	153	130	190	114	70
Diphtheria	1	0	1	1	0
Dysentery, Unspecified	10	25	121	14	6
Impetigo	90	84	70	70	17
Infectious Hepatitis	58	77	143	23	23
Infectious Mononucleosis	30	20	23	18	15
Influenza	437	781	3720	498	125
Measles (Rubeola-Rubella)	1984	2028	1835	759	4527
Meningitis, Meningococcal	2	5	3	2	6
Meningitis, Other	16	12	6	8	6
Mumps	445	441	600	299	734
Pertussis	37	38	28	91	164
Pneumonia	175	159	286	156	100
Poliomyelitis	0	1	1	3	1
Streptococcal Infections	692	1098	1501	495	453
Tinea Capitis	43	39	19	9	12

Investigation

Continued

the examination of witnesses must be entrusted to those who have been vested with authority to conduct such investigations." We, members of Congress, are therefore to a large degree our own policemen.

But I ask you: If the policeman himself scoffs the law, who is there left to protect the basic liberties of American citizens and business?

As you get ready to adjourn and to return to your own communities, businesses, drugstores, I want you to carry with you one final thought: Let these trials of the drug industry not be in vain. Let us all utilize this opportunity for the constant self-searching and stock-taking that are necessary for a society that believes in progress. I have pledged before you to tend to the honest and unbiased execution of the business of Congress. Yet this does not relieve you of your responsibilities in this matter. As long as thousands of people in this country—old, indigent and sick—remain unable to pay the high prices of drugs, it is your moral responsibility, and the moral responsibility of all others connected with the health and welfare of the nation, to continue in your efforts to make medical care and attention available to all those that desire them, regardless of wealth and station.

We believe in free enterprise. But free enterprise does not mean selfishness—to me it means public cooperation, widespread moral responsibility and the constant striving for private and public improvements.

It was a great pleasure meeting with you—and I wish you the best of luck in your work and public service. Unfortunately, I am not planning on campaigning in Iowa, or else I would plan on stopping in your corner drugstore and having a cup of coffee, a coke, or preferably—a glass of milk with you. ◄

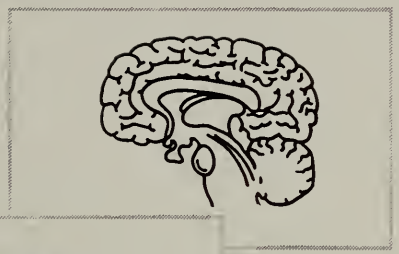
As a result of the Red Cross water safety instruction program, 3,273 Indianapolis people—both children and adults—learned to swim last summer. And more than two thousand more certificates were given to swimmers who completed advanced classes in swimming.

To keep an ever-expanding water safety program supplied with qualified instructors, the Indianapolis Area Red Cross trained 57 new swimming and water safety instructors. Some 280 persons completed the Senior Lifesaving course.



basic in the care of the aging

℞ Metalex®



when body tone, mental and sensory faculties begin to fade—*she's irritable, confused, forgetful, apathetic*



when vision begins to dim—*in loss of visual acuity, in loss of peripheral vision*



when voices begin to fade—*in loss of auditory acuity, in tinnitus*

Metalex® *cerebral stimulant/vasodilator*

The stimulant—pentylenetetrazol—facilitates cerebral and reflex nerve activity.

The vasodilator—nicotinic acid—augments blood and oxygen supply to vital areas—

Thus, METALEX increases body tone and aids mental and sensory faculties.

Composition: Each teaspoonful (5 ml.) of the Elixir and each Tablet contains: Pentylenetetrazol 100 mg., Nicotinic Acid 50 mg.

Dosage: One or two teaspoonfuls of the Elixir or one or two Tablets four times a day—one-half hour before meals and before bedtime.

Available: Elixir: Pint and Gallon bottles. Tablets: Bottles of 100 and 1000.

References: 1. Goodman, L. S. and Gilman, A.: The Pharmacological Basis of Therapeutics, 2nd Ed., New York, Macmillan Company, 1955. 2. O'Reilly, P. O., Demay, M. and Kotlowski, K.: Cholesteremia and Nicotinic Acid. A.M.A. Arch. Int. Med. 100:797-801 (Nov.) 1957.

STORCK Pharmaceuticals, Inc.,
2326 Hampton Blvd., St. Louis 10, Mo.



". . . There is a marvelous strange thing, that to better it and that it growe taller . . . it be sowne with curses and injurie done unto it. . . ."

BASIL

(Ocymiun Basilicam)

by Miki Wilson
San Francisco

This little herb, voyaged from India or Persia, was carried by sea-farers, merchants, Crusaders, princes and monks. It gathered unto itself many divergent uses as it traveled from the East, probably including its name, Basilicum, Greek for King.

Dioscorides warns against eating too much, for ". . . it dulleth the eyesight . . ." and "is hard of digestion." The latter is not only now disproved, but the good Dioscorides should have tried it on fresh tomatoes with olive oil.

From Pliny onward there have been those seekers after the relationship between all things to the stars, particularly plants astrologically associated with parts of the body. So we have the herbs of Mercury used in connection with the brain . . . for the breast and liver, only the herbs of Jupiter, like Balm and Asparagus, can be employed . . . or Bay and Angelica under the sun for the heart and vitals.

It becomes astronomically complicated, however, when we find Basil of Mars under Scorpion, along with Bedstraw. One wonders just what part of the anatomy is involved, since Basil is a well-known addition to love philters and is of great help in childbirth. The woman in labor must hold in her hand the root of Basil and a swallow's feather and she will be delivered without pain.

On the other hand, those who tend to headache should shun Basil, as it "begetteth paine and heaviness" and is known to have engendered

small worms in the brain "like unto scorpions." Obviously it is not an herb of Mercury.

The association between Basil and Bedstraw (Galium verum) is merely planetary, for Bedstraw is also found under Venus. But the many-named Bedstraw is as different in history, use and appearance as possible. Our Lady's Bedstraw (because it lined the manger) was in a more frivolous time called "Maid's Hair" and used as a hair dye, or "Cheese Rennet" when the yellow dye was used for coloring cheese. Its greatest claim to fame, other than its association with the manger, is in the preparation of a soothing foot-bath. Among the Germans, both ancient and modern, it is used in connection with disorders of the kidneys and is very favored in clearing the skin of impurities.

Basil, however, is of great help in alleviating nervous conditions of the stomach and liver, and for hyperacidity caused by the over-civilized mind unable to find external release from strain. A good teaspoonful of the freshly cut herb infused in one cup of boiling water for five or 10 minutes and taken after eating will aid considerably in relieving the internal effects of the pressures of modern society.

And one should bear in mind that Basil, given or received, symbolizes love . . . and poverty. ◄



"Oh come come, Sir, that was just a little Band-aid . . . now wait until I pull the plaster off!"

THE HARDING SANITARIUM

WORTHINGTON
OHIO

For the Diagnosis and Treatment of Psychiatric Disorders
and with
Limited Facilities for the Aging

GEORGE T. HARDING, M.D.
HARRISON S. EVANS, M.D.
Medical Directors

CHARLES W. HARDING, M.D.
Clinical Director

DONALD H. BURK, M.D.
GEORGE T. HARDING, Jr., M.D.
HERNDON P. HARDING, M.D.
C. RICHARD JOHNSON, M.D.
ARNOLD L. NIELSEN, M.D.
R. EUGENE PROUT, M.D.

GRACE M. COLLET, Ph.D.
VERNON W. SHAFER, Ph.D.
Clinical Psychologists

MARY JANE McCONAUGHEY, M.S.W.
BENJAMIN E. WHEATLEY, M.S.W.
Psychiatric Social Workers

PAULINE L. TOOILL, R.R.L.
Medical Record Librarian

JAMES L. HAGLE, M.B.A.
Administrator

ESTHER L. SIMPSON, R.N.
Director of Nurses

Phone: Columbus TUXEDO 5-5381

1960 Science Fair



DR. CARL L. LINCKE, representing AMA, presents awards for outstanding medical subject exhibits to Philip Bockman, Grand Rapids, Mich., and Brenda Lisle, Chattanooga, Tenn.

ONE WAS ABLE to travel a long way into the hidden frontiers of the space-age by touring the National Science Fair-International at Butler University Fieldhouse, Indianapolis, May 10-14.

The scientific world's newest ideas and problems were in the spotlight, as were some 356 teenage scientists from throughout the U. S. and seven foreign countries, creators of the colorful panorama of exhibits.

Each youngster participating in this, the 11th national annual event, represented some 1,875 exhibitors at regional and supplementary fairs.

It was a week of heartbreak and happiness . . . missed planes, late and damaged exhibits . . . awards totaling several thousands of dollars . . . and a whirl of social events including a barbecue, choice of city and industrial tours, awards banquets and mixers.

Visitors shook hands with a 120-pound robot that walked, talked, counted, grasped objects and contained a maze of 43 light bulbs and a quarter mile of wire. They saw a complete system that permits survival of animals on other plants and a telemetering system for an earth satellite.

Most important, they quickly sensed a determined spirit in this assembly of youngsters—teenagers with aggressive and questioning minds—preparing themselves to step into the adult world.

A 17-year-old Lafeyette, Ind., youth, James K. Bramblett, took four awards with his project "Ultraviolet Flying Spot Microscope," an ultraviolet microscope which scans living cells.

At the National Science Fair-International awards banquet, he received a National Navy Science Cruiser Award consisting of precision binoculars and an invitation for Navy Science Cruises next fall, a trip to the Army Ballistic Missile Agency, Huntsville, Ala., and an Air Force and Space Education Foundation citation. As electronics citation winner, he was selected to receive a plaque and an expense-paid trip to attend and exhibit at the annual Aerospace Panorama Exposition, San Francisco, Calif., Sept. 22-25, second honors and a $75 wish award.

Other Hoosier winners included Wayne Lee Settle, 17, Portland, Ind., "Mutations in German Millet Introduced by Gamma Radiation"; and James Harold Collins, 17, Evansville, "The Bubble Chamber—a Device Used to Study Subatomic Particles." Both won third place awards and $50 wishes.

Presentation of awards followed a talk by Dr. Paul A. Siple, scientific advisor, Army Re-

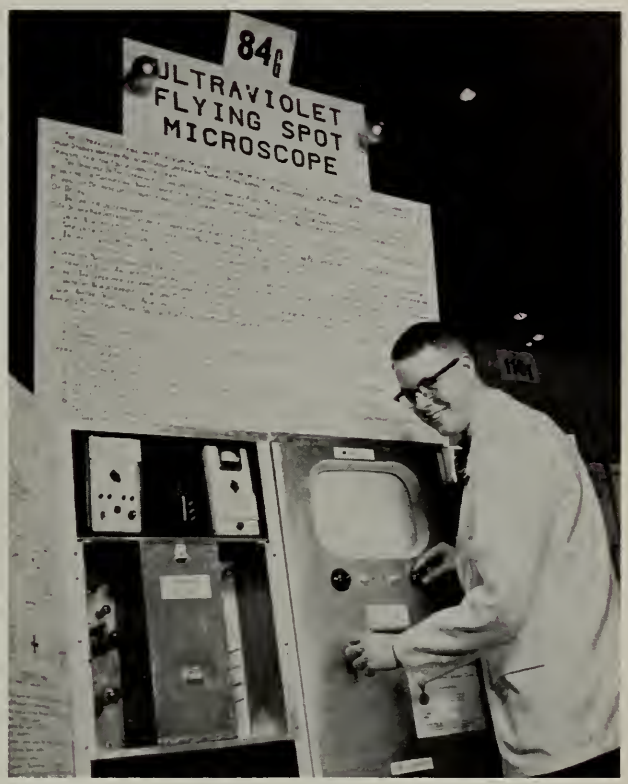
—Young Scientists Have Future Well in Hand

search Office and president of the Association of American Geographers.

At the special Health Awards Banquet, sponsored jointly by the AMA, American Dental Association, American Veterinary Medical Association, and American Pharmaceutical Association, awards were given for the best projects in the medical, dental, veterinary medical and pharmaceutical fields.

The top AMA citations were presented by Dr. Carl L. Lincke, chairman of the judges, and chairman of AMA's Council on Scientific Assembly. They went to Brenda Wright Lisle, 16, Chattanooga, Tenn., for "Effect of Radiation on Chick Embryos" and to Philip C. Bockman, 18, Grand Rapids, Mich., for "Construction and Insertion of a Prosthetic Tendon."

National Science Fair-International is an activity of Science Service, Washington, D. C. Arrangements for the fair at Indianapolis were made by a local committee. Representing ISMA were Dr. Harry Pandolfo, vice-chairman; Dr. Earl Mericle, tours and trips; and Mr. James A. Waggener, recreation and hospitality. ◄



LAFAYETTE'S James K. Bramblett, 17, and his four-award winning exhibit, "Ultraviolet Flying Spot Microscope."



THE HEALTH Awards Banquet. Youngsters were recognized for outstanding exhibits in the fields of medicine, dentistry, veterinary medicine and pharmacy.

Federal Employees Choose a Health Program

One in a series prepared by Blue Cross-Blue Shield.

During June some 32,000 federal employees living in Indiana will select a health program for themselves and their dependents. Each such employee, on an individual basis, will choose either Blue Cross-Blue Shield or a commercial insurance plan. Both plans offer two levels of benefits, a High Option and a Low Option. The high level provides coverage for longer stays in the hospital, bigger payments for surgical and medical care, higher maximums—and naturally costs more.

Hospital room and board charges are not the same in each Indiana community. They range from $9 to $23.50 a day for room and board in a 2-bed room. To furnish maximum protection throughout the state, the Blue Cross plan expresses its coverage by the number of days—not just so many dollars. The Low Option covers 30 days and the High Option 120 days. The commercial insurance plan makes a dollar allowance toward room and board—the first $250 plus 75% of the charges over that on the Low Option; the first $1,000 plus 80% over that on the High Option. These cash allowances will buy fewer hospital days in some parts of the state than in others, especially in the larger cities.

The same situation is true with regard to hospital "extras." The Blue Cross plan treats these extras as another part of the total hospital "package." All covered extras are provided without cost to the patient—30 days of extras in the Low Option and 120 days of extras in the High Option.

Under the Low Option commercial insurance plan, if the patient has not already satisfied the deductible, he must pay the first $50 of the extras, plus 25% of the remaining charges. Under the High Option the patient must pay the first $50, plus 20% of the remainder.

For surgical and medical expenses the Blue Shield plan will pay according to a national schedule of indemnities. In Indiana this national schedule in the Low Option approximates our Standard Schedule, and in the High Option approximates our Preferred Schedule. Blue Shield in-hospital medical care provides 120 days per confinement under the High Option, and 30 days under the Low Option.

The commercial insurance surgical and medical plan will pay doctors and surgeons a straight percentage of their fees. These plans will pay 80% of fees under the high option and 75% under the Low Option, providing the patient has already paid his $50 deductible on the hospital extras. If he hasn't he'll have to pay the first $50 of his physician's bill plus 25% (Low) or 20% (High) of the remainder. In no case will the whole doctor bill be paid in full.

Both Blue Cross-Blue Shield and the commercial insurance plans have "Major Medical" or "Supplemental" features designed to take care of a broad scope of extra medical and hospital costs. These cover, among other things, physician home and office visits, x-ray and pathological services in and out of hospital, drugs, transfusions, prosthetics, private nurses, and costs for those prolonged illnesses that may require treatment and hospitalization for periods longer than covered under the basic program.

Under the Blue Cross plan, by the time the patient is at the point of paying out the deductible, he's had 30 or 120 days of hospital service benefits without cost to him. At the same point, if he were under the commercial insurance plan, he already would have paid the deductible plus a husky percentage of the remainder of the charges.

There are many more differences. For example, our benefits are renewable each admission. This means, if the patient should require two admissions for himself, separated by 90 days, he'll be covered each time for the full 30 or 120 days (Low or High Option). The commercial insurance plans pay a set amount per year, regardless of the number of days.

Any detailed analysis of the competing plans shows that both Blue Cross and Blue Shield have put their benefits where they will give greater service to more federal employees and their dependents.

W. C. Huddlestone
Public Relations Division ◄

When summertime chores bring on **LOW BACK PAIN**

Trancopal®

Brand of chlormezanone

relaxes skeletal muscle spasm— ends disability.



When any of a host of summer activities brings on low back pain associated with skeletal muscle spasm, your patient need not be disabled or even uncomfortable. The spasm can be relaxed with Trancopal, and relief of pain and disability will follow promptly.

Lichtman[1,2] used Trancopal to treat patients with low back pain, stiff neck, bursitis, rheumatoid arthritis, osteoarthritis, trauma, and postoperative muscle spasm. He noted that Trancopal produced satisfactory relief in 817 of 879 patients (excellent results in 268, good in 448 and fair in 101).

Gruenberg[3] prescribed Trancopal for 70 patients with low back pain and observed that it brought marked improvement to all. "In addition to relieving spasm and pain, with subsequent improvement in movement and function, Trancopal reduced restlessness and irritability in a number of patients."[3] In another series, Kearney[4] reported that Trancopal produced relief in 181 of 193 patients suffering from low back pain and other forms of musculoskeletal spasm.

Trancopal enables the anxious patient to work or play. According to Gruenberg, "In addition to relieving muscle spasm in a variety of musculoskeletal and neurologic conditions, Trancopal also exerts a marked tranquilizing action in anxiety and tension states."[3] Kearney[4] found "... that Trancopal is the most effective oral skeletal muscle relaxant and mild tranquilizer currently available."

Side effects are rare and mild. "Trancopal is exceptionally safe for clinical use."[3] In the 70 patients with low back pain treated by Gruenberg,[3] the only side effect noted was mild nausea which occurred in 2 patients. In Lichtman's group, "No patient discontinued chlormethazanone [Trancopal] because of intolerance."[1]

How Supplied: Trancopal Caplets®
200 mg. (green colored, scored), bottles of 100.
100 mg. (peach colored, scored), bottles of 100.

Dosage: Adults, 200 or 100 mg. orally three or four times daily. Relief of symptoms occurs in from fifteen to thirty minutes and lasts from four to six hours.

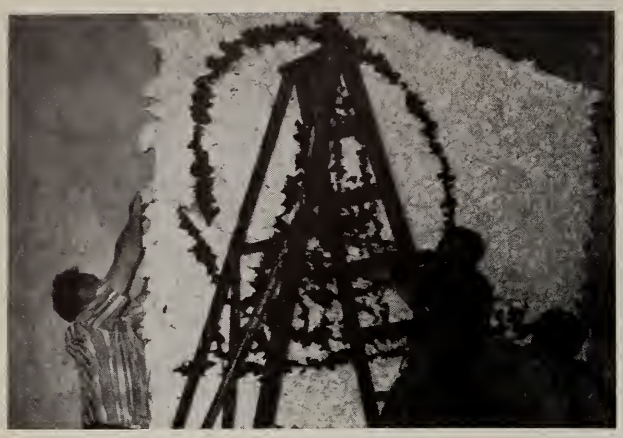
References: *1.* Lichtman, A. L.: *Kentucky Acad. Gen. Pract. J.* 4:28, Oct., 1958. *2.* Lichtman, A. L.: Scientific Exhibit, Internat. Coll. Surgeons, Miami Beach, Fla., Jan. 4-7, 1959. *3.* Gruenberg, Friedrich: *Current Therap. Res.* 2:1, Jan., 1960. *4.* Kearney, R. D.: *Current Therap. Res.* 2:127, April. 1960.

Winthrop LABORATORIES
New York 18, N.Y.

TRANCOPAL (BRAND OF CHLORMEZANONE) AND CAPLETS, TRADEMARKS REG. U.S. PAT. OFF.

1500M

Auxiliary Meeting



JACKSON COUNTY physicians add the finishing touches to decorations.







Masses of brightly-flowered spring bonnets . . . golf . . . tours . . . chit-chat . . . reception . . . banquet . . . business meetings . . . earnest discussions . . . midnight brainstorming . . . ideas and more ideas. And the annual meeting of the ISMA Woman's Auxiliary House of Delegates, at French Lick April 27-29, came to a close.

The program was a combination of education and entertainment, planned to examine the problems ahead and devise methods of tackling and solving them. Each came to gain and to resolve anew to do her part in upholding the standards of medicine for this and the following generations.

Mrs. Mary Black's report for her presidential year of 1959-60, given at the House of Delegates meeting, follows.

UPPER LEFT: Mrs. Mary Black receives her past-president's pin from Mrs. William Tindall.

CENTER LEFT: Incoming president Mrs. Ina Rigley explains projects for the coming year.

LOWER LEFT: Dr. and Mrs. Joseph Black take time from busy schedules to greet guests at the reception.

Spotlights Accomplishments and Future Problems



SOME NEW leading ladies take a bow.



RIGHT:
'BY THE SEA'—the camera catches three ladies of a skit cast on their way to the stage.

LOWER:
DR. EARL MERICLE, ISMA president, joins Mrs. Black (left) and Mrs. Rigley at the banquet.



Presented at the ISMA Woman's Auxiliary House of Delegates Meeting, April 29, 1960, French Lick, Ind.

Woman's Auxiliary to the ISMA President's Report—1960

MRS. MARY BLACK

Immediate Past-President

THIS HAS BEEN a wonderful year for me, and one that I shall always remember. I feel that our auxiliary family has been very closely knit and that many true friendships have been formed.

The president's report is in a great part a composite picture of work that her officers and chairmen have accomplished. This year, I have indeed been fortunate in having such enthusiastic and devoted helpmates, and I want to sincerely thank them for the many hours that they have spent. As you can see by their reports, this has been a year of progress for our auxiliary.

Membership has increased, two new counties have been organized, our A.M.E.F. donations were $13,713.88, the largest amount ever received, and much fine work has been done in legislation. Our members have written hundreds of letters and telegrams to their senators and representatives and I feel they have played a large part in keeping the Forand bill in committee.

One of our new projects this year is the Health Citation Award. The response has been most gratifying with 19 outstanding candidates being nominated. Many counties awarded their own candidates with certificates and gifts. Our state winner will be presented to you tonight at dinner. We feel that a great deal of good public relations has been gleaned from this award.

We must stress public relations at all times and realize that our auxiliary is an auxiliary for a wonderful group of men. Our husbands are dedicated individuals that have a strong, helpful bond for members of their profession, and it is up to us, their wives, to help them in all of their undertakings. We must become interested in community affairs and politics so that we can take medicine's opinions to the public. We can no longer be complacent; we have to work. We were given all of our wonderful freedoms—let's help preserve them for the next generation.

Our four area meetings in the Spring were well attended. A speaker from the State Civil Defense office spoke and helped inaugurate our program for the year. We also had instructions on parliamentary procedure.

Our paramedical recruitment program has grown, as you will hear when the county presidents make their reports this afternoon.

Please read the printed reports carefully and see how much each of you has accomplished. Without so many of you working so diligently, our accomplishments could not have been attained.

Meetings—Motors—Meals

Your president has represented you at the state meetings in Illinois, Kentucky and Michigan, and at a national public relations meeting in Chicago. I attended a state legislative meeting where Dr. Orr, AMA president, spoke, and also attended a joint meeting of the auxiliary and the ISMA legislative commision at the I. U.

Medical Center. Last year, I attended legislature almost twice a week to help in any way possible.

Last month at the I. U. Junior-Senior Medical School Day in Indianapolis, I gave a brief talk. Your president attended an annual conference at Chicago in October where the presidents and presidents-elect from our 50 states gathered. Last year, I attended the AMA convention in Atlantic City, and am to give the response this year at the convention at Miami Beach.

I have attended many district meetings, county meetings, teas and luncheons. For all of these invitations and for the chance of getting to know you better, I say thank you sincerely. Traveling has been done by car, plane, helicopter and bus. The dinner hour came in the middle of one four-hour bus ride and the driver gave me an extra ten minutes at one stop so that I might get crackers and candy for dinner.

In February, your president and president-elect had a dinner conference with the Executive Committee of the ISMA and discussed our plans and problems. The ISMA has been most cooperative and helpful.

In October, your president presided at the fall board meeting and gave an oral report to the delegates of the ISMA. She has been responsible for our monthly page in the *Journal.*

Indiana was selected to send a representative to the Rural Health Conference sponsored by the AMA in Grand Rapids, Mich., last February. Her letter is included in our printed reports.

I have had many wonderful experiences and know that our auxiliary membership is composed of the best ladies in the state. This has been a friendly year, and more than ever I realize how fortunate we are to be able to work for such a worthwhile organization.

As my year as president comes to an end, I more firmly than ever believe that "A Job Worth Doing, And Friends Worth Having, Make Life Worth Living." Thank you all for allowing me to have had the privilege and honor of serving you this year. I shall cherish your friendships forever. ◄



"I'm afraid this Todkin case is one of advanced second childhood . . . he said he was going home and play with his mental blocks."

ISMA
CONVENTION DATES
OCTOBER 3-5

OVER 80 YEARS' SPECIALIZED EXPERIENCE IN THE RESTORATIVE TREATMENT OF

"THE PROBLEM DRINKER"

At The Keeley Institute your patients are assured of receiving:

- the most modern, coordinated, comprehensive, rehabilitative regimen
- in addition to medical, nutritional and physiotherapeutic treatment, we also offer psychiatric diagnosis and psychotherapy
- full cooperation throughout with the referring physician
- in addition to the care of the alcoholic we also treat narcotic and drug addiction
- surprisingly low cost—to cover all medical care, medicines, laboratory work, room and excellent cuisine

You can obtain more detailed information by writing us direct.

WE WELCOME YOUR REFERRALS...

THE KEELEY INSTITUTE
DWIGHT, ILLINOIS

Member American Hospital Association, Member Illinois Hospital Association. Licensed by the Department of Public Health, State of Illinois.



Indiana Groups Organize Joint Council To Improve Health and Care of Aged

In an effort to improve health of Indiana's aged population, Indiana medical, dental, hospital and nursing home associations have organized a Joint Council, the first combined effort of the four organizations solely for the over-65 age group.

Primary objectives of the council will include an identification and analysis of health needs of the aged, development of community programs of health education and information, appraisal of health resources and fostering effective methods of health care payment.

Facilities of health organizations in the council are to be offered to Governor Harold W. Handley and the Indiana Committee on Aging.

Organization of the Joint Council to Improve the Health of the Aged in Indiana was announced by Dr. Earl W. Mericle, ISMA president; Dr. James W. Jones, State Dental Association president; Clyde W. Turner, Indiana Nursing Home Association president and Wilbur McLin, Indiana Hospital Association president.

Dr. Emmett B. Lamb, chairman of the ISMA's Commission on Public Health, is chairman of the newly-formed joint council. Assisting him will be Dean Maynard K. Hine, I. U. School of Dentistry, vice-president; Mrs. Margaret Nickols, of the Indiana Association of Licensed Nursing Homes, secretary and Miss Gladys Post, of the I. U. Medical Center, treasurer.

Mr. Beesley Named Chairman-elect Of Pharmaceutical Manufacturers

Eugene N. Beesley, President of Eli Lilly and Company, was recently elected chairman-elect of the Board of Directors of the Pharmaceutical Manufacturers Association.

Harry J. Loynd, president of Parke, Davis & Co., is the chairman for 1960-61; Mr. Beesley will serve in 1961-62. Kenneth F. Valentine, president of Pitman-Moore Co., division of Allied Laboratories, was chosen as one of the vice presidents of the association for 1960-61.

'Improve Total Care of Surgical Patients' College of Surgeons Congress Goal

Improvement in the total care of surgical patients will be the goal of 10,000 doctors expected to attend the 46th annual Clinical Congress of the American College of Surgeons in San Francisco, Calif., Oct. 10-14.

Doctors from all parts of the nation and many foreign countries will attend sessions at this largest meeting of surgeons. More than 1,000 participants will take part in the various programs as authors of research reports, teachers of postgraduate courses, participants in panel discussions, lecturers and operating surgeons in motion pictures and closed-circuit telecasts.

Major addresses will be made by Dr. I. S. Ravdin, Philadelphia, chairman, Board of Regents, and incoming president of the College; Dr. Joseph Trueta, Oxford, England, will speak on trauma and the living cell; Dr. Wendell M. Stanley, director of the virus laboratory at University of California, Berkeley, and Nobel winner in chemistry, will deliver the Martin Memorial Lecture, named for the College founder Franklin H. Martin, on the subject of virus-cancer relationships; and Mr. Leslie Philip Le Quesne, London, England, will give the annual Baxter Lecture, speaking on body fluid disturbances resulting from stomach obstruction.

Nine postgraduate courses offered will be headed by surgeon-teachers distinguished in their respective fields: Pre- and Postoperative Care, Fraser N. Gurd, Montreal; Gastrointestinal Disease, John A. Schilling, Oklahoma City; Diseases of Liver, Biliary Tract and Pancreas, Charles Eckert, Albany; Cardiovascular Surgery, John W. Kirklin, Rochester, Minn.; Burns and Associated Complications, Curtis P. Artz, Jackson, Miss.; Gynecology and Obstetrics, George E. Judd, Los Angeles; Management of Multiple Severe Injuries, Francis J. Cox, San Francisco; Surgical Aspects of Pulmonary Disease, Lyman A. Brewer, Los Angeles; Recent Advances in Pediatric Surgery, Orvar Swenson, Boston.

The Surgical Forum sessions will include 258 reports, demonstrating clinical and laboratory research in progress in leading medical centers. Operations will be telecast from Stanford University Medical Center, and doctors in the television audience may ask questions of the operating surgeon and listen to discussions of the operations, conducted by panels of consultants. New motion pictures made especially for this meeting will be shown all week. Panel sessions in general surgery, and in the surgical specialties of gynecology and obstetrics, neurologic surgery, orthopedic surgery, plastic surgery, thoracic surgery and urology will be held throughout the five-day meeting.

Dr. Harris B. Shumacker, Jr., Indianapolis, will supervise the program of research reports known as the Surgical Forum.

Hoosier Cardiologists Participate in National Convention at Indianapolis

Several Indiana physicians took part in the ninth annual convention of the American College of Cardiology, held in Indianapolis, May 24-28.

Among them were Dr. A. D. Dennison, Jr., Indianapolis, Indiana governor of the organization member of the public relations and scientific program committees chairman of a section of the scientific sessions, and chairman of local arrangements.

Drs. John V. Thompson, Indianapolis, and Dan L. Urschel, Mentone, were members of the public relations committee, and Dr. Pasquale Genovese, Indianapolis, served as co-chairman of the local arrangements committee.

Participating in the scientific program were Dr. John B. Hickam, Indianapolis, chairman of the first section of scientific sessions; and Drs. Roy H. Behnke, Douglas H. White, Harris Schumacker, Jr., Charles Fisch, B. L. Martz, Fred Priebe, Robert B. Failey and Kenneth G. Kohlstaedt.

An Auburn, Ind. physician, Dr. J. A. Sanders, was the recipient of that town's Community Award Plaque for 1960, given by the local Junior Chamber of Commerce.

Dr. Lester H. Hoyt, Indianapolis, was recently elected secretary-treasurer of the American Society of Clinical Pathologists.

Continued

75 I.U. Senior Medics to Intern In Several Hoosier Hospitals this Year

Seventy-five of the 132 senior medical students who received M.D. degrees from Indiana University June 5, will serve internships in Hoosier hospitals during the coming year, it was announced recently by Dean John D. VanNuys of the I. U. School of Medicine.

Other members of the class, including seven going on duty with the armed services, will join the medical staffs of 42 hospitals in 21 other states. The hospital internship is an accepted part of the newly-graduated physicians' clinical experience before engaging in professional practice or continuing his medical education.

Dean VanNuys pointed out that 56% of this year's graduates would be interning in Indiana hospitals, an increase of 10% over previous years. In recent years the reverse has been true with more than half of the class going to other states. "We anticipate," he said, "that regardless of where they receive their intern experience, most of the class will select Indiana as their permanent location."

The 75 graduates interning in Indiana will be on the medical staffs of 12 hospitals, as follows:

Indianapolis

Indiana University Hospitals—Drs. David L. Alvis, Lee F. Beamer, James A. Bixler, Jack L. Bratton, James C. Harris and James L. Stribling, all of Indianapolis; Betty C. R. Corya, North Vernon; James W. Kilman, Terre Haute; Suzanne B. Knoebel and David L. Nahrwold, Ft. Wayne; Robert L. Peake, Vincennes; James L. Shumaker, Paducah, Ky.; John L. Tofaute, Rockville and David J. Trout, Lafayette.

Marion County General Hospital—Drs. Robert M. Lands, Michael T. Long, Byron L. Teegarden, Richard C. Travis and Norman K. Wilson, all of Indianapolis; Philip R. Akre, Linton; Donald R. Allen, Charles W. Link, Jr., Charles W. McClary and Edward C. Wheeler, Evansville; Jerald L. Andrew, William R. Clark, Jr. and Ian H. Cook, Ft. Wayne; John A. Bowers, Kokomo; Paul E. Brose, Lebanon; Milton R. Carlson, Hobart; Donald D. Cheesman and Joseph C. Kerlin, Speedway; John R. Crise, Winamac; Ray E. Fortner, Vincennes; Donald R. Gill, Washington; Russell L. Malcolm, Jr., Richmond; Doyle B. Manhart, Anna, Ill.; Ralph L. Rea, Coal City; Robert A. Richey, Lewis; Masato Takahashi, Tokyo, Japan and John P. White, Jr., Kendallville.

Methodist Hospital—Drs. Robert V. Barrett, Frederick F. Boling, Andrievs J. Dzenitis, Donald J. Hooker, John J. Klingerman and Andrew Thomas, all of Indianapolis; Larry L. Hanley and C. Bishop Hathaway, Jr., Danville; Ronald H. Scheeringa and Robert M. Sweeney, Highland.

St Vincent's Hospital—William O. Irvine, Indianapolis; Latimer E. Dunn, Terre Haute; Ralph F. Montgomery, Albany; Charles H. Warneke, Rushville; Bruce Hopkins, Speedway; Malcolm Long, Mentone.

East Chicago: *St. Catherine's Hospital*—Dr. Andrew A. Roque, East Chicago.

Evansville: *St. Mary's Hospital*—Drs. Walter B. Hassel, Brownsburg; Keith R. Kooken, Hammond; Gene E. Ress, Tell City and William L. Walling, Mt. Vernon.

Hammond: *St. Margaret's Hospital*—Drs. Charles D. Egnatz, Munster and Walter A. Repay, Hammond.

Muncie: *Ball Memorial Hospital*—Drs. Raymond S. Beights, Indianapolis; George J. David, East Gary; Miles W. Donaldson, Marion and Richard G. Ingram, Daleville.

South Bend

Memorial Hospital—Drs. Frank D. Pairitz, South Bend; Joseph D. Richardson, Rochester; Thomas Stogdill, Bluffton and Millard R. Taylor, Jr., New Castle.

St. Joseph's Hospital—Drs. Melvyn J. Kielton, South Bend and William R. Potzler, Monterey.

Dr. Sputh Named to Faculty

Dr. Carl B. Sputh, Jr., Indianapolis, will be one of the members of a faculty of 36 surgeons of the United States who will conduct a two-week postgraduate course in "Reconstructive Surgery of the Nasal Septum and External Pyramid" in Mexico City, starting on July 4.

Doctors undergoing instruction are from the United States, Central and South America, Australia and Israel.

Continued

Picture of Relaxation . . .



. . . In a Genuine CONTOUR Chair Lounge

What a picture of relaxed contentment . . . welcome relief from keeping busy schedules during hot, sweltering summer days. Contour's cradle comfort with six-point support and elevation of legs and feet provides head-to-foot restfulness and relaxation . . . like you've never enjoyed before! Contour's smart functional design and latest decorator coverings enhance the home or office.

Take a furlough from fatigue!
Try a CONTOUR this week.

THE ORIGINAL PATENTED Contour® CHAIR LOUNGE

2162 N. Meridian St.
WA 3-1526

10 N. Illinois St.
ME 4-8219

Indianapolis, Indiana

Wesson Creates $100,000 Grant For Research in Edible Fats and Oils

An annual grant of $100,000 for basic and clinical research in the field of edible fats and oils was announced recently by The Wesson People, world's largest producer of cottonseed oil.

E. A. Geoghegan, Wesson president, said the grant is to be administered through the newly-established Wesson Fund for Medical Research and Education, aided by a distinguished medical advisory board. The board will review requests for financial aid from research centers, laboratories and private individuals whose primary work is in nutritional research.

At the outset, approximately 40% of the funds will be devoted to studies of the digestibility of fried foods, the gastrointestinal reactions to specific fats, and related subjects. Another 40% will be used to support research into the dietary factors related to hardening of the arteries. Approximately 20% will be allotted for special lectureships, symposia and other educational endeavors.

"The Wesson organization feels a direct responsibility for supporting research into the influence of edible fats and oils on human nutrition," Mr. Geoghegan said, "and we will naturally welcome requests for aid from those engaged in such research. It is our wish at Wesson to help those researchers who heretofore have been restricted by a lack of funds. In addition to grants of money, we propose to provide without cost pure cottonseed oil of a constant composition for the specific research to be undertaken.

"We hope that many areas will be fully explored, including those involving the digestibility of fried foods and the use of vegetable oils in children's diets, for example. To this end we at Wesson will be guided by a distinguished board of medical advisors representing the major fields, of cardiology, general nutrition, gastroenterology, biochemistry and pediatrics."

The Wesson Fund advisory board, Mr. Geoghegan said, will be composed of the following: Dr. Grace Goldsmith, Professor of Medicine, Tulane University, representing biochemistry and nutrition; Dr. Robert Jackson, Professor of Pediatrics, University of Missouri; Dr. Joseph Kirsner, Professor of Medicine, University of Chicago, representing gastroenterology; Dr. Herbert Pollack, Associate Professor of Clinical Medicine, New York University, representing internal medicine and nutrititon and Dr. Howard Sprague, cardiologist, Boston.

Noblesville Hospital Project Approved Hill-Burton Status Listed for March

The Department of Health, Education and Welfare reported that during March 1960, one project was approved for Indiana under Hill-Burton Grant for Riverview Hospital, Noblesville—estimated at a total cost of $60,000, with a $10,000 federal share.

As of March 31, 56 projects, at a total cost of $64,614,925, including a $22,032,439 federal contribution and supplying 3,084 additional beds, were complete and in operation.

Under construction were 12 projects, costing $19,930,723, with a $5,262,563 federal contribution and supplying 879 additional beds.

One project, costing $2,155,450 with a $717,-333 federal contribution and supplying 65 additional beds was approved but not yet under construction.

I.U. MEDICAL ALUMNI NAME NEW OFFICERS

Dr. J. Donald White, Indianapolis, is the new president of the Indiana University School of Medicine Alumni Association.

Other officers elected at the organization's 13th annual Alumni Day are Drs. Stephen L. Johnson, Evansville, president-elect; Howard L. Allen, Bedford, vice-president; Olga Bonke Booher, Indianapolis, secretary; Dennis S. Megenhardt, Indianapolis, treasurer; Frank Forry, Indianapolis, historian and Joseph B. Davis, Marion, executive council representative.

Association of Military Surgeons Plans Fall Convention

The Association of Military Surgeons of the U. S. will hold its Annual Convention at the Mayflower Hotel, Washington, D. C. on October 31 and November 1 and 2. The theme of the meeting this year will be "The Military Role in Medical Progress."

Fourth National Cancer Conference Set for September 13-15

The Fourth National Cancer Conference will be held at the University of Minnesota, Minneapolis, September 13-15, 1960. The theme of the Conference is "Changing Concepts Concerning Cancer," and more than 2,000 scientists and physicians from the United States and abroad are expected to attend. The Conferenec is sponsored jointly by the American Cancer Society and the National Cancer Institute of the Public Health Service, Department of Health, Education, and Welfare.

The Conference will focus on three general topics—etiology, pathogenesis and spread, and therapy of malignant disease. In addition, panels of scientists will discuss the state of knowledge of the leukemias and lymphomas, and cancer of the breast, lung, gastrointestinal tract, genitourinary system, head and neck, and skin. Other panels will be devoted to cancer control and the role of environmental factors in the occurrence of cancer.

Interested scientists and physicians are invited to attend.

Copies of the Conference program and registration cards may be obtained from the National Cancer Conference Coordinator, American Cancer Society, 521 West 57th Street, New York 19, N. Y.

Five Hoosiers Certified in Ob-Gyn

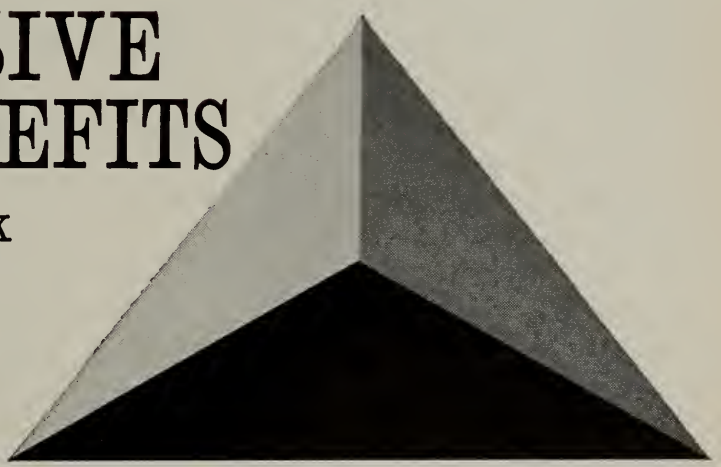
Hoosier physicians recently examined and certified in the specialty of obstetrics and gynecology by the American Board of Obstetrics and Gynecology include Drs. Lawrence Benken, Muncie; John K. MacLeod, South Bend; Henry R. Schroeder, Jr., Washington; Barton T. Smith, Marion, and Richard W. Stander, Indianapolis.

Applications for certification by the board, new and reopened, Part 1 and requests for re-examination in Part 11 are now being accepted. All candidates are urged to make such application at the earliest possible date. Deadline for receipt of applications is August 1, 1960. No applications can be accepted after that date.

Continued

COMPREHENSIVE OLD AGE BENEFITS

- ▲ brightens the outlook
- ▲ lightens the load of poor nutrition
- ▲ heightens tissue/bone metabolism



NEW

1 small capsule every morning

GEVRESTIN®

Geriatric Vitamins-Minerals-Hormones-d-Amphetamine Lederle

Each capsule contains: Ethinyl Estradiol 0.01 mg. • Methyl Testosterone 2.5 mg. • d-Amphetamine Sulfate 2.5 mg. • Vitamin A (Acetate) 5,000 U.S.P. Units • Vitamin D 500 U.S.P. Units • Vitamin B_{12} with AUTRINIC® Intrinsic Factor Concentrate 1/15 U.S.P. Unit (Oral) • Thiamine Mononitrate (B_1) 5 mg. • Riboflavin (B_2) 5 mg. • Niacinamide 15 mg. • Pyridoxine HCl (B_6) 0.5 mg. • Calcium Pantothenate 5 mg. • Folic Acid 0.4 mg. • Choline Bitartrate 25 mg. • Inositol 25 mg. • Ascorbic Acid (C) as Calcium Ascorbate 50 mg. • l-Lysine Monohydrochloride 25 mg. • Vitamin E (Tocopherol Acid Succinate) 10 Int. Units • Rutin 12.5 mg. • Ferrous Fumarate (Elemental iron, 10 mg.) 30.4 mg. • Iodine (as KI) 0.1 mg. • Calcium (as $CaHPO_4$) 35 mg. • Phosphorus (as $CaHPO_4$) 27 mg. • Fluorine (as CaF_2) 0.1 mg. • Copper (as CuO) 1 mg. • Potassium (as K_2SO_4) 5 mg. • Manganese (as MnO_2) 1 mg. • Zinc (as ZnO) 0.5 mg. • Magnesium (MgO) 1 mg. • Boron (as $Na_2B_4O_7.10H_2O$) 0.1 mg. Bottles of 100, 1000.

LEDERLE LABORATORIES, a Division of AMERICAN CYANAMID COMPANY, Pearl River, New York Lederle

Two Postgraduate Courses Offered By Illinois Medical School

Two departments of the University of Illinois College of Medicine, Otolaryngology and Medicine, have announced plans for postgraduate courses next fall.

The Department of Otolaryngology's intensive postgraduate basic and clinical program for practicing otolaryngologists is set for Sept. 24-30. Offered is a compact program of one week of daytime and evening sessions, designed to bring to specialists a wide variety of current advances in management, therapy and philosophies. Review of basic morphologic features is also included by means of laboratory demonstrations, dissection and prosection, all augmented by visual aids.

Panel programs have been designed to bring out special features of otologic and reconstructive surgery and tumors of the head and neck. Luncheon chats are part of the daily program.

A postgraduate course in Laryngology and Bronchoesophagology will be held from Oct. 17-29, under the direction of Paul H. Holinger, M.D.

Registration will be limited to fifteen physicians who will receive instruction by means of animal demonstrations and practice in bronchoscopy and esophagoscopy, diagnostic and surgical clinics, as well as didactic lectures.

Interested registrants will please write directly to the respective departments, University of Illinois College of Medicine, 1853 W. Polk St., Chicago 12, Ill.

Internists' International Congress To Meet in Switzerland

The 6th International Congress of Internal Medicine will meet August 24-27, 1960, in Basle, Switzerland.

Seventy leading internists from all over the world will take part in the main scientific program; simultaneous translations being made for all principal presentations. Official languages for the Congress are English, French and German.

Programs and registration forms may be obtained by addressing the secretary of the 6th International Congress of Internal Medicine, Steinentorstrasse 13, Basle, 10, Switzerland.

Congress of Physical Medicine Set for August 21-26

Plans are being formed for the Third International Congress of Physical Medicine, August 21-26, 1960 inclusive, at The Mayflower, Washington, D. C.

A preliminary prospectus covering the international conference carries in detail information on registration, application to present a paper, scientific exhibit, scientific film, etc. Copies of this preliminary program may be had on request by writing: Dorothea C. Augustin, Executive Secretary, Third International Congress of Physical Medicine, 30 N. Michigan Avenue, Chicago 2, Ill.

Indiana Blood Banks Organize

The Indiana State Association of Blood Banks, to be affiliated with the American Association of Blood Banks, was organized recently at a meeting in Indianapolis.

Officers will include Drs. J. L. Arbogast, Indianapolis, president; Jene Bennett, South Bend, president-elect; and Mr. J. J. Lantz, Vincennes, secretary-treasurer.

FOUNDATION FORMS COMMITTEE TO STUDY PUBLIC-SUPPORTED AGENCIES

Rockefeller Foundation has announced the formation of a committee composed of distinguished civic leaders to conduct an exploratory study of local, regional and national health and welfare agencies that are primarily supported by voluntary contributions from the public.

The present study is intended to be preliminary and may, according to the findings, be extended into a more comprehensive study. Hospitals are not included in the agencies to be studied.

Dr. Lester D. Bibler, Indianapolis, spoke on Relative Value Studies at a May 17 meeting of the Mutual Claims Conference in Chicago.

Deaths

Howard T. Craven, M.D.

A former Indianapolis physician, Dr. Howard T. Craven, died April 27 while visiting in Fort Wayne, Ind. He was 39.

A graduate of the Indiana University School of Medicine, Dr. Cravin served his residency in pathology and surgery at Methodist Hospital, Indianapolis, and practiced privately in Indianapolis before entering the Armed Services in 1953. He had resided in Washington, D. C. the last five years.

Joseph E. Dudding, M.D.

Dr. Joseph E. Dudding, Hope, Ind. physician since 1936 and an active member of ISMA for many years, died May 20 in Indianapolis at the age of 53.

A member of the ISMA Council from 1954 to 1959, Dr. Dudding was ISMA delegate for several terms and had served on several ISMA committees and commissions. He was a member of the Indiana board of directors of Blue Cross-Blue Shield.

Dr. Dudding graduated from Indiana University in 1935. He was former coroner of Bartholomew County, and a member of the staff of Bartholomew County Hospital, Columbus, and Major Hospital, Shelbyville.

William M. Dugan, M.D.

An Indianapolis physician for many years, Dr. William M. Dugan, passed away May 19 at the age of 55.

Dr. Dugan, who was secretary of the Marion County Medical Society from 1939-45, was a graduate of the Indiana University School of Medicine. He had served on the board of Marion County Tuberculosis Hospital and as physician for the Civil Aeronautics Administration. He was past president of the staffs of Methodist and Marion County General hospitals in Indianapolis and was also a member of St. Vincent's, Community and Indiana University Hospital staffs, and secretary of the Indianapolis Diabetic Association.

Harold Oliver Murphy, M.D.

Dr. Harold O. Murphy, former secretary of the Kosciusko County Medical Society, passed away April 27 at Warsaw.

A graduate of the Indiana University School of Medicine, Dr. Murphy established his practice in Warsaw in 1953; in 1958 he opened a clinic in Claypool.

Dr. Murphy was a former member of the Indianapolis Motor Speedway medical board; he belonged to VFW, the Masonic lodge, Scottish Rite and Shrine.

Ross C. Ottinger, M.D.

Dr. Ross C. Ottinger, who practiced medicine for 52 years in Indianapolis, passed away May 24 in Indianapolis. He was 76.

A graduate of the Purdue Medical School, Dr. Ottinger had been on the Methodist Hospital staff for 50 years. He specialized in gynecological surgery.

Dr. Ottinger was a 50-year member of the Masonic lodge and belonged to Phi Chi medical fraternity.

John F. Take, M.D.

Orange County's oldest physician, Dr. John F. Take, passed away May 12 at the age of 96. He had retired from active practice five years ago.

A graduate of Bennett Medical College, Chicago, now Loyola University, Dr. Take formerly practiced in Whiting, Valparaiso, Gary and in Canada before moving to French Lick in 1927.

Guthrie H. Wisener, M.D.

Dr. Guthrie H. Wisener, 74, Richmond, widely recognized for his work in radiology, orthopedic and general surgery, passed away May 18 at Indianapolis. He was formerly president and secretary of Wayne-Union Medical Society.

Author of many papers on treatment of orthopedic conditions and the inventor of several types of instruments, beds and frames, Dr. Wisener was a charter member of the Bone and Joint Club. He graduated from Indiana University School of Medicine in 1917, and later served in the Army Medical Corps during World War I.

Dr. Wisener was chief radiologist at Reid Memorial Hospital, Richmond; he also served on surgical staffs of Earlham College, Richmond State Hospital and Smith-Esteb Memorial TB Hospital. ◄

District, County News

First District

Dr. George Kungchao Yea, Chinese ambassador to the United States, spoke at the evening dinner of the First District Medical Society, May 24 at Mt. Vernon.

Second District

Newly-elected officers of the Second District Medical Society, chosen on May 26 at the group's annual meeting in Vincennes, include Drs. C. P. Fox, president; Horace Norton, vice-president; J. S. Brown, secretary-treasurer and T. E. Edwards Jr., councilor.

Third District

Doctors of the Third District Medical Society heard Dr. Lester Reed, Louisville, Ky., speak on "Intracranial Hemorrhage: Head Injuries and Strokes" and Dr. R. D. Hawkins, Bedford, discuss "Practical Pediatrics" at the group's annual meeting May 18 at French Lick.

New district officers are Drs. Elton Heaton, president and Alfred Scales, secretary.

Fourth District

Officers elected at the annual Fourth District Medical Society meeting May 18 in Columbus included Drs. Harry Baxter, president; Lloyd Hisrich, vice-president and K. E. Bobb, secretary-treasurer.

Fifth District

Greencastle was the site of the Fifth District Medical Society meeting on May 25. Following dinner, Mr. Tom Mont, DePauw University football coach, spoke.

Newly-elected district officers include Drs. Richard S. Bloomer, president; Casper Harstad, vice-president; Welbon Britton, secretary-treasurer; V. Earle Wiseman, councilor and A. W. Cavins, alternate councilor.

Sixth District

Speakers for the annual meeting of the Sixth District Medical Society, May 11 at Shelbyville, included Judge Ralph Hamill, "Medical-Legal Problems"; Dr. George Parker, "Review of RH Factor" and Dr. Norman Richard, "Differential Diagnosis of Jaundice."

New officers elected at that time were Drs. John Smith, president; John Davis, vice-president and Davis W. Ellis, secretary-treasurer.



PICTURED WITH Dr. Lloyd Harris (right), Mayo Clinic, guest speaker at the Ninth District Medical Society meeting May 18, is Dr. Harry Klepinger, president of the Society.

Seventh District

Dr. Ted Grisell became president of the Seventh District Medical Society at the group's annual meeting May 18 at Franklin. Assisting him will be Drs. O. T. Scamahorn, president-elect; Herbert L. Egbert, secretary-treasurer and Glen Ryan, Blue Shield board.

Eighth District

"How Physicians Can Become More Effective in Politics" was the program for the Eighth District Medical Society meeting June 8 at Anderson.

Ninth District

Dr. Lloyd E. Harris, Mayo Clinic, presented a program entitled "The Doctor's Child" at the May 18 meeting of the Ninth District Medical Society.

Tenth District

Mr. Richard Kilborn spoke on "Blue Shield in Your Future" at the May 11 meeting of the Tenth District Medical Society at Gary.

Eleventh District

The scientific program at the 105th semi-annual meeting of the Eleventh District Medical Society was a panel discussion entitled" Psychiatry Debunked." Taking part in the program were Dr. Jack Oatman, "Classification of Psychiatric Syndromes Frequently Met in General Practice"; Dr. John Keating, "Pointers on Recognizing Patients' Needs for Psychiatric Referral"; Dr. John H. Wilms, "Use and Misuse of Psychotropic Drugs" and Dr. Frank Hogle, "Do's and Don'ts of Psychiatric Referral."

Continued



The physician listens to a tense, nervous patient discuss her emotional problems. To help her, he prescribes Meprospan (400 mg.), the only continuous-release form of meprobamate.



The patient takes one Meprospan-400 capsule at breakfast. She has been suffering from recurring states of anxiety which have no organic etiology.



She stays calm while on Meprospan, even under the pressure of busy, crowded supermarket shopping. And she is not likely to experience any autonomic side reactions, sleepiness or other discomfort.



She takes another capsule of Meprospan-400 with her evening meal. She has enjoyed sustained tranquilization all day—and has had no between-dose letdowns. Now she can enjoy sustained tranquilization all through the night.



Relaxed, alert, attentive . . . she is able to listen carefully to P.T.A. proposals. For Meprospan does not affect either her mental or her physical efficiency.



Peacefully asleep . . . she rests, undisturbed by nervousness or tension. (Literature on Meprospan is available from Wallace Laboratories, Cranbury, N. J.)

District, County

Continued

Twelfth District

Capt. Alvin S. Hyde, Assistant Chief of the Aero Medical Library at Wright-Patterson Air Force Base, spoke on "Medical Problems in Aero Flight" at the Twelfth District Medical Society annual meeting, May 3 at Fort Wayne.

Adams

Dr. Jesse W. Bowman and his associates spoke at the May 10 meeting of the Adams County Medical Society at Geneva. There were 14 members present.

Allen

Dr. Walter E. Kruse was installed as president of the Allen County Medical Society recently. Other new officers are Drs. Donald S. Painter, president-elect; Gerald R. Nolan, secretary and George C. Manning, treasurer.

Delegates to ISMA convention include Drs. E. D. Hamilton, F. L. Land, F. L. Schoen, F. W. Brown and E. F. Senseny.

Alternates for these delegates are Drs. F. A. Bryan, J. W. McCallister, V. C. Moeller, H. A. Stellner and J. E. Jackson.

Cass

The Cass County Medical Society met at Logansport May 2 for a general business meeting. Twenty-six members present voted to give their support to the local cancer detection clinic.

Clark

Thirty members of the Clark County Medical Society met at Charleston May 17 for a general business meeting.

Clinton

Clinton county doctors met at Frankfort May 24 for a legislation discussion. There were 12 present.

Daviess-Martin

Members of the Daviess-Martin Medical Society recently sponsored a program whereby one day was set aside to provide free necessary immunizations to those persons unable to pay for them.

At the group's April 19 meeting, ISMA president Dr. Earl Mericle spoke.

Elkhart

The Elkhart County Medical Society, in cooperation with the Indiana Academy of General Practice, held a seminar on psychiatric problems May 5 at Elkhart.

Speakers included Drs. Stewart T. Ginsberg, George R. Bloom, Bernard Edwards and Charles Anderson.

Floyd

Dr. John M. Paris spoke on "Hospital Construction" at the May 13 meeting of the Floyd County Medical Society. Twenty-six members attended.

The Society will send a local high school student to a two-week science institute at DePauw University this summer.

Hancock

Eleven members of the Hancock County Medical Society and their wives met at Greenfield May 23 for a legislative discussion.

Laporte

Dr. Richard Richter, Professor of Neurology at Chicago University School of Medicine, spoke on "Cerebral Vascular Occlusive Diseases and the Anti-Coagulant Therapy Thereof" at the May 17 meeting of the Laporte County Medical Society.

Lawrence

Twenty-one members of the Lawrence County Medical Society met at Bedford May 4 for a general business meeting.

Johnson

A Federal Bureau of Narcotics agent spoke at the recent joint meeting of the Johnson County Medical Society and the Johnson County Pharmaceutical Society.



"Oh, ah! I've got a hunch this is going to be one of those long operations."



"Psst, buddy, ya got a good vintage year on antibiotics?"

Orange

Mr. Richard Rembold, executive director of the Southeastern Indiana Rehabilitation Center at Jeffersonville, spoke on "General Review of Rehabilitation Center Service" at the Orange County Medical Society's June 7 meeting. Ten members attended.

Porter

Twenty-three members of the Porter County Medical Society held a general business meeting May 31 at the county hospital.

Pulaski

Newly-elected officers of the Pulaski County Medical Society are Drs. Harold Halleck, president; E. L. Hollenberg, secretary-treasurer; William R. Thompson, delegate to ISMA convention and Henry R. Eshelman, alternate delegate.

Putnam

Twelve members of the Putnam County Medical Society discussed their experiences at recent postgraduate courses and seminars at their May 13 meeting at Greencastle.

Wayne-Union

Dr. John F. Mueller, Associate Professor of Internal Medicine at Cincinnati University, spoke to 40 members of the Wayne-Union Medical Society at their May 10 meeting.

At the group's April 12 meeting, former Congressman Ralph Harvey spoke on "Outlook for the Medical Profession" and Dr. Arthur A. Weaver Jr., Dayton, Ohio, discussed "Intervertebral Disc Syndrome."

St. Joseph

New officers of the St. Joseph County Medical Society are Drs. Louis Bixler, president; J. M. Wilson, president-elect; Herbert Frank, secretary-treasurer and R. D. Dodd, assistant secretary-treasurer.

Also Drs. R. A. Ganser, D. L. Dunlap, M. D. Whitlock and F. R. N. Carter, delegates; William McCraley, C. F. Martin, Stephen Phelps and B. J. Dolezal, alternate delegates; H. A. Schiller, board of trustees and N. N. Holtzman, board of censors.

Vanderburgh

Dr James Crawford took office as president of the Vanderburgh County Medical Society at the group's recent meeting Assisting him will be Drs. Joseph Lawrence, president-elect; A. W. Ratcliffe, treasurer and Mr. Arthur P. Tiernan, executive secretary. ◄

Commission Meetings

Voluntary Health Agencies

April 3, 1960

The meeting was called to order at 1:45 p.m., Sunday, April 3, by Dr. Kenneth H. Brown, chairman, at the Student Union Building, immediately following luncheon.

The following were present: Drs. Norman R. Booher, R. Case Hammond, Herbert O. Chattin, Anne S. Nichols, H. Glenn Gardiner, James Gosman, Wendell A. Shullenberger and Louis C. Bixler.

Dr. Shullenberger moved that the minutes of the Feb. 28 meeting be approved as circulated. Dr. Chattin seconded the motion, motion carried.

Dr. Brown mentioned that we perhaps could not continue with the discussion of the Dec. 13 meeting until Dr. Doenges prepared his summary. However, Dr. Booher stated that he believed we should continue with the discussion of this in the absence of Dr. Doenges.

Dr. Hammond mentioned that he felt the notation concerning the Polio Foundation billboard should be mentioned in the commission's annual report.

Dr. Brown read a portion of a letter which he received from Mr. Patty of the Indiana Heart Foundation.

Discussion was held concerning the Dec. 13 meeting.

Dr. Shullenberger said he would like to have clearer in his own mind just what the functions of this commission should be. It seemed to him that if we are to fulfill any definite function that it would be as much as anything to protect the people so they are not victimized on a medical basis by one of these voluntary groups. Dr. Shullenberger said that if this is true, how can we best implement our attitude towards such an agency and let the public know?

Dr. Gardiner said that at the original meeting of the group it was stated just what the purposes were. Dr. Gardiner said he believed that what has been done this year is more encouraging than anything which has been done in the past. Dr. Gardiner believed that the fact that these agencies know what we are doing is as profitable an activity as we could conceive.

Dr. Shullenberger asked if we think any of the groups which participated in the Dec. 13 meeting should be asked to meet again with the commission.

(Dr. Booher called attention to our minutes of Jan. 31, in which we stated our purposes.)

Dr. Gosman mentioned that he had not received any communication from the Indiana Health Foundation, for which he is a liaison officer.

Dr. Brown asked if there were any other reports from members of the commission who are acting as liaison officers with the voluntary groups.

Dr. Nichols read a letter concerning polio from Mr. Eberline.

Dr. Shullenberger mentioned the fact that he believed the Polio Foundation is not following up on the activities of the vaccine.

Dr. Nichols mentioned another letter from Mr. Eberline concerning a meeting to be held in Chicago, to which they invite representatives from the voluntary health agencies to attend. The meeting is to be held April 25-26.

Dr. Shullenberger moved that if it is possible, through proper channels, the commission go on record to the effect that they believe the Polio Foundation is not practicing adequate follow-up with respect to preventive treatment of poliomyelitis. This refers in particular to lack of attempts to educate the public of the necessity of conducting new vaccination and re-vaccination of the susceptible group of the population. Further, it is pointed out that the foundation is making efforts in other directions, which are at least partially covered by organizations already existing and active in the voluntary health field. This commission questions the advisability or desirability of the polio people entering these new fields as long as the original problem remains as large as it is. Dr. Bixler seconded the motion, motion carried.

Dr. Brown mentioned the letter from the Indiana State Medical Association concerning the fact that the Executive Committee will act favorably on the issue of the billboard advertisement of the Polio Foundation.

Dr. Bixler reported on the tuberculosis group's chest x-rays.

Dr. Gosman reported a follow-up on his visit to Clay County. The Indiana Division of the American Cancer Society had another meeting with the physicians and the Clay County Cancer Society. As of now, the local cancer society has rejoined the Indiana division and everything seems to be going along well.

Dr. Booher added that as a representative to the Heart Foundation, he has been invited to sit with their executive committee, as previously noted in our minutes. He has been invited to digest the excellent report given by Dr. Bill Martz, at our Dec. 13 meeting, and has also studied the written material given him at the meeting. He recommended that this commission support the Indiana Heart Foundation.

Dr. Booher mentioned the mental health group. He said that he has received a lot of material for study. He has not been invited to sit in on any of their meetings. He had the feeling that the mental health organization needs greater correlation with the state authorities on this subject, and probably needs more activity on the part of the members of the Indiana State Medical Association to accomplish just this.

Dr. Bixler moved that we accept these reports as given and that they be incorporated in our minutes. Dr. Chattin seconded the motion, motion carried.

Dr. Booher moved that in view of the information presented to us by Dr. Nichols concerning the National Health Foundation inviting representatives of this commission to attend a meeting in Chicago on April 25 and 26, this commission recommend to the Executive Committee of the State Medical Association that Dr. Wendell Shullenberger's expenses to this meeting be defrayed. Dr. Bixler seconded the motion, motion carried.

Dr. Bixler read a letter from Mrs. Pauline Matthis concerning Tuberculin Testing Statement.

Dr. Brown read a letter from the Indiana Tuberculosis Association.

The Mantoux test was discussed.

Dr. Gardiner said he believed there are two aspects—one is the professional aspect and the other is what part does the Tuberculosis Association play in this.

Dr. Gosman moved the adoption of the three points set out in the Tuberculin Testing Statement. They are as follows:

1. The intradermal test (Mantoux) is more accurate than the Vollmer (patch), and is therefore the procedure of choice for use in case-finding programs.
2. All tuberculin testing should be done by, or with the supervision of, a physician.
3. Positive tuberculin reactors and students in the schools should be x-rayed by standard equipment rather than survey machines in order to minimize exposure to radiation.

Dr. Bixler seconded the motion, motion carried.

Dr. Booher moved that we answer the second request concerning the Indiana Tuberculosis Association requesting the Commission on Voluntary Health Agencies to endorse and support the recommendations of the Indiana State Board of Health regarding the tuberculin testing program in schools by saying that we feel that this is in the province of the Commission on Public Health and that we should turn to them for answer. Dr. Gosman seconded the motion, motion carried.

Dr. Shullenberger mentioned that at the Dec. 13 meeting, Dr. Robert L. Rudesill reported on the proposed section of the Indianapolis Diabetes Society, including discussions of the summer camps for diabetic children. The relationships of the lay section of the Indianapolis Diabetic Society were not mentioned. However, there is such an organization which is interrelated with the professional section by way of staggered appointments of directors but which otherwise is separate and has its own lay officers properly elected. The lay section of the Indianapolis society also publishes a report of their activities several times per year and supports the annual diabetic detection week in November.

Dr. Hammond mentioned that at the Dec. 13 meeting, Judge Addison Beavers represented the Society for Crippled Children. He discussed the activities of the two rehabilitation centers in the state—one in Indianapolis and one in Evansville. It is the feeling of this commission at this time that no criticism of this organization is noted.

Dr. Shullenberger mentioned the Arthritis and Rheumatism Foundation. He said they are in the process of organizing a local chapter. The lay representative, Dr. Fred Priebe, and Dr. Shullenberger will meet with interested lay representatives to consider a constitution along the line suggested by the Arthritis and Rheumatism Foundation.

It was mentioned that copies of the commission's annual report should be sent to each member of the commission. Those who do not return the report, it is assumed, approve the report.

Dr. Hammond moved that the annual report be mailed to each member of the commission—that these reports be returned to Dr. Brown, together with any suggestions, additions or deletions, on a date specified by him, and that failure to return the copy of the annual report shall constitute approval. Dr. Bixler seconded the motion, motion carried.

It was agreed that there was no need for any general meeting of this commission.

It was unanimously agreed that there was no need for any further meeting of this commission and that the annual report would constitute the final activity of this commission.

The meeting was adjourned at 3:30 p.m.

Public Health

April 2, 1960

The Commission on Public Health convened at 12:45 p.m., Saturday, April 2, 1960, following luncheon. Dr. Emmett B. Lamb, chairman, called the meeting to order. Present were Drs. E. S. Rifner, Daniel M. Hare, Richard C. Swan, Howard T. Hammel, John A. Davis, John R. Stanley, Mr. Howard I. Wells, Jr., executive secretary of the Joint Council to Improve the Health Care of the Aged and Mr. James Waggener, executive secretary of the Indiana State Medical Association.

The minutes of the last meeting held Jan. 24, 1960, were approved as circulated, upon motion of Dr. Hare, seconded by Dr. Rifner.

Dr. Rifner reported on a meeting with representatives from the Farm Cardiac Study.

Dr. Hammel asked if the State Medical Association ever decided what they were going to do about being a member of the National Safety Council. Nothing definite has been done on this.

The commission then met as a whole as a committee for the care of the aging. Discussion was held concerning this activity. Dr. Lamb said that he followed the suggestion at the last meeting and tried to get together an article for the *Journal*. Dr. Hare stated that he thought the article was quite good and that we should get reprints and get them out to the doctors in the state. Dr. Hare wondered if the newspaper had been notified of this, and wondered why we could not send a fixed number of these reprints to the members of the commission so that we can use them as we see

fit. Discussion was held concerning this. Dr. Hare moved we have two thousand (or any approximate, practical number which might be set) of these reprints printed to be paid for by the commission—100 copies to be sent to each member of the commission. (This is the article written by Dr. Lamb which appeared in the March issue.) Dr. Hammel seconded the motion, motion carried.

Dr. Lamb reported on the National Health Forum, which meeting was held in Miami, Fla. Mar. 14. Dr. Lamb presented copies of a written report to the members of the commission present.

Mr. Howard Wells represented the Joint Council to Improve the Health Care of the Aged at this forum. Dr. Lamb asked Mr. Wells to say a few words to the commission concerning this meeting. Mr. Wells remarked about the good work the AMA has done concerning the activities of the National Health Forum. He said he was assigned to report three of the group discussions from the standpoint of the individual action. He said this is an area where everyone is trying to get in the act. He said that the National Joint Council was formed in 1958 at the invitation of the AMA essentially to strengthen programs for the health care of the aged. Even though the National Joint Health Council hasn't done too much that they can report, there has been much activity on their part. The meetings which they have had offer a forum in which ideas can be voiced. The AMA had in mind that different groups get together to discuss these problems at a state level. We have 20 state joint councils. An organizational meeting is scheduled for Indiana on April 13. The most effective immediate action outside of the publicity that can be taken by a state joint council is to go to the Governor and offer assistance in preparing for and conducting a little White House conference, which will precede the 1961 White House Conference.

Dr. Hare asked where we stand in Indiana with this Joint Council.

Dr. Lamb reported on the meeting which he attended at the Indiana University Medical Center in February. He also mentioned that he is to attend another meeting on April 13. Dr. Lamb asked how many can go to the meeting to be held at the Medical Center April 13. Dr. Hare asked Dr. Lamb why he doesn't go to the meeting on the 13th and see what can be done, then call a meeting of the commission at a later date and invite the other people who attended the April 13 meeting to our commission meeting. It was suggested that Mr. Wells come to the meeting to be held on April 13.

Dr. Swan moved we pay a portion of Dr. Lamb's expenses to attend the forum in Miami. Dr. Hare seconded the motion, motion carried. (This is to be recommended to the Executive Committee for approval.)

Dr. Lamb called for reports of committees.

Dr. Swan had been asked to bring some recommendations to us, as a commission, regarding the industrial immunization program. Dr. Swan made a brief report on this program.

Dr. Swan moved that this commission recommend to the Council that the *Guide for Industrial Immunization Program* be adopted. Dr. Davis seconded the motion, motion carried.

Dr. Rifner reported on the Fifteenth National Conference on Rural Health, which he attended as a representative of the commission. The conference was held in Grand Rapids, Mich. The whole idea was how we could educate the rural people on immunization. Dr. Rifner said he enjoyed the meeting very much. They had several interesting speakers.

Dr. Rifner also discussed details of the Junior-Senior Day activities.

Dr. Hare suggested that we wait until after the April 13 meeting to decide on the next commission meeting.

Meeting adjourned at 2:05 p.m.

Medical Economics and Insurance

March 20, 1960

The meeting of the Commission on Medical Economics and Insurance was called to order at 2:00 p.m., Sunday, March 20, 1960, at the Indiana University Student Union Building, Indianapolis, Indiana.

Those present were Drs. John W. Beeler, Edward T. Edwards, Richard P. Good, Hubert T. Goodman, Albert T. Jones, John Langohr, Murray E. Harden, William Scharbrough, George E. Paine and Lowell I. Thomas. Guy A. Owsley, M.D., president-elect of ISMA, also attended most of the meeting.

Absent were: Drs. Wendell C. Stover, William H. Garner, Jr., Morris D. Wertenberger, Robert N. Bill and J. L. Arbogast.

The minutes of the previous meeting were approved as circulated.

Dr. Edwards reported that letters about proposed meetings on Relative Value Study were sent to societies of the Second District, and he had received no replies up to that time.

Dr. Good reported that an Eleventh District meeting on relative values was held in Howard County and the membership will be polled for opinions. He is scheduling a program at the Eleventh District meeting, in May, for explanation of the Relative Value Study.

Dr. Thomas reported a meeting of the Marion County Society is scheduled for April 26, at which a panel, consisting of the Marion County insurance committee, Lester Bibler, M.D., Chairman of the AMA Medical Service Committee, and Lowell Thomas, M.D., will present the Relative Value Study.

Letters were sent to the other counties in the Seventh District, and up to that date no reply had been received.

Dr. Paine (from the Thirteenth District) reported that the doctors in Elkhart have approved the Relative Value Study idea. The doctors in South Bend have expressed opposition to it.

Dr. Jones reported that Dr. Lamey had a meeting of the Eighth District executive committee, at which he asked if meetings could be set up with representatives from various county societies to present the Relative Value Study.

Dr. Goodman reported no district meetings in the Fifth District up to that time.

Dr. Harden of the Ninth District reported no meetings in his district up to that time.

Dr. Edwards introduced a letter from Mr. Arthur P. Tiernan, Executive Secretary of Vanderburgh County Medical Society, addressed to John Ivy, M.D., Elkhart, commenting on the San Joaquin County Medical Society's foundation for medical care. He moved that a sub-committee study this plan for informational purposes and report back. Motion seconded by Dr. Goodman and passed.

It was noted that Blue Shield minutes of a year ago contained details on the San Joaquin Plan. A condensation is to be sent to the commission members from Mr. Waggener's office.

Report of Committees:

(a) Relative values: Dr. Jones stated that he is preparing a statement setting forth a number of arguments opposing relative value study and will send the commission members a copy of this in the near future.

(b) Cooperative care of a surgery patient: The question was asked whether word had been passed to Blue Shield regarding paragraph 6, second page of the January 10 minutes. The secretary knew of no direct correspondence on this subject.

(c) Dr. Beeler reported on the Blue Cross—Blue Shield pathology and x-ray transfer committee. He says that an April meeting is due on the subject of Blue Cross—Blue Shield laboratory and x-ray fees.

(d) Dr. Edwards stated that O.P.B.S. care hinges on what is done in the April meeting of Blue Cross—Blue Shield as in item (c) above.

Dr. Edwards read a letter from Dr. Barnes, Area Medical Director, U.M.W., Louisville, Ky., regarding repeated service hospitalization of members and the subject of over-utilization of insurance.

Informal discussion followed.

The meeting adjourned at 4:00 p.m., to meet again April 24, 1960, at the Student Union Building, and members were asked to submit items for the agenda for that meeting and for our meeting with H.I.C.

Constitution and Bylaws

April 24, 1960

The meeting of the Commission on Constitution and Bylaws was called to order at 2:00 p.m., Sunday, April 24, 1960, by Dr. Lowell Hillis, vice-chairman.

The following members were present: Drs. Lowell J. Hillis, John B. Cleveland, William M. Sholty, Robert Hansell, A. W. Cavins, Gordon S. Fessler, Howard E. Sweet and Truman E. Caylor.

The minutes of the Jan. 17, 1960 meeting were read by Dr. Cleveland and approved as read.

Dr. Cleveland read the general qualification for membership as per the American Medical Association model constitution and bylaws. He also read the membership qualifications set forth in the model constitution and bylaws as presented by the Commission on Constitution and Bylaws.

Dr. Caylor asked Mr. Waggener if there was an urgency for the preparation of a final draft of a model constitution and bylaws.

Mr. Waggener said that actually there is no immediate need for such a model, as most counties already have filed their constitution and bylaws with the headquarters office. These were to be in the office by May 1.

Mr. Waggener said that the Council questioned in what county a physician should be a member if he lives in one county and practices in another: Chapter XXV, Section 7 of the Bylaws.

There was a motion that the words "on request" be eliminated from Chapter XXV, Section 7 of the Bylaws, a comma be added after the word "cost" and a comma after the word "transferred." In the present form Section 7 reads as follows:

Sec. 7—When a member in good standing in a component society moves to another county in this state his name, on request, shall be transferred without cost to the roster of the county society into whose jurisdiction he moves, provided the transfer is approved by majority vote of the membership of said society to which the membership is proposed.

With the amendment, as per the motion made by the commission, Section 7 would read as follows:

Sec. 7—When a member in good standing in a component society moves to another county in this state his name shall be transferred, without cost, to the roster of the county society into whose jurisdiction he moves, provided the transfer is approved by majority vote of the membership of said society to which the membership is proposed.

The motion was seconded and passed.

The Council also wondered if there was not a conflict between Chapter I, Section 1 of the Bylaws and Chapter XXV, Section 4 of the Bylaws—the definition of the word "member."

There was a motion made that Chapter XXV, Section 4, which reads as follows:

Sec. 4—Each county society shall be judge of the qualifications of its own members, but, as such societies are the only portals to this Association, every reputable and legally registered physician, who does not practice or claim to practice, nor lend his support to any exclusive system of medicine, shall be entitled to membership. Before a charter is issued to any county society, full and ample notice and opportunity shall be given to every physician in the county to become a member.

Should be amended to read as follows:

Sec. 4—Each county society shall be judge of the qualifications of its own members, but, as such societies are the only portals to this Association and to the

American Medical Association, every reputable and legally registered physician, who holds a degree of Doctor of Medicine or Bachelor of Medicine, who does not practice or claim to practice, nor lend his support to, any exclusive system of medicine, shall be entitled to membership. Before a charter is issued to any county society, full and ample notice and opportunity shall be given to every physician in the county to become a member.

This motion was seconded and passed.

Mr. Waggener stated that the Council suggested that this Commission again consider the remission of dues—Chapter XXV, Section 12—fourth paragraph. The Council does not understand exactly what is meant by "good cause." It is wondered if "good cause" should be defined in the Bylaws.

It was the feeling of the Commission that Chapter XXV, Section 12, paragraph 4 of the Bylaws, which concerns the remission of dues, should have a definite clarification of the phrase "good cause."

Chapter XXV, Section 12, paragraph 4, now reads as follows:

Sec. 12 (paragraph 4)—In the event the county society remits a member's dues for good cause, the secretary of the county medical society shall recommend in writing to the councilor of his district the remission of the state association dues of said member of the society, showing good cause why such recommendation should be granted. The councilor in turn may present the recommendation to the Council, which shall have the power to remit such dues.

There was a motion that the words "on account of financial hardship" be substituted for the words "good cause" in the second sentence. Also the words "good cause" in the sixth sentence be eliminated. It was also felt that the word "shall" should be substituted for the word "may" in the eighth sentence.

The fourth paragraph of Chapter XXV, Section 12, as amended, would read as follows:

In the event the county society remits a member's dues, on account of financial hardship, the secretary of the county medical society shall recommend in writing to the councilor of his district the remission of the state association dues of said member of the society, showing why such recommendation should be granted. The councilor in turn shall present the recommendation to the Council, which shall have the power to remit such dues.

The motion was seconded and passed.

It was decided to hold the next meeting of the commission at the Student Union Building at 1:00 p.m., Sunday, June 19, 1960.

The meeting adjourned at 4:15 p.m.

John B. Cleveland, M.D., Secretary. ◄

Association News

THE COUNCIL

April 10, 1960

The Council of the Indiana State Medical Association convened for its spring meeting at 10:00 a.m., Sunday, April 10, 1960, in Room M-124, Indiana University Student Union Building, Indianapolis, with Dr. Maurice E. Glock, chairman, presiding.

Roll call showed the following present:

Councilors:

First District—William B. Challman, Mount Vernon
Second District—J. H. Crowder, Sullivan
Third District—John M. Paris, New Albany
Fourth District—Joe M. Black, Seymour
Fifth District—Robert K. Webster, Brazil
V. Earle Wiseman, Greencastle, alternate
Sixth District—Harry P. Ross, Richmond
William R. Tindall, Shelbyville, alternate
Seventh District—Ralph V. Everly, Indianapolis
Eighth District—Guy A. Owsley, Hartford City (also president-elect); Gordon B. Wilder, Anderson, alternate (also AMA delegate)
Ninth District—Kenneth O. Neumann, Lafayette
Tenth District—James P. Vye, Gary
Ralph C. Eades, Valparaiso, alternate
Eleventh District—Max R. Adams, Flora
Earl W. Bailey, Logansport, alternate
Twelfth District—Maurice E. Glock, Fort Wayne
Milton F. Popp, Fort Wayne, alternate
Thirteenth District—Burton E. Kintner, Elkhart

Officers:

Earl W. Mericle, Indianapolis, president
Frank B. Ramsey, Indianapolis, Editor, *The Journal*
A. W. Cavins, Terre Haute, Associate Editor, *The Journal*

Executive Committee:

Wendell E. Covalt, Muncie, member

Guests:

Cleon A. Nafe, Indianapolis, member Board of Trustees, AMA
Robert M. Brown, Marion, alternate AMA delegate
Jack G. Weinbaum, Terre Haute, vice-chairman, Commission on Convention Arrangements
Charles R. Alvey, Muncie, chairman, Commission on Governmental Medical Services
John Langohr, Columbia City, chairman, Commission on Medical Economics and Insurance
Philip B. Reed, Indianapolis, chairman, Grievance Committee
E. B. Lamb, Indianapolis, chairman, Commission on Public Health
A. C. Offutt, Indianapolis, State Health Commissioner
John D. VanNuys, Indianapolis, Dean, I. U. School of Medicine
John B. Twyman, Gary, executive secretary, Lake County Medical Society

Staff:

Robert J. Amick, field secretary
Howard Grindstaff, field secretary
J. A. Waggener, executive secretary

By consent the minutes of the January 10, 1960, Council meeting were approved as printed in the March, 1960 issue of *The Journal.*

Reports of Councilors

The councilors announced the dates, time and places, and programs for their spring district meetings.

The chairman called attention to Chapter XXVI, Section 8, of the Bylaws which specifies that programs for district meetings are to be in the headquarters office 45 days in advance of district meetings to allow time for distribution to all district members 30 days prior to district meetings.

Reports of Officers

DR. EARL W. MERICLE, president: You have had from me some notes that I sent out to you about two weeks ago and since that time the only thing that has happened is that I attended the medic-civic dinner in Evansville, which incidentally is a fine practice. Each year the doctors there put on a medic-civic dinner and bring with them as guests, the leaders of the community of Evansville. They had about 350 there that night, and Dr. Orr, president of the American Medical Association, was the chief speaker. Dr. Orr took his gloves off and really laid it on the line as to what this Forand-type legislation would mean if it comes to pass.

The only other item has to do with the last paragraph in the notes that I sent to you in regard to this situation in which the medical practice in a certain county in Indiana was being criticised. It so happened that that county was in Dr. Glock's district, so about two weeks ago Dr. Owsley, Jim Waggener and I met Dr. Glock and went on to see what could be done about this situation. We talked to the complaining individual, whose complaints, in a measure, could hardly be questioned. There was some doubt on some of the things that he said about it. He had written first to Indiana University hoping that the new doctors coming forth would be indoctrinated better in community responsibilities than the ones that were in his district.

After our meeting with this gentleman we came back and last Sunday the liaison committee of the state association with the University met, and we learned that the University is not remiss in trying to inculcate into the students the proper principles of community responsibilities. It seems that Ed Smith throughout the whole sophomore year is doing a pretty good job of that and Don Wood has some time with them too. We did learn one factor in this community that is disturbing to us, and that is, that the local county society meets once a year.

Continued

We are going ahead to do what we can about this situation, as things like that come up. I feel that the only thing that the state association can do, when we have a complaint which comes from that type of an individual, that we had better investigate it, and Dr. Glock is going to further do what he can to correct any situation, should there be a glaring one there.

TREASURER'S REPORT. In the absence of Dr. Okla W. Sicks, treasurer and the assistant treasurer, Dr. Harry Pandolfo, the following report on receipts in the General Fund of the Association, and disbursements from that fund, as of March 31, 1960, was distributed to members of the Council and was read by the chairman:

RECEIPTS, October 1, 1959 to March 31, 1960 ---------- $205,005.16

CASH BALANCE, March 31, 1960 ---------- $ 32,932.00

COMMITTEES	BUDGETED	EXPENSE CURRENT MONTH	DISBURSED TO DATE	BALANCE
Grievance	$ 300.00	$ 74.92	$ 356.57	$ (56.57) over
Student Loan	100.00	----	6.70	93.30
Building	1,000.00	81.18	196.18	803.88
Medical—Legal	50.00	----	----	50.00
Executive	700.00	85.70	663.63	36.37
COMMISSIONS				
Constitution and Bylaws	$ 200.00	----	143.90	56.10
Inter-Professional Relations	450.00	----	----	450.00
Legislation	6,000.00	695.70	3,169.78	2.830.22
Public Health	2,500.00	----	385.89	2,114.11
Public Information	7,000.00	172.17	5,768.87	1,231.13
Special Activities	200.00	----	----	200.00
Voluntary Health Agencies	300.00	52.32	543.62	(243.62) over
Medical Economics and Insurance	2,000.00	160.70	655.92	1,344.08
Medical Education and Licensure	3,000.00	61.51	688.25	2,311.75
Governmental Medical Services	1,000.00	72.48	280.26	719.74
COUNCIL—Meetings	1,200.00	----	257.38	942.62
COUNCIL—Travel	800.00	----	298.50	501.50
HEADQUARTERS Expense	75,255.00	5,597.62	38,536.37	36,718.63

The chairman also read the following treasurer's report, formulated by Dr. Sicks, on investments in the General Fund and in the Medical Defense Fund, as follows:

INVESTMENTS IN BONDS:

	March 11, 1959	February 29, 1960	March 31, 1960
GENERAL FUND	$301,000.00	$336,000.00	$336,000.00
MEDICAL DEFENSE	25,000.00	26,000.00	26,000.00
	$326,000.00	$362,000.00	$362,000.00

Out of 1960 income from dues, $85,000.00 has been invested in U. S. Treasury Bills. Of this amount $36,000.00 is earmarked for AMEF, and $17,950.00 is earmarked for the Building Bond Retirement Fund.

As Treasury Bills mature, they are reinvested in Treasury Bills in order to have money readily available for the Building Fund.

General Fund Securities consist of:

		Interest Rates
U. S. Treasury Bills	$100,000.00	4.00 to 4.77%
U. S. Treasury Bonds	145,000.00	2¾ to 3¼%
U. S. Treasury Notes	15,000.00	4%
U. S. Savings Bonds	76,000.00	2.5 to 2.76%
TOTAL INVESTMENT, GENERAL FUND	$336,000.00	

Medical Defense Fund Securities include:

U. S. Treasury Bills--	$ 3,000.00	3.94%
U. S. Treasury Bonds-	14,000.00	2¾%
U. S. Savings Bonds--	9,000.00	2.5 to 2.76%
TOTAL INVESTMENTS, DEFENSE FUND	$ 26,000.00	

DR. FRANK B. RAMSEY, editor of *The Journal:* The cover for the April number of *The Journal,* in honor of Easter, represents a church window. The girls obtained the art work and the story for this from the Stewart-Carey Glass Company. Stewart-Carey has a TV program on Sunday evening, at six o'clock; it's been running about 10 years now; it's the oldest sponsored TV program in Indiana, and on Easter Sunday, April 17, a part of their program will be devoted to this cover which they are going to pinpoint. They have ordered 3,000 reprints of the cover story and expect to offer to send these to any TV viewers who ask for them.

Unfinished Business

1. *Building Committee.* Dr. Everly, chairman, reported that his committee had had one telephone conference to agree on the basic principles under which they were going to operate. The committee will bid on the site of the old governor's mansion, behind the Marott Hotel, on April 28. The association also will be represented by its realtor and legal advisor. "I can assure you that the Building Committee is an adept group of individuals, and we will do our level best to expedite the program as much as we possibly can."

DR. OWSLEY: Many of you on the Council will remember that when the Building program was first discussed we discussed many methods of financing the program and among those methods was the voluntary subscription idea, as at that time, if my memory serves me right, most of the councilors said that they would start the contributions and many of them indicated that they would donate at least $100.00. That's been a long time ago.

Since this new Building Committee has been designated by our House of Delegates, they have had no direction to proceed with anything other than that defined in the House's directive and that did not include methods of financing other than to use money out of the general fund of the association and whatever mortgage that would seem to be prudent.

Now, it's just this simple, it seems to me. If we would approve a method of raising funds by popular subscription, we wouldn't have anything to lose and we might have a lot to gain. If we did collect, say $100,000.00 that way, we could either not put in so much from our general fund, or we wouldn't have to have such a big mortgage, or we could use this money for furnishings, which a new building would need.

Some idea has been put forth that this might be a good project for the Auxiliary, to go out and see how many doctors would like to make a donation.

I will call your attention, before you get into discussion about it, this would be deductible; it could be given over a three-year period, much as you give to your churches and your other local community projects, and you could pay it in any year where it was to the best tax advantage for you. So, I would like to make a motion, Mr. Chairman, that the Building Committee be authorized to conduct a popular subscription campaign to raise funds for the construction and furnishing of the new headquarters building.

(Motion seconded by Dr. Vye.)

DR. EVERLY: At the time we had our telephone conference I brought up the subject of fund raising and the expression of opinion of the committee was that they felt, as far as the Building Committee was concerned, they had their hands full with building the building. I can recall that Dr. Pandolfo, vice-chairman of the committee, and I had been considering the fund raising campaign and decided that the vice-chairman of the committee would be chairman of the steering mechanism for the fund raising campaign.

Now, I don't know exactly how far Guy expects the Building Committee to go with a fund raising campaign. If it is a matter of stimulating the Auxiliary into that project, that's one thing; but I think if it is a matter of the Building Committee being very active in fund raising, it might not meet the approval of the committee.

DR. OWSLEY: I didn't mean to load this committee with any more work. That was the idea—that since they are in charge of the whole project, I thought that they had the authority, if they elected, say, to pass it on to the Auxiliary, with their blessing, etc., that would be perfectly satisfactory. Just so the thing had some organization to head it . . . and it seemed to me the Building Committee was the most logical. I didn't expect them to do all the work on it.

CHAIRMAN GLOCK: Does this motion direct the committee to proceed with a fund raising drive, or does it just authorize them to conduct?

DR. OWSLEY: Well, direct would be more positive—authorize and direct. I will rephrase the motion—authorize and mandate the building committee to set up the necessary machinery.

(This change in the motion was accepted by Dr. Vye.)

DR. KINTNER: Is there anything in this that would imply that an immediate fund raising campaign be started, or at the discretion of the committee?

DR. EVERLY: Of course, it's a little difficult to start a fund raising campaign unless you hold title to a site to build on. I think it would lend force to the fund raising campaign if you could say we have a spot on which to build.

(On voting, Dr. Owsley's motion was carried.)

2. *Student Loan Fund.* Dr. Ross, chairman, reported that the balance in the Student Loan Fund at this time is $748.72, with the expectation of an interest payment in the near future of $21.50. Five or six applications are pending for review, one from an out-of-state resident. Inasmuch as the original resolution creating the Student Loan Fund set up the fund for only *bona fide* legal residents of the State of Indiana, it was taken by consent that the

Council would not take upon itself the authority to change the rules established by the House of Delegates.

3. *Medical Care for Military Dependents.* (a) Veterans Home Town Fee Schedule. This fee schedule was revised two years ago, and Dr. Charles R. Alvey, chairman of the Commission on Governmental Medical Service, said his commission recommends that the schedule, when it comes up for renewal at the beginning of the new fiscal year, be reaffirmed and approved as it was two years ago.

(On motion of Drs. Ross and Paris, the Council approved of this action.)

(b) The use of generic terms rather than the trade names or other such terms in writing prescriptions for welfare recipients was discussed by Dr. Alvey as one of the matters which had been referred to his commission for study. He asked for an expression from the Council on whether or not his commission should go on record as approving the use of generic terms in writing prescriptions for welfare patients. Discussed by Drs. Paris, Everly, Challman, Owsley and Nafe.

(On motion of Drs. Challman and Ross, the Council voted that no action be taken on this at this time and that it be deferred for further study.)

4. *Report of Liaison Committee between Council and Blue Shield.* Dr. Challman, chairman, and Dr. Neumann, reported on the national conference with Blue Shield, which they attended in Los Angeles early in April.

(a) Dr. Challman asked for an expression from the Council on the following two matters:

(1) On the advisability of having a closed meeting between the Council and the medical representatives on the Blue Shield Board, and

(2) On how the surgical assistants' fee business should be handled.

Item No. 1 was discussed by Drs. Paris, Challman, Neumann, Glock, Mericle, and Nafe, following which:

The Council, on motion of Drs. Paris and Vye, voted that a meeting of the physician members of the Indiana Blue Shield Board and the Indiana Blue Cross Board with the members of the Council should be held.

THE CHAIRMAN: The next question that Dr. Challman has is in regard to surgical assistants' fees, and our Council Liaison Committee feels that such surgical assistants' fees should be in addition to those fees already provided for in the various Blue Shield schedules. Does anybody care to make a resolution regarding this?

(Dr. Vye moved that Blue Shield pay a surgical assistants' fee in addition to their regular surgical charge, especially on the standard schedule. Motion was not seconded.)

The chairman read the resolution passed by the House of Delegates in October, 1959, as follows:

"BE IT RESOLVED, that the Board of Directors of Indiana Blue Shield be respectfully requested to issue a new schedule of indemnities for the assisting or cooperating physician, listing these indemnities, for procedures now listed in the schedule of Surgical Indemnities, payable to the assisting or cooperating physician and the certificate holder jointly on submission by the assisting or cooperating physician of proper and separate claim forms."

This was discussed further by several, including Dr. Langohr, chairman of the Commission on Medical Economics and Insurance.

(Here someone said: "It still doesn't say whether that's to be subtracted from the surgical indemnity; that's the question that has been raised.")

CHAIRMAN GLOCK: No, it's real specific—"a new schedule for the assisting or cooperating physician." It says nothing about the surgical figure. My feeling would be that that adequately covers it.

(b) DR. JOHN LANGOHR, chairman of the Commission on Medical Economics and Insurance, asked for instructions on the following two items:

(1) *Special rider for surgical assistants' fees* "which matter was presented by Dr. Edwards at your last meeting and tabled until now; your instructions also in that regard to whether Blue Shield should be requested to eliminate from their present claim report form the provision that is on it at the present time—that which forces the operating surgeon to designate whether or not a portion of the indemnity shall be turned over to an assistant and what portion. And your instructions about how we can go about helping Blue Shield to implement the House of Delegates' resolution of last October in that regard, and

(2) "Your instructions about whether we should proceed with the subject Dr. Alvey's committee is interested in and that is, a study of whether it is ultimately possible for the medical aid recipients in Indiana to be covered by some sort of Blue Cross-Blue Shield coverage for all services—a method which has been followed with good success in Washington, more recently in Colorado, and which offers, we think, some opportunities for considerable savings to the welfare department and to the taxpayer in coverage of those services."

Following discussion of Item No. 1 by Drs. Neumann, Langohr, Nafe and Black:

It was taken by consent that it probably would be best to leave this matter stand as it is at the present time until some decisions are made on the assistants' fee scale level and a report had from the AMA Judicial Council regarding its ethics status.

Feeling "that this is a step in the right direction if it can be accomplished,"

On motion of Drs. Paris and Everly the Council authorized Dr. Langohr and his Commission to continue working on the joint studies with the Indiana State Department of Public Welfare, as well as Blue Cross and Blue Shield, on the possibility of coverage by Blue Cross-Blue Shield for all services for medical aid recipients in Indiana.

5. *Osteopathic Matters.* Dr. Webster, chairman of the Council Fact-Finding Committee, reported on the activities of his committee.

Dr. Philip Reed, chairman of the Grievance Committee, also reported on the activities of his committee on this subject.

The chairman thanked Dr. Webster and the Council Fact-Finding Committee and Dr. Reed and expressed the hope that they would continue their study and would be able to give the Council a report covering this study and any action or further study that should be taken in this matter, which in turn can be passed on to the House of Delegates.

6. *Board of Impartial Medical Witnesses.* DR. VYE, chairman of the Council Committee on Establishment of Panel of Impartial Medical Experts, reported as follows:

I was unable to get a meeting of our group, but I talked with all but Dr. Neumann by telephone.

Your committee has been instructed to try and bring to the Council suggestions and recommendations for the forming of an Impartial Medical Witness Panel of Doctors who are fully qualified in their respective fields and would be completely impartial in their testimony.

We invited Dr. Richard Bennett of Chicago, who was instrumental in taking the lead in Illinois in the forming of such a panel, to a meeting of our council. Also present were Dr. Sherman Egan of South Bend, and Judge Luther Swygert of the United States District Court of Hammond. He originally had called on the state association to form such a panel and the association referred it to this committee.

The purpose of such a panel would be to, first, review all evidence on a pre-trial basis, and possibly to avoid personal injury suits going to trial; second, to avoid loss of time of a physician in a court procedure, and third, it might save considerable expense involved in such litigation of suits because they could be settled without a court action. This plan has been put into effect in Illinois, New York and California, and I think in Ohio, and it has been proven successful.

It was agreed that it would be better to divide the northern part of the state into three divisions: the Hammond division, the South Bend division, the Fort Wayne division.

I spoke to some members of the Bar Association—like everyone else, part of them are very strong for it, and part of them are against it. But in the majority, even those who are against it, are interested because of the impartiality of the panel.

We feel that this has merit for the reasons outlined above, and we recommend at least that a study should be made of the formation of the panel for those who want it. We don't think it should be forced on anybody. And we think it would be of great service in personal injury suits because a lot of them wouldn't come to trial if they were handled by impartial medical witnesses.

I think the actual details in the formation of this panel should be worked out on a local level, so that doctors who are highly qualified in the particular fields could be called by the court. A court wouldn't know who they were calling—they would be called by numbers, like they are in Illinois. The judge never knows who he is calling—he is only calling a man in that line, they are called by numbers, and the numbers are changed, so he won't get to know what number a particular man has.

If you have any questions, we will try to answer them if possible.

Following discussion by Drs. Neumann, Kintner, Challman, and Cavins:

On motion of Drs. Challman and Kintner the Council voted that inasmuch as this is a pressing problem in the northern part of the state, that the chairman of the Council's special committee be authorized to contact the local counties involved in the Hammond, South Bend and Fort Wayne areas and ask them if they would care to set up such panels on a trial basis for one year, and report back to the Council on how this system works.

7. *Unfinished business of the Commission on Medical Education and Licensure.*

(a) *School Health Policies.* Dr. A. C. Offutt, and Mr. Robert Yoho, of the State Board of Health, explained that some rules and regulations on which school health programs can be based had been developed by the State Board of Health and the Commission on Medical Education and Licensure of the state medical association, in order that there would be no misunderstandings about the feelings of the Board of Health and organized medicine pursuant to the actual operation of school health programs.

Discussed by Drs. Eades, Owsley and Paris.

By consent, the Council instructed Dr. Eades and the Commission on Medical Education and Licensure to have these suggested school health policies printed for presentation at the next meeting of the Council, in order that the Council may have them in their entirety.

The State Board of Health and the Commission on Medical Education and Licensure would like to complete preparation of these policies and have them in printed form for the fall term of the school year, and, therefore, they hope to get the approval of the state medical association prior to that time.

(b) *Mantoux testing in schools.* Dr. Offutt presented the following recommendations, which:

On motion of Drs. Paris and Challman were accepted by the Council:

1. The intradermal test (Mantoux) is more accurate than the Vollmer (patch), and is therefore the procedure of choice for use in case-finding programs.
2. All tuberculin testing should be done by, or with the supervision of, a physician.
3. Positive tuberculin reactors and students in the schools should be x-rayed by standard equipment rather than survey machines in order to minimize exposure to radiation.

(c) *Arden House meeting, Harriman, New York,* For the information of the Council Dr. Offutt reported on this meeting of specialists in tuberculosis control.

1960 Annual Convention, French Lick October 2-5, 1960

DR. JACK G. WEINBAUM, vice-chairman of the Commission on Convention Arrangements, outlined the program briefly, as follows:

Sunday, October 2, 1960

Executive Committee and Council meetings.

6:30 p.m. Meeting of House of Delegates

Monday, October 3, 1960

Morning

8:00 a.m. Annual golf tournament

9:00 a.m. Annual trap and skeet shoot

9:00 a.m. Reference Committee meetings

10 to 12 n. Instructional courses

12 n. Luncheon meeting of past-presidents of ISMA

Afternoon

1:30 to 5 p.m. Panel type of program on "Coronary Heart Disease," directed to the general practitioner and emphasising general medicine

Evening

7:30 p.m. Dinner and dance and entertainment for members, their wives and guests

Tuesday, October 4, 1960

Morning

9 to 11:30 a.m. Panel discussion on "Diseases of the Gastro-Intestinal Tract"

Noon

Section meetings

Afternoon

2 to 5 p.m. Program dealing with Socio-Economic Problems, covering the following three topics:

"The Doctor and How to Keep His Money"

"Medical Politics on a Nationwide Basis"

"Malpractice Problems"

Evening

7:00 p.m. President's Night and annual dinner

Wednesday, October 5

Morning

9:00 a.m. Final meeting of House of Delegates

10 to 12 n. Instructional courses

Afternoon

1:00 p.m. Organization meeting of 1960-61 commission and committee members of ISMA

Membership Matters

1. *Membership report:*

Number of members as of March 31, 1959		3,942
1960 members as of March 31, 1960:		
Full dues paying	3,513	
Interns	21	
Residents	161	
Council remitted	29	
Senior	380	
Military	34	
Honorary	1	
Total 1960 members as of March 31, 1960		4,139
Gain over last year		197
Number of members December 31, 1959		4,256
Number of AMA members as of March 31, 1959		3,590
1960 AMA members: Dues paying	3,377	
Exempt, but active	633	
Total 1960 AMA members as of March 31, 1960		4,010
Gain over last year		420
Number of AMA members as of December 31, 1959		4,120
Number who have paid state dues but not AMA dues in 1960		118

2. *Remission of state dues.* The Council voted remission of state dues of members as follows:

KNOX COUNTY—one member, because of illness, on motion of Drs. Paris and Vye.

VIGO COUNTY—three members, because of hardship, illness and retirement, on motion of Drs. Webster and Challman.

FAYETTE-FRANKLIN—one member, due to retirement, by consent.

MARION COUNTY—two members, because of serious illness, and not in practice (woman physician with children), on motion of Dr. Everly, unanimously seconded.

WELLS COUNTY—one member, due to retirement, on motion of Dr. Popp, duly seconded.

KOSCIUSKO COUNTY—one member, due to ill health, on motion of Dr. Kintner, duly seconded.

ST. JOSEPH COUNTY—one member, due to ill health, on motion of Dr. Kintner, duly seconded.

Two St. Joseph county members refused remission of dues as the Council felt they did not qualify for exemption under the Bylaws of the association.

Legislative Matters

The chairman complimented Dr. Don E. Wood and his Commission on Legislation for the excellent job they are doing. "I think we have had real good relations with the press. I hope all of you get a copy of the fine article that Earl Mericle wrote which was carried in one of the local papers. They had a full-page spread on the Forand bill, which I think was a marvelous piece of work, and I would like to thank all of the councilors who have been active in their districts and in the local societies for the effort they have put forth on this."

Dr. Nafe discussed pending legislative matters from the AMA level.

New Business

1. *Matters referred to Council by Executive Committee.* In the absence of Dr. Don E. Wood, chairman, Dr. Mericle presented the following matters:

(a) *Guide for Industrial Immunization Programs,* which follows:

"The following statement, prepared by the Committee on Industrial Health Emergencies of the Council on Industrial Health, has been approved by the Board of Trustees of the American Medical Association.—B. Dixon Holland, M.D., Secretary.

"Health maintenance is primarily the responsibility of the individual person; however, the employer has an obligation to provide a safe work environment for his employees, and he has a valid interest in the prevention of loss of work time and of work efficiency from his employees ill health. Definitive diagnosis and therapy of nonoccupational injury or illness is not a responsibility of the employer; but he may provide certain preventive health measures in a given situation where the employee, the employer, and the community stand to benefit. While it is impossible to forsee every situation which might occur locally where an employer might properly make immunization procedures available to his employees, the following principles are offered as a guide.

"1. Toward fulfillment of his obligation to provide a safe work environment, or to take appropriate precautionary measures, an employer should provide immunization procedures to employees who, by reason of their occupation or job assignment, may be exposed to significant hazards against which immunization procedures are available.

"2. In keeping with his legitimate right to operate efficiently and profitably in a free enterprise system, with his responsibility to the community, and in demonstration of his good corporate citizenship and concern over his employees' health, an employer may provide immunization procedures in the face of an impending epidemic which threatens to disable so large a proportion of his employees as to interfere materially with operations and against which immunization procedures could not be applied by community health resources in a short enough period of time to afford the optimum protection. The component medical society's approval of company immunization programs conducted under these circumstances should be sought, and to the extent feasible and practicable local physicians should be afforded an opportunity to participate in them.

"3. Additionally, an employer may wish to participate in community-wide immunization programs at the request of and in cooperation with a local medical society and community health agencies."

Dr. Emmett B. Lamb, chairman of the Commission on Public Health, reported that the *Guide for Industrial Immunization Programs,* had been referred to his Commission and had been discussed at length by the commission at its meeting on April 2, 1960. It was voted unanimously by the members present at that meeting to recommend the endorsement of this "guide" by the Council of the Indiana State Medical Association.

Following discussion by Drs. Mericle, Paris and Nafe, the Council, on motion of Dr. Owsley, duly seconded, voted to refer this matter to the House of Delegates.

(b) *Billboard advertising of the National Foundation.* The Commission on Voluntary Health Agencies called the attention of the Executive Committee to the signs which the National Foundation has erected in Indiana on which the statement, "Guarding America's Health" is printed. The commission feels that this is improper advertising, indicating that the National Foundation is the sole guardian of the health of the nation, and the commission asked that the Executive Committee write a letter protesting the use of this phrase in future advertising. This was discussed by Drs. Paris and Challman.

It was taken by consent that the Council should make no specific recommendations in this instance.

(c) *Request of National Foundation for appointment of Scholarship Advisory Committee.* On February 23, 1960, Dr. Kenneth L. Olson received a letter from The National Foundation, requesting the Indiana State Medical Association to nominate three physicians from whom one would be invited to serve as a member of the scholarship committee from Indiana, this group to make available scholarships for people in health fields.

It was taken by consent that the Council confirm its opinion of January 18, 1959, at which time the members of the Council voted not to participate in the Health Scholarship Program of The National Foundation.

2. *Nominations for two members on the Editorial Board* (to be voted on at fall meeting of the Council) to succeed Drs. George M. Johnson, Richmond, and Irvin W. Wilkens, Indianapolis, whose terms will expire December 31, 1960, were deferred until the fall meeting of the Council.

3. *AMA Disciplinary Committee.* Dr. Philip Reed, chairman of the Grievance Committee, reported that his committee had discussed the July 7, 1959, letter received from Raymond M. McKeown, M.D., chairman of the AMA Disciplinary Committee, and referred to the Grievance Committee by the Executive Committee through the Council. The letter reads in part as follows:

"In planning the program of the Committee we would like to have the benefit of your thinking. Initially, we would like to know:

(a) Whether there is a need in your area for more effective procedures of professional discipline.
(b) The major disciplinary problems with which you are now confronted.
(c) Whether, in your opinion, there has been improvement or deterioration in recent years in the role of professional discipline on the part of medical societies. Why?
(d) What you believe are the types of improper or illegal conduct, on the part of physicians, with which a committee of this nature should be concerned."

Dr Reed said when this letter was discussed "paragraph by paragraph at the January 17, 1960 meeting of the Grievance Committee it was the consensus at that time that existing bodies and procedures had rather effectually handled medical discipline in the State of Indiana, and I was instructed to so report to the Council at this meeting today.

"However, at the March 27, 1960 meeting of the Grievance Committee, several members felt that we had moved too hastily, and it was voted to reopen the question. . . . Accordingly the Committee reconsidered its action and recommended that the pattern of the State of Washington Medical Disciplinary Board be presented to the Council, that it might consider its further study."

Dr. Reed here briefed the Medical Disciplinary Act of the State of Washington, copy of which had been sent to each councilor.

Dr. Reed quoted from the supplementary report of the AMA Board of Trustees in meeting of the House of Delegates under date of November 29, 1959, in reference to the A.M.A. Medical Disciplinary Committee, as follows:

"The Committee has not altered its previous opinion regarding its timetable. It believes it should continue to proceed slowly as it attempts to develop every aspect of the medical disciplinary problem. In its final report the Committee plans to discuss the status and effectiveness of existing medical disciplinary mechanism and, if necessary, to recommend methods by which such existing systems can be supplemented or improved."

DR. REED: The Grievance Committee, therefore, recommends to the Council that further study be made to determine if cause exists for the establishment of more effective discipline of all licensed practitioners of medicine. You will please note there is nothing about this that would reopen the Medical Practice Act. This applies only to physicians.

By consent, the Council approved of the Grievance Committee's study, and further study, of medical discipline in Indiana.

THE CHAIRMAN: To implement this, probably it would be well, Doctor Reed, to prepare a suitable act for this state to possibly present to the next House of Delegates.

Blue Shield Board Members

Attention was called to the fact that terms of the following Blue Shield Board members will expire March 1, 1961, and nominations of candidates for these positions should be made by the respective districts:

	Branch of Medicine	Represents
Robert H. Denham, South Bend	Orthopedics	District 13
Harry R. Stimson, Gary	General Practice	District 10
J. E. Dudding, Hope	General Practice	District 4
Glen V. Ryan, Indianapolis	General Practice	District 7

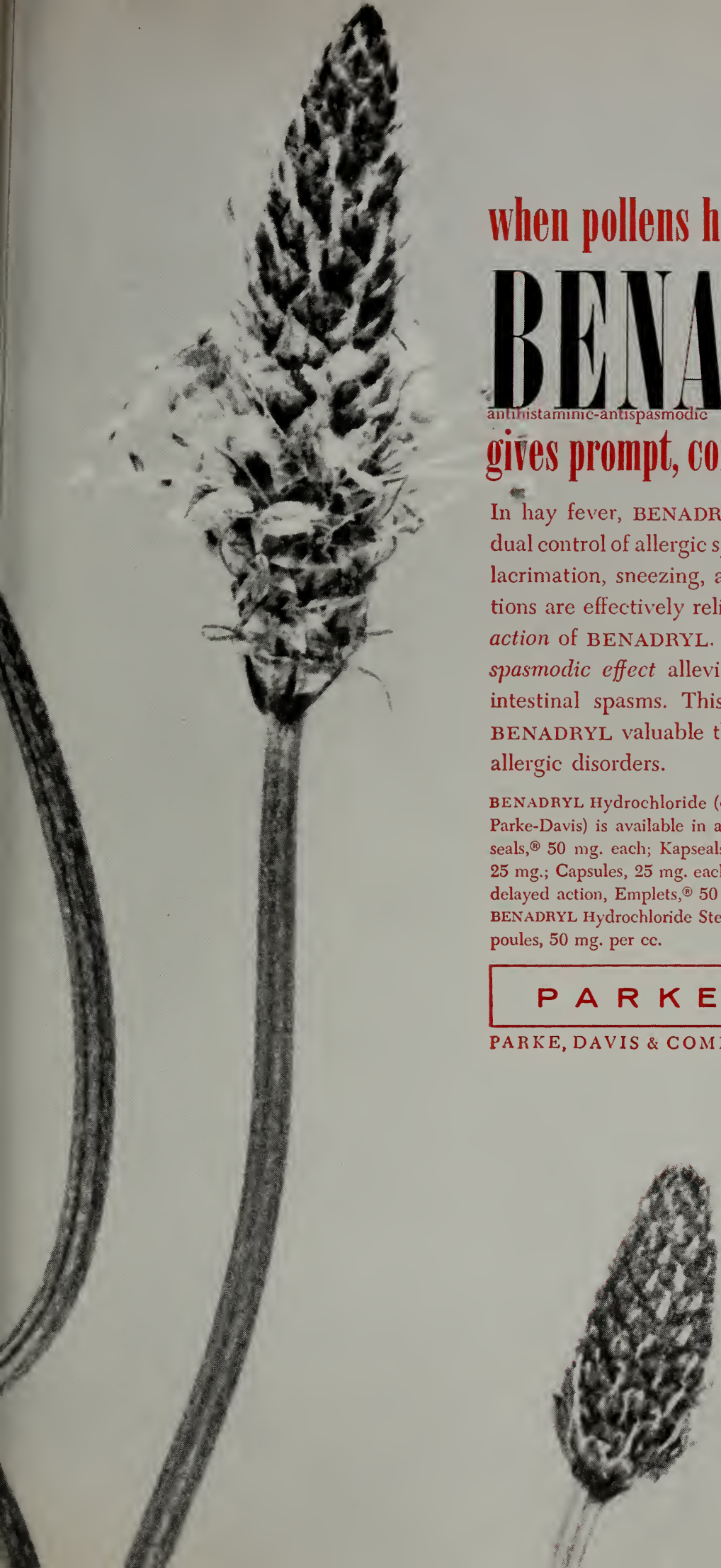
Members at large whose terms expire March, 1961, nominations to be made by the Council, are:

	Branch of Medicine	Represents
John W. Beeler, Indianapolis	Radiology	At large
Marlow W. Manion, Indianapolis	E. N. T.	At large

Summer Meeting of the Council

By consent, July 10, 1960, was set for the summer Council meeting.

There being no further business, the meeting was adjourned. ◄



when pollens harry the unwary

BENADRYL®

antihistaminic-antispasmodic

gives prompt, comprehensive relief

In hay fever, BENADRYL provides simultaneous, dual control of allergic symptoms. Nasal congestion, lacrimation, sneezing, and related histamine reactions are effectively relieved by the *antihistaminic action* of BENADRYL. At the same time, its *antispasmodic effect* alleviates bronchial and gastrointestinal spasms. This duality of action makes BENADRYL valuable throughout a wide range of allergic disorders.

BENADRYL Hydrochloride (diphenhydramine hydrochloride, Parke-Davis) is available in a variety of forms including: Kapseals,® 50 mg. each; Kapseals, 50 mg., with ephedrine sulfate, 25 mg.; Capsules, 25 mg. each; Elixir, 10 mg. per 4 cc.; and for delayed action, Emplets,® 50 mg. each. For parenteral therapy, BENADRYL Hydrochloride Steri-Vials,® 10 mg. per cc.; and Ampoules, 50 mg. per cc.

26760

PARKE-DAVIS

PARKE, DAVIS & COMPANY • DETROIT 32, MICHIGAN

The Journal

August 1960

of the INDIANA STATE MEDICAL ASSOCIATION

Office of Publication:
1019 Hume Mansur Building, Indianapolis, Indiana

$1.00 per copy
except Yearbook
$5.00 per year

Contents

SCIENTIFIC

Treatment of Acute Intestinal Obstruction, Manuel E. Lichtenstein, M.D., Chicago, Ill. 1465
Cancer—The Research Approach, Clarence C. Little, Sc.D., Ellsworth, Me. 1469
Three Hydrocephalic Newborns—Each of a Successive Pregnancy of a White Female, Richard G. Mehne, M.D., Brazil, Ind. 1472
Which Tranquilizer? Mark I. Hewitt, M.D., New Brunswick, N. J. 1475
Chest Injuries, George D. Buckner, M.D., Fort Wayne, Ind. 1484
Gonorrhea and Syphilis—a New Problem? Elmer Hess, M.D., Russell B. Roth, M.D., Anthony Kaminsky, M.D., Harold McLaren, Jr., M.D., Erie, Pa. 1487
The Case of the Juvenile Jetsam, Arnold Lieberman, M.D., New York, N. Y. 1493
ELECTROCARDIOGRAM OF THE MONTH: Abnormal Electrocardiogram and a Normal Heart, Charles Fisch, M.D., Indianapolis.... 1497

EDITORIALS

Dangers of Mail Order Dispensing 1502
Population on the Rise 1503
Health vs. Wealth 1503
The Newer Progestins 1503

SPECIAL FEATURES

Drug Prices . . . Here and Abroad, Smith, Kline & French Laboratories 1505
111th Annual ISMA Convention 1506
Instructional Course Application Blank 1510
Law-Science Academy of America, Hubert Winston Smith, LL.B., M.D., Austin, Texas 1512
On Behalf of Pharmaceutical Manufacturers, Dr. Thomas P. Carney, American Pharmaceutical Association 1526
Hoosiers Participate in AMA Miami Meeting; House of Delegates Actions Listed 1533

REGULAR FEATURES

Month in Washington 1434
Fourth Estate 1440
Letters to the Editor 1460
Wanted: Locations, Physicians 1462
Journal Medical Essay Contest for 1960-61 1483
Abstracts, Book Reviews 1530
Blue Cross-Blue Shield Program for Federal Employees (one of a series) 1532
News Notes 1540
I.U. Lists 36 Promotions in School of Medicine Faculty 1540
Surgeons, Anesthesiologists Program Features 14 Hoosiers 1542
Medical Assistants Meet at Richmond 1546
Indiana State Board of Health Report 1547
Deaths 1548

BUSINESS

County and District News 1548
Commission Meetings: Constitution and Bylaws, June 19, 1960 1550

EDITORIAL AND ADVERTISING INFORMATION

All articles must be typewritten, double-spaced with margins of one inch.

Photographs should be printed on glossy paper. Negatives cannot be used.

Illustrations are desirable. Selection of illustrations submitted at discretion of editor and editorial board members. Cost of color illustrations must be shared by the author.

Contributors are responsible for all statements made in their articles. The editors and editorial board members may not be in agreement with all views expressed by authors, but it is desired to give all authors as great latitude as possible. However, the right is reserved to reduce in length or reject any article.

Articles are accepted for publication with the understanding that they are submitted for exclusive publication in THE JOURNAL of the Indiana State Medical Association.

Communications dealing with editorial matter should be sent to Frank B. Ramsey, M.D., Editor, 1802 North Illinois Street, Indianapolis 2, Indiana. All other communications should be sent to THE JOURNAL of the Indiana State Medical Association, 1019 Hume Mansur Building, Indianapolis 4, Indiana.

Advertising rates will be furnished on request. Copy must be received by the 5th of the month preceding month of issue. (Scientific manuscripts must be received at least two weeks earlier if geared for a specific issue.)

Entered as second class matter January 25, 1933, at the Postoffice at Indianapolis, Indiana. Copyright, 1960, by the Indiana State Medical Association. Published monthly at 1019 Hume Mansur Bldg., Indianapolis 4, Indiana.

in rheumatic disorders

whenever aspirin proves inadequate



Sterazolidin®

brand of prednisone-phenylbutazone



Even in the more transient rheumatic disorders, an anti-inflammatory effect more potent than that provided by aspirin is often desirable to hasten recovery and get the patient back to work.
By combining the anti-inflammatory action of prednisone and phenylbutazone, Sterazolidin brings about exceptionally rapid resolution of inflammation with relief of symptoms and restoration of function.
Since Sterazolidin is effective in low dosage, the possibility of significant hypercortisonism, even in long-term therapy, is substantially reduced.

Availability: Each Sterazolidin® capsule contains prednisone 1.25 mg.; Butazolidin®, brand of phenylbutazone, 50 mg.; dried aluminum hydroxide gel 100 mg.; magnesium trisilicate 150 mg.; and homatropine methylbromide 1.25 mg. Bottles of 100 capsules.

Geigy, Ardsley, New York

Geigy

165-60



This summary of what is happening in Washington is prepared by A.M.A.'s Capital office and airmailed to *The Journal* on the ninth of each month preceding month of issue.

MONTH IN WASHINGTON

Washington, D. C., July 9—Congress returned to work this month to take up its unfinished business, including the controversial issue of health care for the aged, an atmosphere dominated by election-year politics.

The three or four week, tag-end session of Congress loomed as one of the most important meetings in the past decade as far as possible impact on the medical profession is concerned.

The lawmakers are slated to decide whether to embark the Federal government on a course that could threaten the private practice of medicine, or to adopt a voluntary program that would pose no such danger.

The omnibus social security bill approved by the House Ways and Means Committee was easily cleared by the House, 381 to 23, and sent to the Senate Finance Committee, which held two days of hearings. The measure contained a voluntary, Federal-State program for assisting needy aged persons meet their health care costs. Both the Administration and the American Medical Association endorsed the House measure as in keeping with the concept of giving the states prime responsibility for helping their citizens, for aiding those who are most in need of help and for avoiding the compulsory aspects of health plans involving the social security mechanism.

FORAND PROPONENTS STILL FIGHTING

A vote by the Finance Committee, headed by Sen. Harry F. Byrd, (D.,Va.) was scheduled shortly after the Senate resumed operations in August. Whatever action the Committee took, however, proponents of schemes such as the Forand bill to provide a compulsory, federal medical program promised a determined fight on the floor of the Senate.

In the event Congress should approve a government medicine plan, opponents were counting on a Presidential veto to kill the measure. The Chief Executive repeatedly has asserted in strong language his all-out opposition to any compulsory plan for health care financing.

At the Senate Finance Committee hearing, Arthur S. Flemming, Secretary of Health, Education and Welfare, renewed the Administration's flat stand against the social security avenue to financing health costs. Such a plan, he said, would inevitably lead to pressures for expanding the benefits and lowering or eliminating the age requirement. Under such circumstances, a 15% or 20% social security payroll tax would not be too

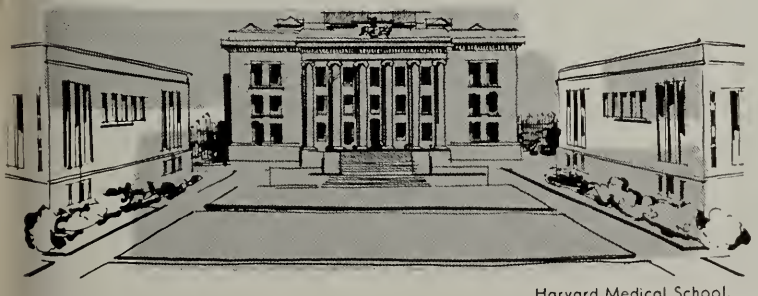
Continued on page 1438

pped!



manufacturer—your assurance of quality. That's another reason why so many hospitals now use Filter Queen.

We urge you to investigate Filter Queen. You'll find a distributor listed in the Yellow Pages.



Harvard Medical School.

Filter Queen Home Sanitation System is used by the Harvard Medical School, and in many other leading scientific and industrial institutions.

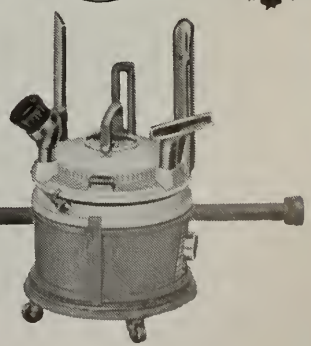
Today's Health

REPLACEMENT OR REFUND OF MONEY
Guaranteed by Good Housekeeping
IF NOT AS ADVERTISED THEREIN

LISTED UNDER REEXAMINATION SERVICE
UL
UNDERWRITERS' LABORATORIES, INC.

FILTER QUEEN

HOME SANITATION SYSTEM



A PRODUCT OF HEALTH-MOR, INC., Chicago 1, Illinois

*Copies available from Professional Dept., Health-Mor, Inc., 203 N. Wabash Ave., Chicago 1, Illinois

Month in Washington

Continued from page 1434

far off, he said. "We believe it is unsound to assume that revenue possibilities from a payroll tax are limitless."

Dr. Leonard W. Larson, President-elect of the American Medical Association, told the Committee the House bill is the "antithesis of the centralized, socialized, statist approach of the proposals advocating national compulsory health insurance."

"To those critics who call this program modest, we say that fiscal irresponsibility, unpredictable cost and maximum nationalization are not the accepted criteria for good legislation," he testified.

INSURERS BOAST OF PROGRESS

A spokesman for the insurance industry pointed out "giant strides" made by private health insurance in recent years in covering aged persons. E. J. Faulkner declared that one of the most prevalent and erroneous assumptions on the matter is that most of the aged aren't able to contribute to financing their own health care costs.

The Social Security health bills, he said, "would impair or destroy the private practice of medicine, would add immeasurably to our already crushing tax burden, would aggravate our severe public fiscal problems and would entail other undesirable consequences."

SENATE TO DEBATE ON KEOGH-SIMPSON BILL

On another legislative proposal of interest to the medical profession --the Keogh-Simpson bill--a Senate debate was scheduled this month. Sen. Gordon Allott (R.,Colo.) said in a Senate speech that "I believe that this legislation will have the overwhelming support of this body."

The bill, which would encourage retirement savings by the self-employed such as lawyers, small businessmen and physicians, has already been approved by the House. The Senate bill, voted by the Senate Finance Committee, would require participating self-employed to establish retirement plans for their employes. ◄



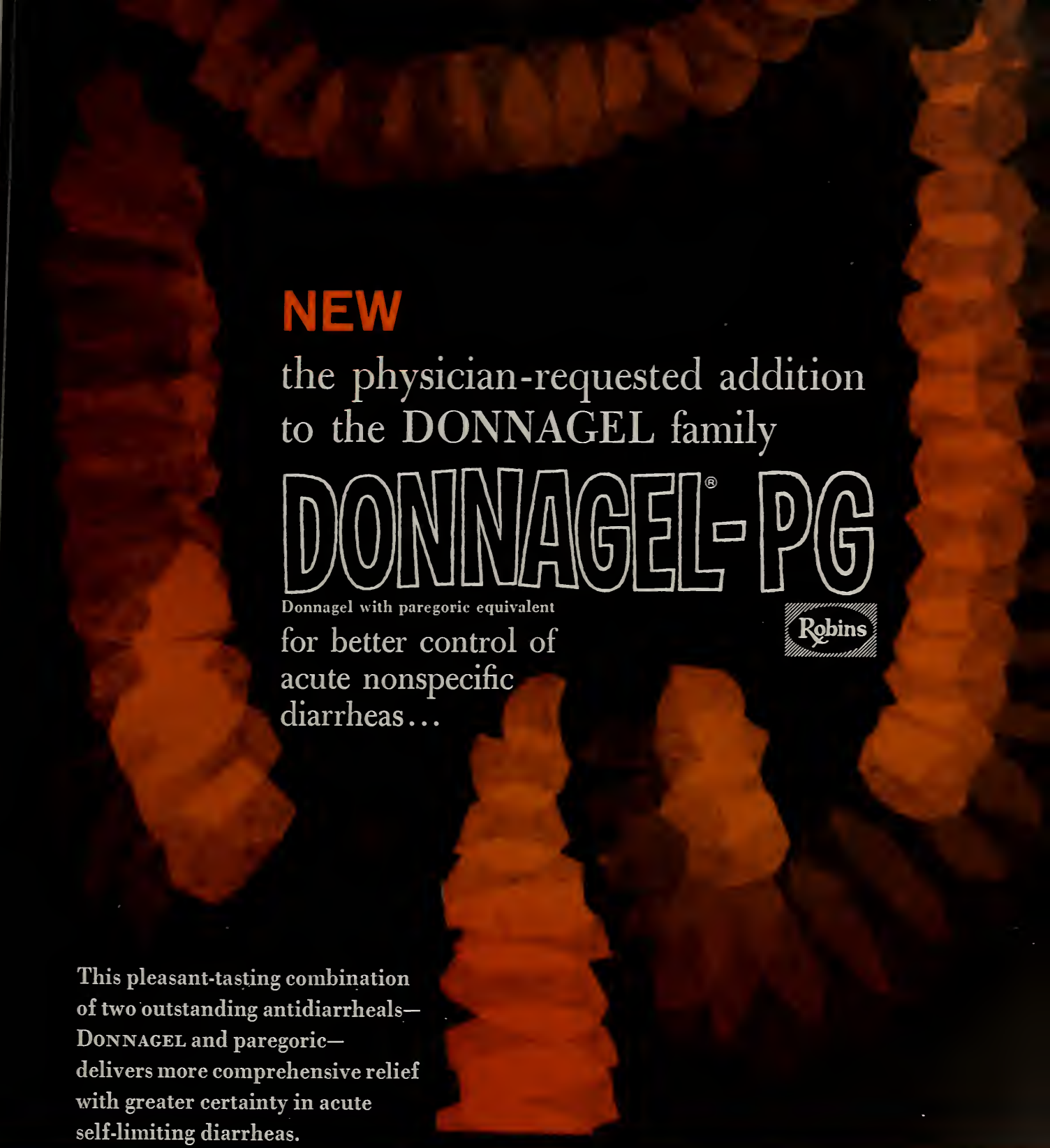
WABASH VALLEY
SANITARIUM—HOSPITAL
Lafayette, Indiana
Telephone Riverside 3-1679

A hospital for the treatment of neuro-psychiatric disorders.

Custodial cases are accepted in limited numbers.

— OPEN STAFF —

DONALD R. KINZER
Manager



NEW

the physician-requested addition to the DONNAGEL family

DONNAGEL®-PG

Donnagel with paregoric equivalent

for better control of acute nonspecific diarrheas...

Robins

This pleasant-tasting combination of two outstanding antidiarrheals—DONNAGEL and paregoric—delivers more comprehensive relief with greater certainty in acute self-limiting diarrheas.

Each 30 cc. (1 fluidounce) of DONNAGEL-PG contains:

Powdered opium U.S.P.	*Kaolin*	*Pectin*	*Natural belladonna alkaloids*	*Phenobarbital*
.....24.0 mg. (equivalent to paregoric 6 ml.)	.....6.0 Gm.	.....142.8 mg.	hyoscyamine sulfate .....0.1037 mg. atropine sulfate .....0.0194 mg. hyoscine hydrobromide ....0.0065 mg.	(¼ gr.) ....16.2 mg.
Diminishes propulsive contractions and tenesmus; makes fecal matter less liquid	Adsorbent and demulcent action binds toxins and irritants; protects intestinal mucosa	Demulcent action complements effect of kaolin	Antispasmodic action reduces intestinal hypermotility; minimizes the risk of cramping	Mild sedative action lessens tension

Supplied: Banana flavored suspension in bottles of 6 fl. oz.

Also available: DONNAGEL® with NEOMYCIN — for control of bacterial diarrheas.

DONNAGEL® — the basic formula — when paregoric or an antibiotic is not required.

A. H. ROBINS CO., INC., Richmond 20, Virginia

Making today's medicines with integrity ... seeking tomorrow's with persistence



LOOKS AT MEDICINE

This section of THE JOURNAL is devoted to the presentation of opinions which appear on the editorial pages of the public press, and which are of interest to the medical profession. Its function is to review comments which may be favorable or unfavorable to medicine. Members are invited to submit editorial clippings for this column.

Doctors to Seek Standards for Fees to Give Insurers Idea of Full Coverage Rate

By Ed Klingler

Articles of incorporation were filed today with the Indiana secretary of state for the Vanderburgh Foundation of Medical Care, a non-profit corporation organized by the Vanderburgh County Medical Society.

Dr. James Crawford, medical society president, said the foundation will "seek to set standards for health insurance policies in this area and study the possibility of establishing insurable fee schedules for full payment of physicians' services for medical care."

It is believed to be the first time a medical society has undertaken such a project outside the state of California.

Dr. Crawford emphasized the foundation will not engage in the insurance business or the group practice of medicine.

Aim at Full Payment

It will, however, seek to close a gap now existing in most group health insurance between the maximum amount an insurance company will pay for medical or surgical service, and the amount physicians actually charge for the service. Most group insurance isn't written to cover the full medical service fee, but provides a maximum amount it will pay.

The foundation will seek to establish fee schedules that would be recognized by the doctors as "full payment" for services. The schedules would be flexible, based on the income level of the group being insured. Doctors here presently do not have any type of fee schedules.

The schedules would be made available to companies offering group health policies. With the schedules in hand, an insurance company figuring on coverage of a group would know what rate to fix to provide payment of total cost of medical service instead of only part of it.

Dr. Crawford said the foundation will work in co-operation with prepaid medical care plans which subscribe to and permit freedom of choice of physician. The foundation's study of fees will be continuous, so they can be adjusted to meet the economic problems of the area.

Two-Year Study

A medical society committee headed by Dr. Patrick J. V. Corcoran has devoted two years to studying the possibility of a foundation. It was decided it was an area problem, rather than an Evansville problem, and that the foundation should enroll physicians from adjoining counties as well as Vanderburgh.

Listed as foundation incorporators are Dr. W. T. Barnhart, immediate past society president; Dr. Corcoran, an ex-president, and Dr. William C. Fisher, president-elect. Arthur P. Tiernan, society secretary, is resident agent. Directors are Dr. Barnhart, Dr. Corcoran, Dr. Fisher, Dr. Robert Arendell, Dr. Ralph Carlson, Dr. Victor Johnson, Dr. John Sterne, Dr. R. K. Dodd and Dr. Harold H. Davidson.

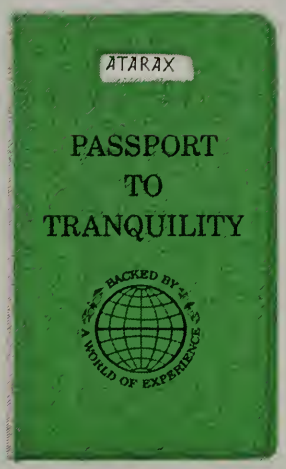
The foundation is patterned after a similar organization operated successfully for several years by the San Joaquin County Medical Society in Stockton, Calif.

Evansville Press,
July 1, 1960

Continued

A GUIDE TO

THE REALMS OF THERAPY BEST ATTAINED WITH



ATARAX®

(brand of hydroxyzine)

World-wide record of effectiveness—over 200 laboratory and clinical papers from 14 countries.
Widest latitude of safety and flexibility—no serious adverse clinical reaction ever documented.
Chemically distinct among tranquilizers—not a phenothiazine or a meprobamate.
Added frontiers of usefulness—antihistaminic; mildly antiarrhythmic; does not stimulate gastric secretion.

Special Advantages	Supportive Clinical Observation	...and for additional evidence
IN CHILDREN unusually safe; tasty syrup, 10 mg. tablet	"... Atarax appeared to reduce anxiety and restlessness, improve sleep patterns and make the child more amenable to the development of new patterns of behavior...." Freedman, A. M.: Pediat. Clin. North America **5**:573 (Aug.) 1958.	Bayart, J.: Acta paediat. belg. **10**:164, 1956. Ayd, F. J., Jr.: California Med. **87**:75 (Aug.) 1957. Nathan, L. A., and Andelman, M. B.: Illinois M. J. **112**:171 (Oct.) 1957.
IN ELDERLY PATIENTS well tolerated by debilitated patients	"... seems to be the agent of choice in patients suffering from removal disorientation, confusion, conversion hysteria and other psychoneurotic conditions occurring in old age." Smigel, J. O., et al.: J. Am. Geriatrics Soc. **7**:61 (Jan.) 1959.	Settel, E.: Am. Pract. & Digest Treat. **8**:1584 (Oct.) 1957. Negri, F.: Minerva med. **48**:607 (Feb. 21) 1957. Shalowitz, M.: Geriatrics **11**:312 (July) 1956.
IN ALLERGIC PATIENTS useful adjunctive therapy for asthma and dermatosis; particularly effective in urticaria	"All [asthmatic] patients reported greater calmness and were able to rest and sleep better... and led a more normal life.... In chronic and acute urticaria, however, hydroxyzine was effective as the sole medicament." Santos, I. M., and Unger, L.: Presented at 14th Annual Congress, American College of Allergists, Atlantic City, New Jersey, April 23-25, 1958.	Eisenberg, B. C.: J.A.M.A. **169**:14 (Jan. 3) 1959. Coirault, R., et al.: Presse méd. **64**:2239 (Dec. 26) 1956. Robinson, H. M., Jr., et al.: South. M. J. **50**:1282 (Oct.) 1957.
IN HYPEREMOTIVE ADULTS does not impair mental acuity	"... especially well-suited for ambulatory neurotics who must work, drive a car, or operate machinery." Ayd, F. J., Jr.: New York J. Med. **57**:1742 (May 15) 1957.	Garber, R. C., Jr.: J. Florida M. A. **45**:549 (Nov.) 1958. Menger, H. C.: New York J. Med. **58**:1684 (May 15) 1958. Farah, L.: Internat. Rec. Med. **169**:379 (June) 1956.

SUPPLIED: Tablets, 10 mg., 25 mg., 100 mg.; bottles of 100. Syrup (10 mg. per tsp.), pint bottles. Parenteral Solution: 25 mg./cc. in 10 cc. multiple-dose vials; 50 mg./cc. in 2 cc. ampules.

Rx PFRIG

New York 17, N. Y.
Division, Chas. Pfizer & Co., Inc.
Science for the World's Well-Being

Continued

Not Against Medical Care

Political opponents of the Eisenhower administration are unfairly picturing President Eisenhower as being opposed to medical care for the aged.

The President is opposing one of the proposals for such care. This is the Forand bill, sponsored by Rep. Aime Forand, Rhode Island Democrat. He is opposing this plan because it would increase social security taxes.

What needs to be understood is that Mr. Eisenhower himself is in favor of legislation to help the aged meet their medical expenses, but he is for a plan that would be financed out of general revenues. The President's approach to the problem is to work out a program that would aid those who are in need, and not tax everyone in order to provide money for citizens who are well able to take care of the medical costs of their parents.

The Eisenhower administration is trying to steer the trend away from a medical program that would lead to socialized medicine. It has before it the bad experience of such programs in other countries where too much government tinkering with socialized medicine has resulted in deterioration of medical service. In providing for the medical needs and other welfare services for our people, we should take advantage of the mistakes that other countries have made and try to avoid them.

Under one of the proposals to increase the social security tax, the social security base would be increased from $4,800 a year to $6,000. This means—as Columnist David Lawrence points out in his column on this page today—that employers would have to pay an additional $420 million, and workers and self-employed people would have to pay $520 million more. The result of such a step would be to cause a further cut in the "take-home" pay of workers.

Under the Forand bill, the social security base would stay at $4,800, but the tax rate would be increased for everybody paying social security taxes. Workers would pay $570 million more, and employers $530 million more.

The President's plan is a more moderate approach. It veers away from the concept that the government should take care of people from the cradle to the grave, with certain taxpayers providing the money for everybody, including those who are able to pay for their medical care themselves.

The federal and state governments already are obligated to bear the cost of care for those who are in need. This cost itself is heavy, but justified. Everyone will agree that the needy must be aided. But if a program is started to provide medical care for everyone, regardless of whether many could pay it themselves, the cost would grow and grow, with further increases in taxes coming through the years.

Kokomo Tribune
Mar. 30, 1960

Deceptive Practices

By Morley Cassidy

Congressional investigators have been having a high old time looking into deceptive practices on TV, and this is okay with me. It's wonderful, watching the pitchmen squirm.

But it does make you wonder: Who investigates the investigators? Who checks on the honesty of the Congressmen's own slogans?

Take for instance, this word "free." We hear a lot from the politicians about the "free" Federal money we're getting for highways or the Port, or what-not. And who gives us this "free" money? Go look at your tax receipts.

And now, some of the same Congressmen who are busy being pious about TV's commercials have just announced that as soon as Congress meets again they will be calling up a bill to provide "free health care for the aged."

"Free," my foot!

The bill they are talking about is the Forand bill (HR 4700) which would guarantee "free" health care to the aged—by taxing them in advance through some 45 years of their working life. Is this "free" health care, or is it compulsory health insurance? And if compulsory health insurance is a good idea, why does it have to be sold under a phony title? That's the sort of thing that has got the TV pitchmen in trouble.

The same sort of less-than-honest salesmanship runs through all the sales talk for this new proposal to let the bureaucrats spend more of your money for you.

Continued



for the acute asthmatic attack elixir synophylate®

(Theophylline Sodium Glycinate)

RAPID ORAL CONTROL WITHOUT G.I. IRRITATION

ELIXIR SYNOPHYLATE relieves wheezing and dyspnea in 5 to 10 minutes after a single dose. Significant blood levels are achieved in 15 minutes, persisting for at least 4 hours.

Because of its built-in buffer, theophylline sodium glycinate [SYNOPHYLATE] is "tolerated in larger doses than are possible with other theophylline preparations,"[1] including aminophylline.[1-3]

the most potent theophylline elixir available... may avoid need for I.V. injection

1. A. M. A. Council on Drugs: New and Nonofficial Drugs 1959, Philadelphia, Lippincott, 1959, p. 389. 2. United States Dispensatory (Osol-Farrar), ed. 25, Philadelphia, Lippincott, 1955, p. 1412. 3. Grollman, A.: Pharmacology and Therapeutics, ed. 3, Philadelphia, Lea & Febiger, 1958, p. 208.

Each tablespoonful (15 ml.) contains 0.33 Gm. (5 gr.) equivalent to 0.16 Gm. (2½ gr.) Theophylline U.S.P. Supplied: Bottles of 1 pint and 1 gallon.

Literature on request.

...particularly useful for children

Products Born of Continuous Research

THE CENTRAL PHARMACAL COMPANY Seymour, Indiana

Fourth Estate

Continued

It is sanctimoniously presented, for instance, as a proposal to assure "everybody" of adequate health care in old age.

About one aged person in four, if he believes this, is going to be bitterly disappointed, when the time comes, to find out he has been deceived as badly as anyone who ever fell for a TV "bait" ad. The bill would take care only of people on the Social Security rolls.

There are about 15 million people over 65 in the United States today. Of these, about four million are not covered by Social Security—so, under the Forand bill, they'll still be out in the cold. So let's not pretend that this bill promises care for "everybody."

Those who would be covered (at least to the extent of 60 days a year in a hospital, 120 days in nursing homes, and major surgical costs) will pay handsomely in advance through all their working years—if the Social Security system is not to go bankrupt.

The sponsors of the bill propose to start with a mere addition of ½ of one percent to the Social Security tax already levied on each worker.

If this levy follows the course that Social Security itself has followed, the rate will rise steadily, and so will the base on which it is levied.

The Social Security levy began in 1937 with a tax of 2% (1% from the employe, 1% from the employer) on the first $3,000 of pay. It has risen steadily until it now stands at 5% (half from employe, half from employer) on the first $4,800 of pay. This is scheduled to go to 6% on January 1, and to a total of 9% by 1965. Add on a new levy for health care, also rising, plus income tax, and how much of his own money will the taxpayer be allowed to spend for himself?

If this were a proposal to help those in real distress in their old age, it would be far more appealing. But the most obvious fact about it is that it specifically excludes those who have not been in a position to earn Social Security benefits, and who are thus more likely to be without an old-age income.

It ignores the fact, too, that more than 124 million Americans today are voluntarily paying for their own health insurance—and that the number of aged covered by such insurance is growing at a dizzy pace.

In 1952, according to the Insurance Information Office of Pennsylvania, only 25% of the aged had health insurance. Since then, a great variety of new plans has been brought forward, all on a sound actuarial basis, to provide health care for those over 65. Today, more than 40% of the aged are thus protected.

This voluntary protection system would undoubtedly be wrecked if Congress, under the false catch-word of "free" health care, were to impose a program of compulsory socialized insurance such as the Forand bill proposes. If that is what the voters want, they are of course entitled to get it. But the package would look more honest if it were not peddled under the phony label of "free" care for "everybody."

Philadelphia Evening Bulletin
Dec. 21, 1959

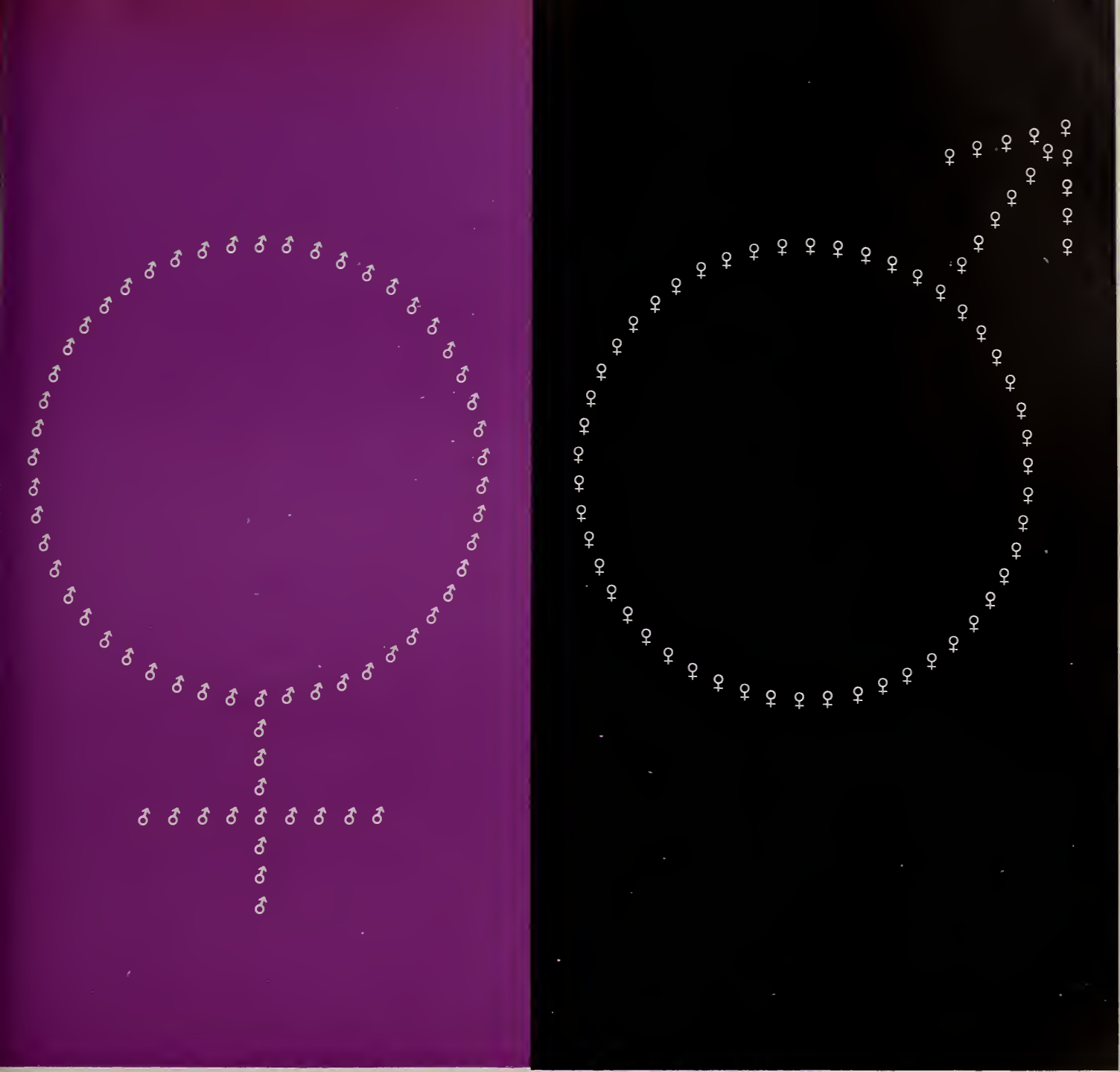
Medical Care for the Aged

Both political parties are talking about improved medical care for the aged. On the Democratic side, Senate Leader Lyndon Johnson predicts that Congress will provide such aid before it adjourns in July. On the Republican side, Vice President Nixon is reported to be working for a medical care bill, and eight Republican senators have in fact proposed one.

The big question is what form the measure will take—a limited use of the Social Security program to help pay the costs or federal-state subsidies. The Department of Health, Welfare and Education envisions federal-state payments, and President Eisenhower, favoring some plan that would not involve a boost in the Social Security tax, has ordered an intensive study of the matter.

If both parties come out for medical care for the elderly, that program may be eliminated as a campaign issue. If Congress does agree on a program, it ought to adopt one that will not mean another tax increase and will not start the government on the road to socialized medicine. The wise course would be one that would aid the expansion of voluntary medical and hospital insurance in such a way as to give the greatest assistance to those least able to pay and would avoid underwriting the bills of those with ample means.

Continued



GONORRHEA *IS ON THE MARCH AGAIN...*

a new timetable for recovery:

only six capsules of TETREX can cure a male patient with gonorrhea in *just one day

Tetrex®

U.S.PAT.NO.2,791,609

THE ORIGINAL TETRACYCLINE PHOSPHATE COMPLEX

TETREX CAPSULES. 250 mg. Each capsule contains: TETREX (tetracycline phosphate complex equivalent to tetracycline HCl activity) — 250 mg.

DOSAGE: Gonorrhea in the male — Six capsules of TETREX in 3 divided doses, in one day.

*Marmell, M., and Prigot, A.: Tetracycline phosphate complex in the treatment of acute gonococcal urethritis in men. Antibiotic Med. & Clin. Ther. 6:108 (Feb.) 1959.

BRISTOL

BRISTOL LABORATORIES,
SYRACUSE, NEW YORK

Fourth Estate

Continued

Those who hoot at the thought of moderation forget that the people generally are burdened with heavy taxation already.

One movement to provide medical care for the aged was the Forand bill which would increase Social Security taxes by one-fourth of one percent on payrolls. It has been rejected by the House Ways and Means Committee, but still could be pushed by the entire House if that body chooses to override the committee action. Enactment of the Forand bill would mean that nearly 14 million beneficiaries and probably two million surviving dependents would become eligible for hospital and nursing care. It would mean that all the participants in the old-age assistance program, constituting approximately nine out of every 10 Americans, would be taxed whether they wished it or not for what some describe as an entering wedge of compulsory socialized medicine.

And in addition, there would remain almost two million men and women who do not have the benefit of coverage under the old-age and survivors insurance system (OASI) but who are on old-age assistance or general relief in the various states. These people probably have the greatest need of aid in meeting their health bills but they would not be helped by the Forand bill. Others who are working beyond the age of 65 because they have to or chose to would presumably have to retire to qualify.

Meanwhile, the expense of the program would be increased because the OASI help would be given not only to those whose old-age benefits are inadequate to cover doctor bills, but also to some beneficiaries who have independent resources or private pensions. When citizens who can meet their own expenses are given handouts, the result is to pad federal spending—and therefore taxes—unnecessarily.

In the discussion of this issue of medical care, it should be kept in mind that because certain groups oppose the shotgun methods of the Forand bill it does not mean that they are against doing anything whatever for the ill and needy. It could very well mean that they believe there are more effective ways of channeling the aid where the need is greatest.

Kokomo Tribune
April 13, 1960

CONTEMPORARY COMMENT

Again the Clamor is Heard for Socialized Medicine

(Jackson, Miss., *State-Times*)

If our system of government were easy to maintain, it would be in force all over the earth.

The high standard of living in countries with freedom of action proves the value of our ideologies.

But people are either too unenlightened as is the case with primitive people or too enslaved politically as is the case with the Iron Curtain countries to enjoy the system which we enjoy.

The trend in America today moves us to ask ourselves, "Do we want the kind of government we have today or do we want to swap it for a different kind of government?"

With this prelude we discuss a proposition which has the elements of popular appeal and also is a part of the system of state socialism—free government medicine for the aged.

Are men inhuman and wicked when they oppose such a thing as free medicine for the aged? People who advocate it say that men are evil if they lend a deaf ear to human misery.

Is President Eisenhower an evil man? He said:

"If the time ever comes when large numbers of our citizens turn primarily to the government for assistance in what ought to remain a private arrangement between doctor and patient, then we shall all have suffered a great loss. . . ."

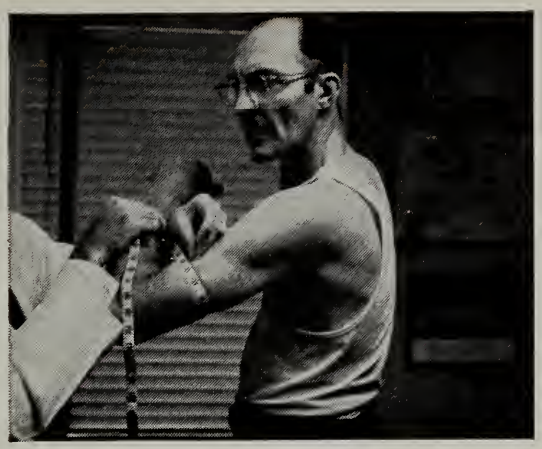
Even the head of the Department of Health, Education and Welfare, Secretary Arthur Flemming, said:

"We are convinced that the objective of making adequate medical care reasonably available to our aged population should, so far as possible, be achieved through reliance upon and encouragement of individual and organized voluntary action."

The Farm Bureau is an organization which is close to the rural people of America and seeking to lift the income and living standard of farm people.

The Farm Bureau has long opposed programs which may lead to socialized medicine. The proposal to provide for health care of the aged, whether retired or not, and for survivors entitled to benefits, is a long step in this direction.

We fear the proposition of compulsory health insurance and medical aid for the aged is another



Dianabol: new, low-cost anabolic agent

By promoting protein anabolism, Dianabol builds lean tissue and restores vigor in underweight, debilitated, and dispirited patients. In patients with osteoporosis Dianabol often relieves pain and increases mobility.

As an anabolic agent, Dianabol has been proved 10 times as effective as methyltestosterone. Yet it has far less androgenicity than testosterone propionate, methyltestosterone, or norethandrolone.

Because Dianabol is an oral preparation, it spares patients the inconvenience and discomfort of parenteral drugs.

And because Dianabol is low in cost, it is particularly suitable for the aged or chronically ill patient who may require long-term anabolic therapy.

Supplied: *Tablets,* 5 mg. (pink, scored); bottles of 100.

Complete information sent on request.

Dianabol®
(methandrostenolone CIBA)

converts protein to working weight in wasting or debilitated patients

CIBA
SUMMIT, NEW JERSEY

2/2829MD

Fourth Estate

Continued

step away from the private enterprise system which has done so much for the American people.

In the United States we have such a high standard of living that we subconsciously believe that this standard is worldwide. It is a far cry from that in a country such as India where a man may own a tree and regard its branches and its shade as shelter for his family.

The Baptist Standard, an organ of the Baptist Church, expressed the idea. It said:

"Whatever concerns human welfare should concern the Christian churches. Consequently, we have sought to study the proposal (H. R. 4700) closely before voicing an opinion on it. The conclusion is that this could be one of the most far-reaching bills to face the Congress because it could easily be the forerunner of socialized medicine and one more big step toward the total regimentation of American citizens by their own government.

"Everyone needs hospital insurance, but the national Treasury is not the place to get it. When the government pays the bill, it will ultimately name the doctor and the hospital."

In Washington again the cry for socialized medicine is on. It failed in previous efforts. Now a new approach is used. This time the goal is sought through a series of steps. Medicine for the aged is one. Compulsory health insurance is another. Meanwhile our American ideology is being tested.

The Terre Haute Star
Mar. 8, 1960

Polio Season Again

Once again the polio season is approaching, and health authorities have the task of trying to persuade Americans to be vaccinated with the Salk vaccine.

Since the discovery of the Salk vaccine and the proof of its effectiveness, there has been widespread relaxation of fears about the disease of polio. In every community, great numbers of children are not given the immunization shots because parents believe the danger is over. This is far from true.

The wise parents will see that their child has the vaccine. The elimination of polio as a threat

Continued

hinges upon the realization by responsible adults that there is no public health without the public's cooperation.

As for the oral polio vaccine which has been developed by Dr. Albert Sabin of Cincinnati and which can be swallowed like cough medicine, the U. S. Public Health Service has not got a license for its public use. However, in Rochester, N. Y., hundreds of school children were to swallow doses of it this week. They are among this nation's first children to receive the oral vaccine.

Dr. Sabin is a celebrity in the Soviet Union, where it is estimated 12 million Russians have swallowed his live-virus syrup since 1957 without ill effects.

The U. S. Public Health Service is sticking by the 85 to 90 percent effective Salk killed-virus vaccine, administered by hypodermic. Controlled studies like the one at Rochester are under way to determine effectiveness and safety of the live vaccines.

Major advantage claimed for the live-virus vaccine is that doses cost only one-tenth to one-hundredth as much as Salk vaccine. Also it is easier to take, provides 95 to 100 percent immunity (and passes immunity on to others who do not take the vaccine), and does not require the individual to take boosters to maintain immunity. Dr. Sabin, however, is the first to warn that everybody should get his full complement of Salk vaccine—at least until the final decision on the Sabin vaccine is made by U. S. health authorities.

Kokomo Tribune
May 17, 1960

Social Security Can Be Overdone

Prairie Farmer worked hard to have Social Security extended to farm people. We have maintained a regular column to help our readers take proper advantage of the benefits available under the law. We have realized at the same time that self-employed people pay a very high price for this security. Young farmers now pay 4½ percent of income and face tax of nearly 7 percent before the present 10-year period is up. Persons who split their Social Security tax with an employer are paying 3 percent now and face 4½ percent in the future. Employer and employee together face an eventual payment of 9 percent.

This tax will mean a tremendous drain on the total income of all wage earners in the future.

Now comes a proposal to increase the tax to provide hospitalization and surgical services to persons of Social Security age. It is known as the Forand bill, listed as HR-4700 in the present Congress. Estimates are that these additional benefits would cost around one-half percent more than the present tax schedule. These estimates are probably too low.

We believe the time has come to call a halt to the rise of both costs and benefits of Social Security. There is a great deal of doubt whether Social Security is paying its way with the present tax. If we permit further increases we can easily reach the point where the young man trying to get ahead must rebel against the tax and where the drain on the national payroll will have a seriously depressing effect on our entire economy.

There are several reasons why the Forand bill is not a healthy development. This is definitely a piece of socialized medicine which will cover a large segment of the population and which will most surely lead to more of the same.

The Forand bill provides that the government make contracts with doctors, hospitals, and nursing homes to take care of its beneficiaries. In other words, the government will be buying services, rather than issuing cash benefits which can be spent by the receiver.

The Forand bill therefore opens the door wide to assignment by the government of patients to hospitals and doctors of its choosing.

We doubt whether older people, many of whom are now covered by fairly adequate prepayment plans, will want to give up the right to choose their doctor and their hospital.

It should also be noted that the greatest distress among older people at present is among those who are not covered by Social Security. Those on relief or public assistance are now receiving some care through the various free-care programs maintained by doctors, hospitals, and local government units. Those who are trying to go it alone will be worse off than ever under the Forand bill.

Prairie Farmer
Mar. 5, 1960

Continued on page 1454

as it calms anxiety!

Smooth, balanced action lifts depression as it calms anxiety... rapidly and safely

Balances the mood – no "seesaw" effect of amphetamine-barbiturates and energizers. While amphetamines and energizers may stimulate the patient *–they often aggravate anxiety and tension.*

And although amphetamine-barbiturate combinations may counteract excessive stimulation–*they often deepen depression.*

In contrast to such "seesaw" effects, Deprol's smooth, *balanced* action lifts depression as it calms anxiety–both at the same time.

Acts swiftly – the patient often feels better, sleeps better, within a few days. Unlike the delayed action of most other antidepressant drugs, which may take two to six weeks to bring results, Deprol relieves the patient quickly – often within a few days. Thus, the expense to the patient of long-term drug therapy can be avoided.

Acts safely – no danger of liver damage. Deprol does not produce liver damage, hypotension, psychotic reactions or changes in sexual function–frequently reported with other antidepressant drugs.

Bibliography *(13 clinical studies, 858 patients)*: **1.** Alexander, L. (35 patients): Chematherapy of depression – Use of meprobamate combined with benactyzine (2-diethylaminoethyl benzilate) hydrachloride. J.A.M.A. *166*:1019, March 1, 1958. **2.** Bateman, J. C. and Carlton, H. N. (50 patients): Meprobamate and benactyzine hydrachlaride (Deprol) as adjunctive therapy for patients with advanced cancer. Antibiotic Med. & Clin. Therapy 6:648, Nav. 1959. **3.** Beerman, H. M. (44 patients): The treatment af depression with meprabamate and benactyzine hydrochlaride. Western Med. *1*:10, March 1960. **4.** Bell, J. L., Tauber, H., Santy, A. and Pulita, F. (77 patients): Treatment of depressive states in office practice. Dis. Nerv. System 20:263, June 1959. **5.** Breitner, C. (31 patients): On mental depressions. Dis. Nerv. System 20:142, (Section Twa), May 1959. **6.** Gordan, P. E. (50 patients): Depral in the treatment af depression. Dis. Nerv. System 21:215, April 1960. **7.** Landman, M. E. (50 patients): Clinical trial of a new antidepressive agent. J. M. Soc. New Jersey. In press, 1960. **8.** McClure, C. W., Papas, P. N., Speare, G. S., Palmer, E., Slattery, J. J., Kanefal, S. H., Henken, B. S., Waad, C. A. and Ceresia, G. B. (128 patients): Treatment af depressian – New technics and therapy. Am. Pract. & Digest Treat. *10*:1525, Sept. 1959. **9.** Pennington, V. M. (135 patients): Meprobamate-benactyzine (Depral) in the treatment of chranic brain syndrome, schizaphrenia and senility. J. Am. Geriatrics Sac. 7:656, Aug. 1959. **10.** Rickels, K. and Ewing, J. H. (35 patients): Deprol in depressive canditians. Dis. Nerv. System 20:364, (Section One), Aug. 1959. **11.** Ruchwarger, A. (87 patients): Use of Deprol (meprobamate cambined with benactyzine hydrochlaride) in the office treatment of depression. M. Ann. District af Columbia 28:438, Aug. 1959. **12.** Settel, E. (52 patients): Treatment of depression in the elderly with a meprobamate-benactyzine hydrachloride combinatian. Antibiotic Med. & Clin. Therapy 7:28, Jan. 1960. **13.** Splitter, S. R. (84 patients): Treatment af the anxiaus patient in general practice. J. Clin. & Exper. Psychapath. In press, April-June 1960.

Dosage: Usual starting dose is 1 tablet q.i.d. When necessary, this dose may be gradually increased up to 3 tablets q.i.d.

Composition: 1 mg. 2-diethylaminoethyl benzilate hydrochloride (benactyzine HCl) and 400 mg. meprobamate.
Supplied: Bottles of 50 light-pink, scored tablets. Write for literature and samples.

Deprol®

WALLACE LABORATORIES/*New Brunswick, N. J.*

CD-2128

Fourth Estate

Continued

Another Health Scheme

At a time when medical care for Americans, especially aged Americans, is embroiled in politics, it's interesting to note a basically similar controversy now raging in the Canadian province of Saskatchewan.

The socialist administration of the province has promised a broad-scale compulsory health plan. Saskatchewan physicians, not surprisingly, are vigorously opposing this swing to socialized medicine because, they contend, it would lead to soaring costs, a deterioration in medical services, and the end of the traditional doctor-patient relationship. Some of these doctors, incidentally, were in Britain when socialized medicine was introduced there and speak from experience.

Province Premier Thomas C. Douglas has threatened the College of Physicians, which is empowered to license medical doctors, with removal of that power if it attempts to pressure its members into opposing the proposed health scheme. The Premier declared: "I would remind the College that what the Legislature has given, the Legislature can take away."

The Premier might have extended this admonition somewhat further. He might have noted that in America, Britain or Saskatchewan, the Government can only give what it first takes away.

Wall Street Journal
June 8, 1960

Defensive Driving

The state-wide traffic safety emphasis in March is "Defensive Driving." A defensive driver has been described as a fellow who "looks out" for everyone else while he's looking out for himself. It is true that if all drivers were defensive drivers we would have little or no problem on our streets and highways. Driving defensively means demonstrating a determination not to have an accident regardless of the circumstances involved. This kind of driver is willing to yield the right-of-way, even if he has it, makes a full stop at all stop signs, passes only when there is ample room, follows at a safe distance, and signals all turns well in advance to give sufficient warning to all other highway users. He anticipates and makes allowance for the mistakes of others.

"Defensive Driving" is actually a way of life and an excellent way to preserve life, say the Indiana Traffic Safety Foundation.

Foresight is an important element of defensive driving. The ability to recognize trouble-in-the-making, to see and think ahead helps to avoid misfortune. School children walking or playing along the road, a parked car some distance ahead with fumes coming from the exhaust, an impatient driver nosing out around an oncoming truck, or a pedestrian in the act of stepping from the curb, are all signals to have your foot on the brake instead of the gas pedal. A defensive driver thinks for the other fellow as well as himself.

Kokomo Tribune
May 8, 1960

Control of Household Poisonings

Nearly 1,500 deaths were reported in the United States in 1959 as the result of poisonings due to agents other than gases and spoiled foods. The actual seriousness of the problem is even greater, for it is conservatively estimated that 200 nonfatal cases were treated by physicians and that uncounted other deaths are averted through the advice of pharmacists, friends, and knowledgeable neighbors.

The frequency of household poisonings is attributed to a lack of adequate supervision, to the fact that caution and experience are in short supply in many homes, and to careless storing of materials. It is not surprising that children in the first four years of life are primarily affected or that poisoning ranks third among causes of accidental death in the home.

Common offenders are drugs and medications, especially aspirin and barbiturates. Running close behind are household agents, such as bleaches, benzene preparations, and insecticides, with externally applied drugs and cosmetics also arousing young curiosities. Among the metals, lead continues supreme, as reports from Ohio demonstrate (Medical Tribune, April 25, page 1).

Although child poisonings seem to occur often in economically depressed areas, an embarrassing share of cases are contributed by careless handling of professional samples by physicians in their own homes and offices. However, there is

when she's not like herself anymore

Metalex® basic in the care of the aging



when body tone, mental and sensory faculties begin to fade—*she's irritable, confused, forgetful, apathetic*

when voices begin to fade—*in loss of auditory acuity, in tinnitus*

when vision begins to dim—*in loss of visual acuity, in loss of peripheral vision*

℞ Metalex® *cerebral stimulant / vasodilator*

The stimulant—pentylenetetrazol—facilitates cerebral and reflex nerve activity.

The vasodilator—nicotinic acid—augments blood and oxygen supply to vital areas—

Thus, METALEX increases body tone and aids mental and sensory faculties.

Composition: Each teaspoonful (5 ml.) of the Elixir and each Tablet contains: Pentylenetetrazol 100 mg., Nicotinic Acid 50 mg.

Dosage: One or two teaspoonfuls of the Elixir or one or two Tablets four times a day—one-half hour before meals and before bedtime.

Available: Elixir: Pint and Gallon bottles. Tablets: Bottles of 100 and 1000.

References: 1. Goodman, L. S. and Gilman, A.: The Pharmacological Basis of Therapeutics, 2nd Ed., New York, Macmillan Company, 1955. 2. O'Reilly, P. O., Demay, M. and Kotlowski, K.: Cholesteremia and Nicotinic Acid. A.M.A. Arch. Int. Med. 100:797-801 (Nov.) 1957.

STORCK Pharmaceuticals, Inc.,
2326 Hampton Blvd., St. Louis 10, Mo.

Continued

no doubt that education by the medical profession can do much to prevent accidental poisonings.

A few simple rules:

All unlabeled containers should be discarded. All poisonous substances should be locked up, out of reach of all save adults. Insecticides should never go on shelves with foodstuffs. All drugs must be kept out of children's reach.

With the help of child safety pamphlets for parents (readily available through insurance companies and other sources) the doctor can act as his own poison control center during home and office visits.

Medical Tribune
May 2, 1960

Strengthen Traffic Laws

If, as law enforcement officers say, it is becoming more difficult to obtain convictions for reckless driving where police use radar, speed timers and aircraft, the Indiana Legislature ought to strengthen the law.

There are reports that bills aimed at this improvement in the law will be prepared for the 1961 session of the General Assembly, and if true this will be a sensible step.

These would not be laws to create "speed traps." They would be far different from the traps which have been used by some constables and justices of the peace to fatten their personal incomes and which are still existing in some areas.

The use of radar and aircraft does not constitute a scheme to snare motorists for anyone's personal profit. It is, instead, a method to help catch drivers who exceed legal speed limits.

Police are handicapped to some extent by resistance to their efforts to use more modern equipment to identify speeders and present more impressive cases against them in the courts. If there is any question about the legality of radar, speed-timers and aircraft for this purpose, it should be clarified by the legislature. There should be no doubt about the legal right of officials to use such things.

It would be difficult to imagine much reasonable opposition to strengthening the right to employ these modern detection methods. With highway slaughter increasing the way it is, the public should welcome anything within reason that will help reduce the death and injury toll.

Kokomo Tribune
Mar. 15, 1960

Food Additives Reprieved

Arrival of the Sunday, March 6 deadline for additive users won't mean an immediate wholesale removal of familiar food items from grocery shelves. The federal Food and Drug Administration is reported granting many one-year extensions to allow food processors and chemical companies additional time to prove that their additives, in the amounts used, are safe for human consumption.

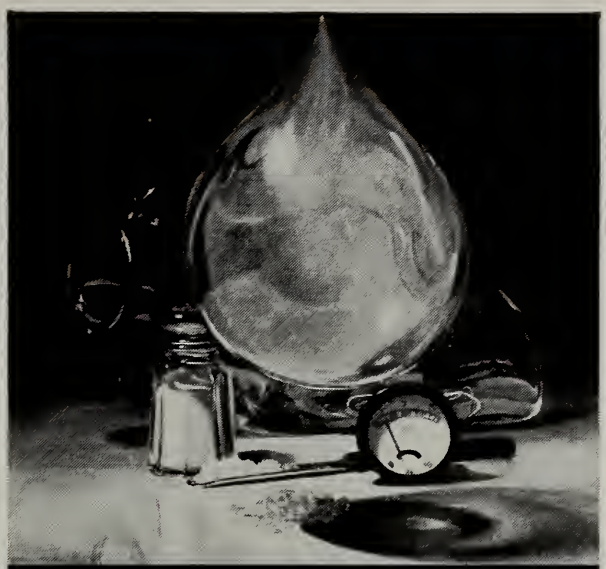
Under an amendment to the Food, Drug and Cosmetics Act passed by Congress in 1958, chemical additives must be proved safe for human consumption before they can be put into foods. The producers and users of additives were given 18 months to make the necessary tests; after the 18-month period of grace, sale of foods containing unproved additives could be forbidden by the FDA.

Scientific data has been submitted on only a small percentage of the hundreds of additives now used in foods. The law applies also to food packaging materials, from which harmful materials may "migrate" to the contents. The food companies contend that more time is needed for adequate testing of the additives and packaging materials.

A few processed foods stand in danger of being barred from sale when the March 6 deadline is reached. These are cases in which the FDA believes that continued use of additives contained in the foods may involve undue risks to health. Some of the standard additives—such as the carbon black and charcoal used in black jelly beans and licorice—already have been cleared for use in limited amounts after March 6, pending the results of further study. Foreign food imports also are being exempted from "any sudden crackdown."

Health and Welfare Secretary Arthur S. Flemming, meanwhile, is running up against stiff industry opposition in his efforts to get Congress to include anti-cancer provisions in a revised law to govern use of coal-tar dyes in such items as lipsticks and for coloring citrus fruits. The FDA wants to set tolerance limits for specific colors; at present it has power only to list a color as harmful, which in effect bans its use.

Continued



Naturetin

Squibb Benzydroflumethiazide

Naturetin c̄ K

Squibb Benzydroflumethiazide with Potassium Chloride

"...a safe and extraordinarily effective diuretic..."[1]

Naturetin — reliable therapy in edema and hypertension — maintains a favorable urinary sodium-potassium excretion ratio . . . retains a balanced electrolytic pattern:

"...the increase in urinary output occurs promptly..."[1]

"...the least likely to invoke a negative potassium balance..."[2]

"...a dose of 5 mg. of Naturetin produces a maximal sodium loss."[2]

"...an effective diuretic agent as manifested by the loss in weight..."[3]

"...no apparent influence of clinical importance on the serum electrolytes or white blood count."[3]

"...no untoward reactions were attributed to the drug."[4]

Although Naturetin causes the least serum potassium depletion as compared with other diuretics, supplementary potassium chloride in Naturetin c̄ K provides added protection when treating hypokalemia-prone patients; in conditions where likelihood of electrolyte imbalance is increased or during extended periods of therapy.

Numerous clinical studies confirm the effectiveness[1-15] of Naturetin as a diuretic and antihypertensive — usually in dosages of 5 mg. per day.

■ the most potent diuretic, mg. for mg.—more than 100 times as potent as chlorothiazide ■ prolonged action — in excess of 18 hours ■ maintains its efficacy as a diuretic and antihypertensive even after prolonged or increased dosage use ■ convenient once-a-day dosage — more economical for patients ■ low toxicity — few side effects—low sodium diets not necessary ■ not contraindicated except in complete renal shutdown ■ *in hypertension*—significant lowering of the blood pressure. Naturetin may be used alone or with other antihypertensive drugs in lowered doses.

Supplied: Naturetin Tablets, 5 mg. (scored) and 2.5 mg. Naturetin c̄ K (5 c̄ 500) Tablets (capsule-shaped) containing 5 mg. benzydroflumethiazide and 500 mg. potassium chloride. Naturetin c̄ K (2.5 c̄ 500) Tablets (capsule-shaped) containing 2.5 mg. benzydroflumethiazide and 500 mg. potassium chloride.

SQUIBB



Squibb Quality—the Priceless Ingredient

References: 1. David, N. A.; Porter, G. A., and Gray, R. H.: Monographs on Therapy 5:60 (Feb.) 1960. 2. Stenberg, E. S., Jr.; Benedetti, A., and Forsham, P. H.: Op. cit. 5:46 (Feb.) 1960. 3. Fuchs, M.; Moyer, J. H., and Newman, B.E.: Op. cit. 5:55 (Feb.) 1960. 4. Marriott, H. J. L., and Schamroth, L.: Op. cit. 5:14 (Feb.) 1960. 5. Ira, G. H., Jr.; Shaw, D. M., and Bogdonoff, M. D.: North Carolina M. J. 21:19 (Jan.) 1960. 6. Cohen, B. M.: M. Times, to be published. 7. Breneman, G. M., and Keyes, J. W.: Henry Ford Hosp. M. Bull. 7:281 (Dec.) 1959. 8. Forsham, P. H.: Squibb Clin. Res. Notes 2:5 (Dec.) 1959. 9. Larson, E.: Op. cit. 2:10 (Dec.) 1959. 10. Kirkendall, W. M.: Op. cit. 2:11 (Dec.) 1959. 11. Yu, P. N.: Op. cit. 2:12 (Dec.) 1959. 12. Weiss, S.; Weiss, J., and Weiss, B.: Op. cit. 2:13 (Dec.) 1959. 13. Moser, M.: Op. cit. 2:13 (Dec.) 1959. 14. Kahn, A., and Greenblatt, I. J.: Op. cit. 2:15 (Dec.) 1959. 15. Grollman, A.: Monographs on Therapy 5:1 (Feb.) 1960.

'NATURETIN' IS A SQUIBB TRADEMARK.

Fourth Estate

Continued

The FDA is performing a useful health service if it does not go to ridiculous extremes. No food processor should want to resist its directives if they are reasonable and if there actually are ingredients in any food or application that could be harmful.

Kokomo Tribune
Mar. 4, 1960

Let's Play It Fair

Producers and processors of vegetable oils may still be sore from the kicking around they received from dairy people who convinced legislators they should pass restrictive laws unfavorable to the oils. We are among those who believe that the dairy industry has gained nothing in the long run by such legislation.

However, the vegetable-oil people seem to be having trouble keeping their own noses clean. We know a housewife who won't touch margarine with a 10-foot pole because she is offended by the sneering illusions of one margarine advertiser to "the high-priced spread."

COOK COUNTY
GRADUATE SCHOOL OF MEDICINE
INTENSIVE POSTGRADUATE COURSES
STARTING DATES—FALL, 1960

Surgical Technic, Two Weeks, September 26, November 7
Surgery of Colon and Rectum, One Week, September 19
Gallbladder Surgery, Three Days, October 17
Surgery of Hernia, Three Days, October 20
Surgery of Hand, One Week, September 26
General Pediatrics, Two Weeks, October 3
Pediatric Surgery, One Week, September 19
Internal Medicine, Two Weeks, October 17
Respiratory Allergy, Two Days, September 9 & 10
Hematology, One Week, October 10
Diagnostic Radiology, Two Weeks, October 17
Board of Surgery Review, Part I, Two Weeks, November 7
Gynecology, Office and Operative, Two Weeks, September 12
Vaginal Approach to Pelvic Surgery, One Week, September 26
Obstetrics, General and Surgical, Two Weeks, October 3
Fractures and Traumatic Surgery, Two Weeks, October 24

TEACHING FACULTY—ATTENDING STAFF OF COOK COUNTY HOSPITAL

Address:
REGISTRAR, 707 South Wood Street, Chicago 12, Illinois

Recently when research indicated there may be an advantage in the unsaturated vegetable oils over the saturated animal fats in their relation to blood cholesterol and heart attacks, overeager oil manufacturers claimed that their product actually prevented heart attacks.

It was necessary for the Food and Drug Administration to slap down these claims with the following statement: Representations to the public that salad oils, shortenings, oleomargarine, and similar products have value in reducing blood cholesterol and preventing heart attacks are false and misleading and will cause such products to be misbranded."

Prairie Farmer
Mar. 5, 1960

Price-Tag on Illness

There is apparently no way to keep a politician from making a good thing out of the misfortune of another. The Forand bill, which has been given backing by organized labor and a sizable number of "liberal" Democrats, is a good example.

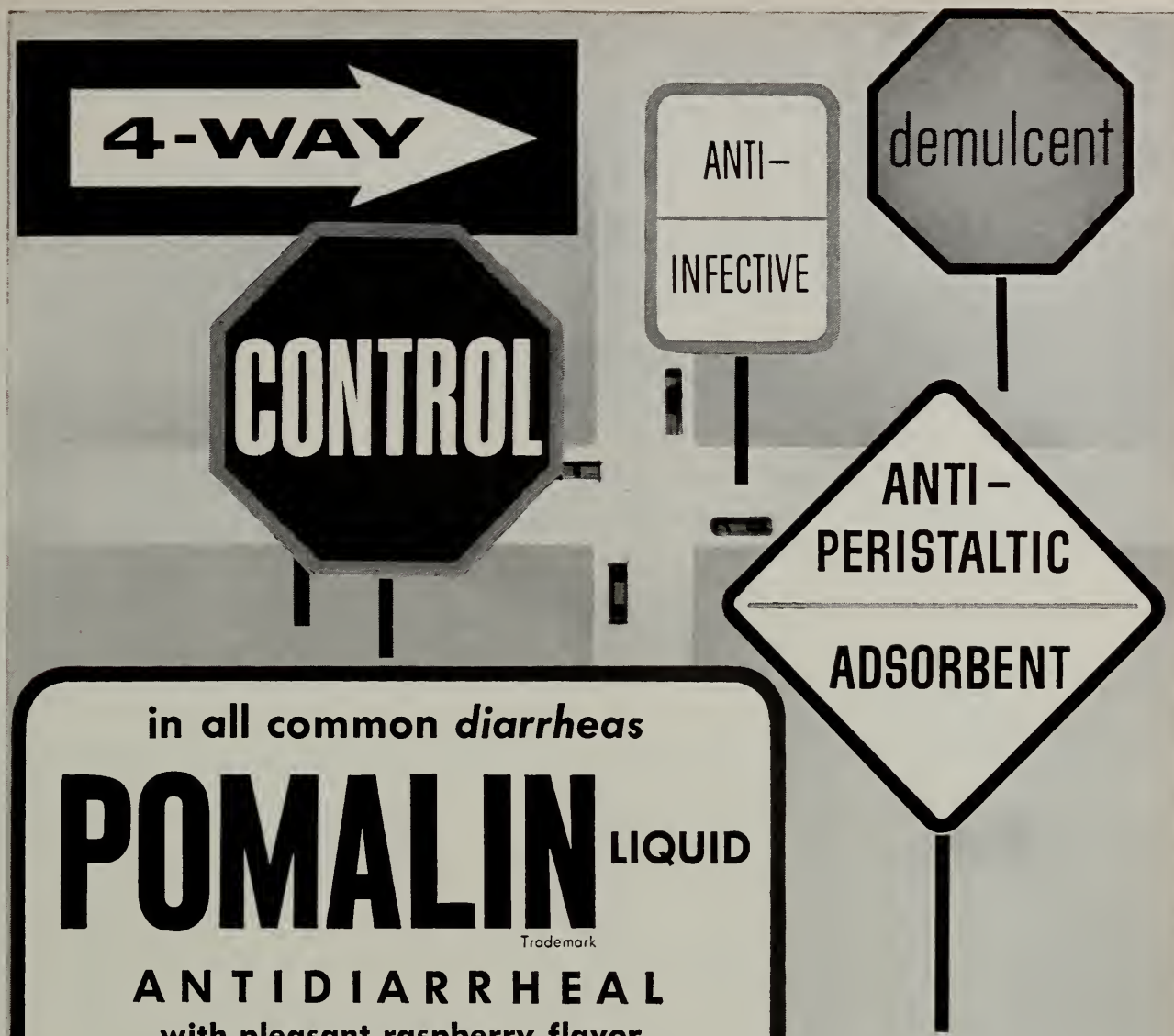
On its face, this proposal would first increase the tax paid by every working person in America for the political insurance known as social security. The reason for this increase supposedly is to provide better hospital and health care for the elderly citizens.

The politicians, however, cannot resist the temptation to make the most out of any situation involving more taxes and more public money to spread around. An older citizen now receiving the political benefits of social security could choose either to get greater monthly payments, under the Forand proposal, or to receive hospital and health care. In other words, the older citizens have a choice of getting more money or getting sick. Illness in old age thus comes with a definite price tag.

This should prove to even the most doubtful the insincerity which riddles such a political scheme. The Forand bill is nothing more than an attempt to buy the votes of many thousands of elderly Americans by using money which would have to be milked out of the taxpayers.

Such a plan would play politics with the physical well-being and lives of older men and women. It has no place in the United States.

The Indianapolis Star
May 9, 1960 ◄



in all common *diarrheas*

POMALIN LIQUID

Trademark

ANTIDIARRHEAL

with pleasant raspberry flavor

— eases and speeds the return to normal bowel function —

The comprehensive antidiarrheal formula of Pomalin brings positive relief to patients with specific and nonspecific diarrheas, bacillary dysentery, nonspecific ulcerative colitis and enteric disturbances induced by antibiotics.

Pectin and kaolin protect against mechanical irritation, adsorb toxins and bacteria, and consolidate fluid stools. Sulfaguanidine concentrates antibacterial action in the enteric tract. Opium tincture suppresses excessive peristalsis and reduces the defecation reflex.

Each palatable 15 cc. (tablespoon) contains:

Sulfaguanidine U.S.P.	2 Gm.
Pectin N.F.	0.225 Gm.
Kaolin	3 Gm.
Opium tincture U.S.P.	0.08 cc.
(equivalent to 2 cc. of paregoric)	

Dosage

ADULTS: Initially 1 or 2 tablespoons from four to six times daily, or 1 or 2 teaspoons after each loose bowel movement; reduce dosage as diarrhea subsides.

CHILDREN: ½ teaspoon (2.5 cc.) per 15 pounds of body weight every four hours day and night until stools are reduced to five daily, then every eight hours for three days.

HOW SUPPLIED: Bottles of 16 fl. oz.

Exempt narcotic.
Available on prescription only.

Winthrop
LABORATORIES
New York 18, N. Y.

Letters

to the editor

Dear Dr. Ramsey:

While not ordinarily given to editorializing, I am taking the liberty of submitting a few thoughts relative to the practice of medicine and the philosophy of man.

While I do not concur with the frequent pastime of applying psychiatric concepts to all that happens to man, there appear to be some interesting parallels between current national trends and some types of psychopathology.

The child develops early those patterns of interpersonal relationships—thinking, feeling and behaving, that are to stay with him to greater or lesser degree as his personality characteristics. The infant is totally helpless and dependent upon the nurturing protection and care of his parents. With the human infant, this is appropriate and acceptable behavior. As growth progresses, however, the child's capacity expands, his powers develop, and he becomes increasingly independent. He begins to emerge from childhood and its dependency. Relatively increasing autonomy is a dimension of maturity. Growing up is an arduous task and one fraught with constant temptation to withdraw from the struggle and return to the safety and security of the parental home and care. He who thus remains disproportionately dependent, however, we are inclined to consider sick.

It is striking though, that on a political scale, dependency is considered progressive rather than regressive. The relinquishing of one's dependence and turning to a benevolent federal parent-figure as a source of all nurturance is viewed by many as a healthy trend. This is alarmingly akin to the child fleeing back to mother rather than facing the vicissitudes of growing up.

Are we not in danger of condoning collectively that which we abhor individually? We are led to believe for example, that efforts to balance the national budget are reactionary. Yet to exterpolate such a philosophy to a person's own business would be considered singularly naive, if not illegal. The expansion of social security and other welfare programs with little regard to cost, is similarly considered progressive. After some years in close association with social welfare

Tested... and proved...

ORAL therapy in diaper rash!



Convenient... simply open a capsule and add the contents to the baby's daily formula, or to fruit juice or water. No lotions... no rinses... no ointments... just oral therapy.

Send for samples and literature.

S. F. DURST & CO., INC.
Philadelphia 20, Pa.

Effective therapy! Thousands of pediatricians and general practitioners prescribe Pedameth for ammonia dermatitis—and they continue to prescribe it. Clinical tests have proved its effectiveness. Pedameth is safe because it contains only dl-methionine (0.2 Gm.) one of the essential amino acids. When Pedameth is administered, the pH of the urine is lowered and an as-yet-unknown antibacterial agent appears in the urine. Pedameth works... it's the safe, effective, convenient answer to ammoniacal diaper rash.

Prescribe

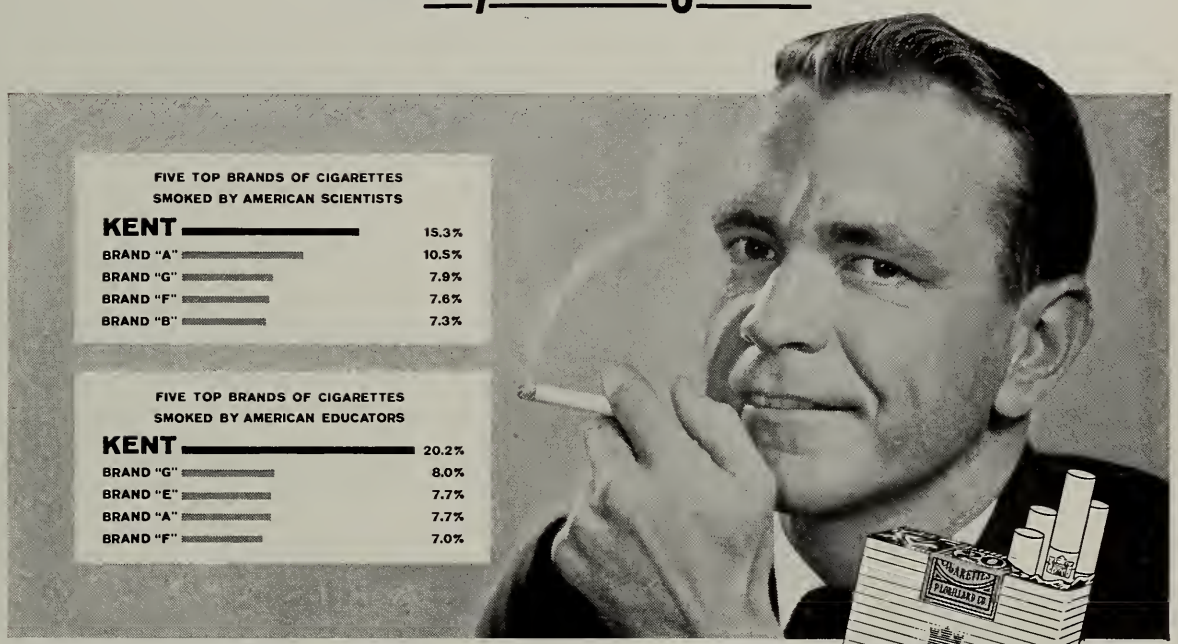
PEDAMETH®

(dl-methionine DURST)

ALL OVER AMERICA!

KENT with the MICRONITE FILTER IS SMOKED BY MORE SCIENTISTS and EDUCATORS

than any other cigarette!*





KING-SIZE, REGULAR-SIZE OR CRUSH-PROOF BOX

THIS does not constitute a professional endorsement of Kent. But these men, like millions of other Kent smokers, smoke for pleasure, and choose their cigarette accordingly.

The rich pleasure of smoking Kent comes from the flavor of the world's finest natural tobaccos, and the free and easy draw of Kent's famous Micronite Filter.

If you would like the booklet, "The Story of Kent", for your own use, write to: P. Lorillard Company—Research Department, 200 East 42nd Street, New York 17, New York.

For good smoking taste, it makes good sense to smoke KENT

*Results of a continuing study of cigarette preferences, conducted by O'Brien Sherwood Associates, N.Y., N.Y.

A PRODUCT OF P. LORILLARD COMPANY · FIRST WITH THE FINEST CIGARETTES · THROUGH LORILLARD RESEARCH

© 1960, P. LORILLARD CO.

Wanted: Locations Physicians

Following is a list of physicians who have made inquiry at our office during the month of June 1960 concerning openings in our state for practice.

General Practice

Frederic A. Helmer, M.D., 2606 East Drive, Fort Wayne, Ind.

Jerome A. Snyder, M.D., U.S.A.H., Dugway, Utah—Group practice.

Stephen M. Dillinger, M.D., 4821 Andover Square, Indianapolis 26, Ind.

William S. Van Bergen, M.D., 19 E. Cedar Street, Chicago, Ill.

John L. Hill, M.D., 752 S. Leavitt, Chicago, Ill.

Edward G. Krug, M.D., 66745 Van Dyke, Romeo, Mich.

Keith R. Hughet, M.D., 6925 Soyaluna Place, Tucson, Ariz.

Specialists

George W. Knabe, Jr., M.D., Univ. of Puerto Rico, San Juan, Puerto Rico—*pathology.*

Edward M. Zohman, M.D., 9 Saint Pauls Road North, Hempstead, N. Y.—*surgery.*

William E. Bruck, M.D., 2842 La Feuille, Cincinnati, Ohio—*Surgery: chest and vascular.*

William D. Minard, M.D., U.S.A.H. 3185, Fort Rucker, Alabama—*OGB.*

Indiana Openings—General Practice

Dearborn County—LAWRENCEBURG—pop. 5,000. County seat town with a new hospital. Opening for a partnership doing essentially internal medicine with a small amount of pediatric and industrial work. For details contact G. G. Morrison, M.D., 209 Fourth St., Lawrenceburg, Ind.

Delaware County—MUNCIE—pop. 59,000. Medical office available, suitable for two physicians. Located at 2210 Janney Avenue in a new and fast growing residential section with plenty of parking space, and only a five minute drive to Ball Hospital. Contact Mr. Chester C. Wingate, 120 North Mulberry St., Muncie, Ind.

Floyd County—GEORGETOWN—pop. 500. Located 12 miles west of New Albany, Ind. This is essentially a farming community. The physician who has practiced in the community for many years has retired. Community willing to assist the physician in getting located. Contact Miss Hazel Kirk, Georgetown, Ind.

Spencer County—CHRISNEY—pop. 600. With a large surrounding territory. A new stone, ultra modern home together with modern equipped offices and drug dispensing rooms all under a common roof available. Strategically situated in Spencer County. Four nearby hospitals available. Real estate and equipment can be purchased at actual cost less 30% on equipment. Little or no money needed down. Contact Mr. Kenneth Ayer, Rockport, Ind. for further details.

St. Joseph County—SOUTH BEND—pop. 200,060. Industrial community with good schools, churches and recreational facilities. Indiana limestone ranch style home and office available. Located close to the hospitals. Physician is retiring for health reasons. Contact Harry C. Davis, Executive Secretary, St. Joseph County Medical Society, 106 West Monroe St., South Bend, for details.

Postgraduate course in

"Heart Disease—with Emphasis on newer Diagnostic Techniques—Medical and Surgical Management"

September 7-8-9-10, 1960

Cardiac Laboratory, Cincinnati General Hospital

Limited to 75

FEE: $75 payable to Cardiac Laboratory
University of Cincinnati

Letters

Continued

efforts locally and elsewhere, it is my growing impression that it demeans a person to do for him that which he can and should do for himself. I propose that it is a person's prerogative, mature responsibility, and indeed, his privilege to care for his own.

There are indications that each person harbors the secret fantasy of getting something for nothing—or at the expense of another. Unfortunately, some politicians have utilized this to foster the illusion among voters that each will be the fortunate one to gain at the expense of "others." The basic morality of rewarding irresponsibility must be questioned—particularly when the "others" may well be our children and our children's children.

Material security is not to be deprecated. But is it to be our ultimate concern? Man's basic drives of sex, aggression and hostility are appropriately and constructively channelled into his work, thereby contributing to the dignity of the person and the civilization of mankind. What happens to these drives without the necessity of this healthy channelling? The increasing rates of suicide, alcoholism and drug addiction in some countries where the welfare state is assured may provide some clues.

In a prison or a mental hospital, one can enjoy rather complete security. There need be little concern for food, clothing, shelter or medical care. The only expense—is one's freedom.

Sincerely,
Gordon T. Brown, M.D.
Indianapolis ◄

The Journal of the INDIANA STATE MEDICAL ASSOCIATION

Supervised by THE COUNCIL

Volume 53 — August 1960 — Number 8

Treatment of Acute Intestinal Obstruction

*MANUEL E. LICHTENSTEIN, M.D.**

Chicago, Ill.

TREATMENT OF intestinal obstruction requires:

Urgent surgical relief in strangulated hernia, markedly distended large bowel and persistent obstruction in small bowel with impending perforation or peritonitis.

Secondly, one must give progressive non-surgical care with the prospect of spontaneous recovery in postoperative adhesions of recent origin, recurrent obstructions due to previous operations and in acute inflammatory disease pending resolution of the inflammatory process.

Treatment must also provide elective surgery for removal or circumvention of an obstructing lesion following relief from distention, correction of fluid and electrolyte imbalance and preparation of the patient for the necessary surgery.

Diagnosis

Suspicion that intestinal obstruction is present is essential for proper management. Congenital or acquired hernias (inguinal, femoral, umbilical, postoperative, diaphragmatic), and postoperative adhesive bands account for most of the patients. Congenital or developmental defects, tumors, foreign bodies, gallstones and inflammatory conditions account for others.

The most common error of omission is failure to remove a fecal impaction or failure to examine for an incarcerated femoral hernia in the elderly female. The most common error of commission is repair of a large strangulated umbilical hernia in an obese patient in whom relief of obstruction is the only indication for surgery.

The most common error responsible for an unnecessary death is reduction of a strangulated hernia by taxis without immediate exploration or observation as to the progress of the patient.

X-Ray Aids Diagnosis, Treatment

X-ray studies are an aid to diagnosis and a guide for proper treatment:

a. *Scout films.* A-P views of the abdomen from thoracic to pelvic diaphragms can be taken, first in the horizontal position for bowel pattern to distinguish small from large bowel obstruction

* Professor, Surgery, Cook County Graduate School of Medicine, Chicago, Ill.

Presented at the Scientific Session, Indiana Academy of General Practice, Fort Wayne, Ind., Feb. 24, 1960.

and both from paralytic ileus; secondly, in vertical or lateral position for fluid levels to localize the site of obstruction.

b. *Barium enema under fluoroscopic control* can determine level of colonic obstruction, volvulus or intussusception.

When the barium has outlined the level of obstruction, pressure should be discontinued to avoid accumulation of barium above the obstructing lesion. In ileocecal intussusception reduction of the ileum may be accomplished and laparotomy avoided. Barium should not be given by mouth to any patient who is suspected of bowel obstruction.

Sigmoidoscopic examination is also useful to detect or rule out lesions in the lower segment of the colon above the reach of the examining finger. Passage of a well-lubricated tube into the lumen of the bowel above the site of obstruction will relieve distention, and permit better preparation of the patient for elective surgery. In volvulus, complete relief from distention may be obtained in some instances.

Clinical Course

Continuous observation concerning the progress of the patient and the local condition of the bowel will determine the effectiveness of therapy and indicate the urgency for surgical relief when this is necessary. Recognition of the changing clinical condition for better or worse is an essential guide to treatment.

Distention, water and mineral imbalance, anemia, hypoproteinemia and malnutrition, toxemia and infection will vary according to:

1. the cause and duration of the obstruction.
2. the level of obstruction in the gastrointestinal canal (high obstructions are proximal to the mid-jejunum; low obstructions are in the left colon).
3. the presence of complications such as strangulation, gangrene or perforation in a hernial sac or in the peritoneal cavity.
4. concomitant disease in other organs of the body.

Treatment

One indication for prompt surgical intervention is in small bowel obstruction where development of abdominal tenderness is indicative of peritoneal irritation from strangulation with gangrene or impending perforation.

Another indication is the sudden or gradual cessation of bowel sounds when these were previously active indicating a paralysis of the musculature and an inability to overcome the obstruction.

In the absence of these indications for immediate surgery, preparation of the patient should be continued until restoration of the fluid and mineral balance is established.

In simple obstructions of short duration such as an incarcerated external hernia, treatment should be undertaken promptly. A nasogastric tube is inserted and with suction the stomach is emptied of its gaseous and liquid content. This is continued after surgery until flatus and feces pass freely per rectum. Intravenous fluids are given during and after surgery for the first 24 hours as follows:

1000 cc of 0.9% NaCl in 5% dextrose solution
2000 cc of 5% dextrose solution

Release of the constricting ring relieves the condition and repair of the hernia may now be done.

Preparation for Surgery

When obstruction has been present for several days or longer immediate decompression is instituted by nasogastric intubation and suction, and preparation is made for the administration of I-V fluids while the necessary x-ray studies are being made, blood is drawn for a determination of the fluid and mineral status of the patient. This initial study serves as a base to measure the progress of the patient's condition. Diagnosis and therapy are combined and simultaneous.

a. *Laboratory studies.*
   1. Blood chemistry: Na, K, Cl, CO_2, NPN, total proteins, blood albumen and blood sugar.
   2. Blood count: Hb, Hct, WBC and differential.
   3. Urine analysis: alb., sugar, bile, blood, specific gravity, chemical reaction, microscopic.

b. *Chart of normal values.*

Na	136-145 meq/L	NPN	25-35 mg/100 cc
K	4.1-5.2 "	Tot. Prot.	6-8 gm/100 cc
Cl	100-106 "	Alb.	3.6-5.6 gm/100 cc
CO_2	24-34 "	Sugar	80-120 mg/100 cc
Hct	37-42%	Hb	13.5-15 mg/100 cc
		Diff. Polym.	55-72%

c. Fluid requirements.

1. For adequate renal function an output of 1000 to 1500 cc of urine with specific gravity of 1.010 to 1.020 is required.
2. For body temperature regulation influenced by the atmospheric temperature, humidity and body temperature 1000 to 1500 cc is required. Both of these are supplied essentially by five percent dextrose solution.
3. For replacement of fluids lost by vomiting and stagnant in the intestinal canal, an estimation must be made according to the factors listed under clinical course. This amount varies from very little to as much as 3000 cc.

Restoration of the water and mineral balance is effected as follows:

a) Water is supplied by the use of five percent dextrose in water to which may be added minerals known to be deficient as determined by the blood chemistry determinations.

b) NaCl is supplied by 0.9% NaCl in 5 percent dextrose solution.

c) Replacement of fluids lost from the gastrointestinal canal by suction is supplied by 0.45% NaCl in five percent dextrose solution.

d) Chloride without sodium deficiency is corrected by the use of 4.5 gms. NH_4Cl in 1000 cc five percent dextrose solution repeated as often as needed.

e) Sodium without chloride deficiency is corrected by the use of 60 cc Molar Sodium Lactate in 1000 cc five percent dextrose solution repeated as often as needed.

f) Potassium deficiency is corrected by the use of 3 gms. KCl in 1000 cc five percent dextrose solution repeated as often as needed.

g) Acidosis is corrected with Lactated Ringer's Solution.

h) Alkalosis is corrected with Sodium Chloride, and Potassium Chloride solutions.

i) Proteins are supplied by protein solutions (Amigen, Protein Hydrolystate, Aminosol).

j) Fats (for calories) are supplied by Lipomul (900 calories in 500 cc of solution).

k) Whole blood is given for anemia, when strangulated bowel is removed, and, to restore blood volume when deficiency of this fluid is noted.

l) Soluble vitamins and antibiotics are added to fluids when required.

Decompression

In small bowel obstruction, decompression can be achieved by nasogastric intubation, using a Levine tube. In some instances of obstruction in the distal small intestine a Cantor tube may rid the bowel of stagnant secretions more effectively and hasten preparation of the patient for abdominal exploration. However, when obstruction is not relieved and evidence of peritonitis is present, time should not be lost by waiting for relief from distention by use of the long tube.

Laporotomy should be done in spite of distention when evidence of peritonitis is present. Decompression of the small bowel is effected by isolation of a single loop, insertion of a suction tube or large catheter held in place with a purse string suture and removal of the gaseous and the liquid content by suction.

The ileostomy or jejunostomy is temporary. Following release of the obstructing band or removal of the involved bowel with restoration in continuity of the lumen, the tube or catheter is removed and the opening in the bowel is closed by suture. Decompression facilitates abdominal wall closure.

In large bowel obstruction, cecostomy is most effective when marked distention is unrelieved by enemas or by attempted intubation from below. The cecum must be exteriorized to provide a large opening for evacuation of gas and feces.

Loop colostomy in the right transverse colon is made when the cause of the obstruction can be removed subsequently without hindrance by the presence of the colostomy.

Volvulus of the sigmoid unrelieved by intubation from below is exteriorized and resection of the involved bowel is done. When continuity cannot be restored immediately, the proximal and distal segments of viable bowel are united to form a spur and a double-barrelled colostomy is established. This is closed as soon as circumstances allow.

Intussusception unrelieved by enema is reduced at laporotomy. When reduction cannot be done and colon resection is too hazardous for the patient, anastomosis between the proximal and distal segments of bowel will relieve the obstruc-

tion. When gangrene involves the entire segment exteriorization with lateral anastomosis between the proximal and distal segments is done. The dead bowel is amputated, leaving a colostomy. This is closed when circumstances are favorable.

Treatment Directed to Spontaneous Recovery

This is frequently successful in recurrent obstruction due to adhesions especially when the patient has already had several or many previous operative interventions. It is useful in inflammatory obstructions and in the early postoperative period when mild pelvic peritonitis involves the small intestines. Conversion of the acute complete obstruction into an incomplete or subsiding obstruction is effected by the "oil and enema routine" as follows:

1. Decompression of the distended abdomen by nasogastric intubation and suction is instituted.
2. I-V fluids appropriate in amount and in composition are administered.
3. Mineral oil (one ounce) is given by mouth every four hours for three doses. Suction is discontinued for two hours after each dose.
4. A two-quart warm tap water enema is given four hours after the last dose of oil. The washings from the colon are examined for oil and feces.

(Note: The presence of oil in the washings indicate an incomplete obstruction and the prospect of complete recovery is good. The absence of oil in the washings indicates persistence of the obstruction and further care is necessary.)

5. Continue suction and I-V fluids. Check blood chemistry, correct mineral and blood deficiencies, especially potassium, proteins and whole blood; in the presence of infection use an effective antibiotic.
6. Repeat Number 4 in eight hours.

Note: Oil is not repeated after the third dose.

7. It is essential to distinguish between ileus involving both small and large bowel with no occlusion of the lumen in which delay favors recovery and small bowel obstruction which fails to yield to conservative therapy. See 3.

Antibiotics should be administered only when strangulation of bowel is present and peritonitis is present or impending.

Operative Therapy

a. Local anesthesia should be employed whenever possible, more especially in the release of an external hernia and for cecostomy. General anesthesia offering a high degree of oxygen should be used with tracheal intubation when indicated.

b. The incision should be large enough to expose the site of obstruction. Its position will be determined by the site of the obstruction noted in the x-ray study or directly over the tender spot, when this evidence of impending perforation is present. A right paramedian incision will expose all of the small bowel.

c. Viability of bowel is determined by observation of its color, pulsations, response to oxygen inhalation and local stimulation. When doubt exists as to viability the involved segment should be resected and continuity restored.

d. Abdominal wall closure. The peritoneum and posterior sheath of the rectus muscle is closed with a continuous chromic catgut suture size 00, using a double strand. The anterior sheath of the rectus muscle is closed with 32-gauge wire and the skin is closed with 35-gauge wire.

e. Ambulation should be started early in the postoperative period.

Postoperative therapy is designed to prevent recurrence of obstruction by use of a bland diet. Mineral oil is useful to maintain a free passage of flatus and feces. ◄

Cancer—The Research Approach

*CLARENCE C. LITTLE, Sc.D.**

Ellsworth, Maine

ALL THAT ONE can hope to do in presenting such a subject is to block out certain broad categories of factors that seem to have earned the right to our continued attention and investigation if we are to hope for the acquisition of new knowledge necessary to understand and to control the many forms of the disease which we call cancer.

I shall discuss two such categories.

The first category deals with factors that may be involved in the basic nature of the complex conditions which we commonly describe by the single word—cancer.

In order to consider them without bias we must distinguish rigidly and clearly between the relatively advanced and critical nature of the disease and the delicate and, as yet, unknown nature of its origin.

There is no more striking and significant contrast in the whole history of clinical medicine than the one which exists in this case.

Cancer becomes a disease and cause of death because it presents to an organism pledged to an orderly control of structure and function a continuing challenge that this organism cannot ordinarily meet. This challenge is the presence of a center or centers of uncontrolled and resurgent growth and vigor in an environment of limited and defined growth activity.

Early cancer—from the first disobedient or anarchistic cell—is a highly effective and efficient biological unit. It can out-metabolize, outgrow and outlive the surrounding cells and tissues.

Why does this phenomenon occur, and why does it appear most commonly in tissues and organs which are not themselves young or in their prime?

Occurs in Physiological Unbalance

If one considers the major types of neoplasia he will find that they occur most commonly under surrounding conditions of impaired or diminishing physiological efficiency, and, in a smaller number of cases, before the peak of physiological activity has been reached and control has been established.

The origin of cancer occurs, therefore, under conditions of physiological unbalance between the affected cell or tissue and its surrounding cells and tissues.

Cancer research should continue and extend its activity into causes of internal unbalance and the prevention or postponement of such unbalance and its correction when prevention fails. Some of the causes of unbalance have been identified and others remain to be discovered.

Certain of these causes may be listed as follows:

1. Excess or deficiency of hormones.
2. Excess or deficiency of vitamins.
3. Presence or effects of former infective agents.
4. Competition between unlike metabolic tempos, such as those that occur in hybridization.
5. Actual or relative excess or deficiency of introduced chemicals.
6. Irradiation or introduced physical unbalance, temperature, etc.

Unbalance may occur between organ systems in an organism, between tissue systems in an organ, between cells within a tissue, between intracellular components such as nucleus and cytoplasm. It can also occur between components

* Scientific Director Tobacco Industry Research Committee.

Presented at the Scientific Session, Indiana Academy of General Practice, Fort Wayne, Ind., Feb. 25, 1960.

of the cytoplasm or of the nucleus. Within the nucleus it can occur between chromosomes and, within the chromosomes, between genes.

Evidence is now appearing that even changes in the configuration of a complex protein molecule, such as a gene, may result in critical unbalance and change of the functional potentialities of that structure.

If we remember that the change or changes from a resting or controlled body cell to a neoplastic cell are very delicate and minute and that the neoplastic cell functions with great biological efficiency, we shall admit, I think, that research into the origin and nature of cancer involves the use of many technics and disciplines to supplement and enlighten each other. It further involves the recognition of the basic truth that no matter what the easily recognized and definable elements in our methods or procedures may be, the actual biological difference between the two types of cells is a matter of great subtlety and involves dynamics of a high degree of complexity.

Second Category of Factors

The second category of factors to be considered is the broad fields of human experience, each of which has indicated that it may play a role in cancer causation and development. These may be listed as follows:

1. *Heredity*—how much does the biochemical nature of the individual depend upon its innate composition? Some individuals in the same environment develop these diseases; others do not.

2. *Infection*—how much do bacteria and/or viruses, either present or previously experienced, influence cell or tissue changes? To what extent do they increase the risk of later disease?

3. *Nutrition*—how much do the various nutritive materials taken, absorbed, stored or excreted by the individual affect cell or tissue changes? Cholesterol is one substance now under extensive investigation, but vitamin deficiencies and other unbalances may be important.

4. *Hormones*—how much do the products of the various glands of internal secretion, transmitted by the body fluids, affect cells or tissues either by amount of secretion, activity of secretion or unbalance between various glands? It is known that they have an important role in breast cancer and adrenal cancer, and that men have four to six times as much lung cancer as women.

5. *Nervous strain or tension*—how much do these factors influence the activity and function of cells and tissues of various systems of the body other than the nervous system itself? Ulcer is already recognized as a disease in which stress is important. Cardiovascular disease is also implicated.

6. *Environmental factors*—how much, if any, do physical or chemical components of the environment, introduced as foreign nonliving agents, affect the cells or tissues? In addition to tobacco, air pollutants, irradiation, humidity and temperature are involved in this question.

All six of these fields are important in obtaining a better and, eventually, a complete understanding of cancer causation and all, or a majority of them, are similarly to be considered in the causation of cardiovascular disease.

The Tobacco Industry Research Committee has supported and has initiated research in these broad fields, and will expand its activity as opportunity arises or can be created.

The Committee's research program is unique in that responsibility for research policy and development is entirely in the hands of a Scientific Advisory Board consisting of 10 doctors and scientists. This board, which came into being six years ago, makes grants to independent scientists on the basis of the merit of their research proposals.

Recognizing from the outset that knowledge about tobacco use was limited and uncertain, the board was given first priority in its program to questions relating to cancer, specifically lung cancer, and heart disease.

While members of an Academy of General Practice are quite properly absorbed in helping people to alleviate or cure critical and specific threats to health, they cannot and should not be expected to engage directly in the long-time difficult research needed to analyze the causal and preventive factors affecting the constitutional diseases.

The GP's Role

They do, however, have the solemn and important duty of recognizing, admitting and sympathetically understanding the complexities inherent in these all-important researches. They can help

to explain to the public that these complexities are not artificial or the result of any ivory-tower attitude on the part of researchers and scientists. They are, in fact, integral and inevitable components of the diseases with which medical research against cancer is and will be concerned.

As a result, members of the Academy should take scrupulous care not to support or subscribe to premature, oversimplified and superficial conclusions as to cancer causation just as they must against similar types of conclusions concerning its cure. It is tempting and temporarily satisfying to our intellects to accept on face value definite theories or claims of cancer causation. This has been done by certain people in their announcement of smoking as the main cause of lung cancer. In the long run, however, such an attitude will boomerang and will end in disillusionment and disappointment to the proponent, the practitioner and the patient.

Cancer is at home and well entrenched in the basic structures and functions of the body. It can only be understood, analyzed and eventually prevented by the accumulation and coordination of new knowledge in many fields of scientific research and after many more years of patient, critical, courageous and creative research that needs understanding and support. This is not encouraged by criticism and misinterpretation or by impatient over-interpretation of partial and incomplete evidence even if that is suggestive, stimulating and demands eventual accurate evaluation. ◄

72% of Americans Have Health Insurance

More than 127 million Americans—72% of the civilian population—had health insurance at the end of 1959, the Health Insurance Council said recently in reporting the results of its 14th annual survey on the extent of voluntary health insurance coverage in the United States. The survey is based on reports from insurance companies, Blue Cross-Blue Shield and other health care plans.

The Council said both the number of persons covered by health insurance and the amount of benefits paid reached new highs last year. Coverage increased by 4.8 million during 1959 to reach a total of 127,896,000 persons with health insurance protection.—Health Insurance Institute.

Three Hydrocephalic Newborns —Each of a Successive Pregnancy Of a White Female

*RICHARD G. MEHNE, M.D.**

Brazil

W. BRENNER has considered the question of heredity in hydrocephalus and suggests that there is a dominate sex-limited inheritance, but this has not been proven. A review of the literature does not prove that there is a distinct hereditary element in hydrocephalus, but enough cases are on record to make one believe that the possibility of a repetition of these abnormalities cannot be denied.

Cause of such monstrosities is not known; a defective germ plasm is generally assumed. Theories that avitaminosis and endocrine abnormalities are causative have little, if any support. Our knowledge of the growth hormones of the anterior pituitary body is not sufficiently large to assign to this organ a role in the production of the monstrosities.

Case Report: First Pregnancy

A 20-year-old woman was admitted to the hospital March 27, 1953, with an admitting diagnosis of "pregnancy, full-term primipera." Physical examination revealed normal heart, lungs and abdomen, with full-term pregnancy and a fetal heartbeat of 144. There was absence of nausea and vomiting, headache, leukorrhea or swelling of the extremities; the pregnancy had been uneventful and without complications. Blood-pressure was 134/65. Past history revealed nothing significant; there were no serious previous illnesses or miscarriages and the husband's health was good. The only abnormal laboratory report consisted of a positive gonorrheal smear.

The patient gave birth to a male weighing 7 lbs. 10 oz., on March 27, 1953, at 3:30 p.m. Position was LOA and the presentation cephalic. Her child was a hydrocephalic with unassociated defects, and episiotomy was necessary. There was considerable molding of the head. A Bartholin abscess ruptured at the time of the repair of the episiotomy, and a smear of the foul-smelling discharge sent to the laboratory, proved to be a gonorrheal pus. After delivery, both mother and babe were isolated from the obstetrical department. She received routine post-partum care. Antibiotics were advised for her infection, but she refused.

The patient was released from the hospital on April 1, 1953, with condition improved, and with a final diagnosis of "pregnancy living child, hydrocephalus delivered, and without associated defects, term birth, and gonorrheal Bartholintis, left." Her child passed away Nov. 15, 1953, at the hospital with considerable enlargement of the original hydrocephalus and complications thereof.

We reassured the patient that a second hydrocephalic child in a subsequent pregnancy was extremely rare; it was explained to her that the possibility of the recurrence of hydrocephalus cannot be denied, but that it is extremely uncommon. We also pointed out that usually, when one child is hydrocephalic, the other children are normal, and that in general, unless there is a positive family history, she would run no greater risk in having additional children similarly affected than do other parents. She was advised to have a subsequent pregnancy.

* Presented at the Scientific Session, Indiana Academy of General Practice, Fort Wayne, Ind., Feb. 23, 1960.

Comment

Review of the world literature of the last 500 years reveals 23 instances in which one woman in successive pregnancies delivered two or more children with hydrocephalus alone. More than two were in combination with other defects. D. P. Murphy reported a case of spina bifida and hydrocephalus in each of three successive pregnancies. In his series of 275 families with one congenital malformed or defective child, 34 (12.4%) gave rise to one or more additional congenitally malformed members. He suggested that it was 24 times as likely for a second child as recorded per birth certificate to have a congenital malformation as the general population at large.

Butler reported a case of three children with spina bifida and two more who were hydrocephalic from the same mother in 1888. H. A. Wright reported a case of two babies both with myelocele and hydrocephalus from the same mother in 1889. An anonymous Massachusetts physician reported a case of two hydrocephalic children from the same mother in 1933; Costelli reported two in one family, Gohlis reported six in one family and Peter Frank reported seven hydrocephalics from one mother.

Allingham reported one woman who in 12 pregnancies delivered three children who were hydrocephalic. Straub reported a man who married his niece; she delivered two hydrocephalic infants. Watterwald reports two male infants with hydrocephalus from the same mother, Wiener reports a case of the first and third child being hydrocephalic, H. R. Leland reported two hydrocephalic children and Murphy reported seven families having two hydrocephalic children. Murphy's study stated there was one chance in two that a second child would show the same congenital defect as the first.

Ford reported two hydrocephalic children from the same mother. His material consisted of 904 cases, which include all children with an encephalus, spina bifida, encephalocele and hydrocephalus born in the five largest maternity units in the state of Rhode Island during the years 1936 through 1952. W. Machado reported a case of one woman who in four pregnancies delivered two congenital hydrocephalic infants.

Second Case Report

On Sept. 3, 1954, the patient was admitted to the hospital with a full-term pregnancy. Her general health throughout her pregnancy had been excellent; there had been no significant weight gain nor history of virus infection during pregnancy, nor had there been radiation therapy, trauma or syphilis, or any other known complicating factors present. She submitted to x-ray pelvimetry on admission, which revealed a hydrocephalic child. It was concluded that the head would not be able to enter the inlet of the pelvis. Cesarean section was advised but was not agreed to by the patient. After four hours of hard labor, abdominal and rectal examination revealed the head engaged.

A female child in ROA position was delivered without episiotomy or forceps but there was considerable molding of the head, with occipitofrontal measurement of 21.5 cm. The mother was released from the hospital on Sept. 6, 1954, and made an uneventful recovery. This child was referred to the Walter Reed Memorial Hospital in Washington, D. C., where surgery was performed on the aqueduct of sylvius. The child survived approximately three months with continued enlargement of the head until it reached a diameter of 24 inches.

Third Hydrocephalic Case

A third hydrocephalic child was delivered and operated on at the Indiana University Medical Center. It was first admitted to Riley Hospital 4-17-56 to 5-7-56, at age 1 month, with progressive enlargement of the head since birth. There were no associated defects. Past history revealed two siblings with the same condition. Ventriculogram was done which showed an atresia of the aqueduct of sylvius.

We performed a third ventriculostomy which resulted in a pronounced decrease in the head size with sinking of the fontanelle. The patient was discharged in good condition.

The hydrocephalic baby was readmitted 5-22-56 to 6-5-56 because of a recurrence of the progressive enlargement of the head. The patient had been seen in clinic and it was obvious that the third ventriculostomy was no longer functioning. He was therefore admitted for further workup. A ventriculogram was done which showed no evidence of function of the third ventriculostomy. This was followed by Torkolson's operation in which a tube was placed from the right lateral ventricle into the spinal subarachnoid space to the left of the spinal cord. The usual cisterna magna was not present, which necessi-

tated the unusual position of the end of the tube. The patient tolerated the procedure well; the wound healed by primary intention. Upon the time of discharge the patient's head showed considerable decrease in size and the fontanelle was sunken.

The patient was then followed in the outpatient clinic. He seemed to be doing well until July 25, when pitting edema of the occipital scalp and bulging of the anterior fontanelle were noticed. However, examination revealed that the tube was still in position. The patient had a return appointment to the clinic on Aug. 8, 1956. To this author's knowledge the baby lived three months.

Discussion

Discussion with the late Dr. C. O. McCormick, Professor of Obstetrics and Gynecology at the Indiana University Medical Center, revealed that to his knowledge of the literature, no previous occurrence of three successive pregnancies each of which produced hydrocephalic children had been reported. The author's discussion with Dr. Nicholson Eastman of Johns Hopkins University in 1957 revealed nothing like this to his knowledge.

From the standpoint of the medical profession, repeated hydrocephalus in the same woman is extremely rare, but it does occur. Hydrocephalus *per se* is encountered in approximately one fetus in 2,000 and accounts for some 12% of all malformations met with at birth. Thus the mathematical possibility of the same woman delivering three hydrocephalic children with unassociated defects in three successive pregnancies is almost an impossibility. Although associated defects are common and serious dystocia is the usual consequence, this patient delivered all three hydrocephalic children vaginally without serious dystocia. None of the three children revealed additional defects. ◄

1½ E. National Ave.
Brazil, Ind.

New Action on Traveler Immunization

A further action to expedite the arrival of travelers from abroad has recently been announced: Travelers arriving in this country from Jamaica who have not gone elsewhere during the two previous weeks are no longer required to show proof of smallpox vaccination.

—U. S. Department of Health, Education, and Welfare.

Which Tranquilizer?

*MARK I. HEWITT, M.D.**

New Brunswick, N. J.

IT HAS LONG BEEN recognized that man is a pill-taking mammal—always looking for some pill that when swallowed and metabolized will somehow magically dissolve all the woes and worries to which his mind and body have fallen heir. In this context physicians are often consulted by patients whose illnesses have been caused or furthered by emotional stress. Some idea of just how large this group is can be gained from the estimate that about one-third of the practice of medicine is devoted to treatment of nervous disorders. This represents about 1,250,000 patients having a primary psychiatric diagnosis who pass through the offices of general practitioners and psychiatrists each year.[1]

Of course, ideal and analagous to the therapy of the allergic patient would be removal of the stressful stimuli such as, for example, change of occupation or solving of family problems. However, the number of patients relieved by these or similar types of environmental adjustment is unfortunately small. The far greater number must learn to live with their noxious stimuli either because there is no other way around it or because the sources of the stimuli have not been delineated clearly.

Avenues of Approach

It is this latter group upon which physicians are asked to concentrate their attention. To do so, there are generally three avenues of approach:

1. Psychotherapy, to help the patient cope better with his stressful stimuli.
2. Drug therapy, to help insulate the patient against his stressful stimuli.
3. Combined drug and psychotherapy, using drugs to make the patient more amenable and accessible to psychotherapy.

Which of the three avenues the physician traverses is dependent, among other things, upon his personal and professional background, his type of practice, his own inclination and upon his individual attitude toward drug therapy.

At first the private physician was wary of using the tranquilizers. This is exercise of historic, medical skepticism, for since the days of Osler, skepticism by physicians has been present with the introduction of almot every new drug. When aspirin and barbiturates were introduced, many reports over a period of years dealt with their toxicity, therapeutic failure, and undesirable side effects. In spite of this, both drugs still occupy a respected place in medicine.

Today's physician has become more and more accustomed to new drug announcements and I believe has a more realistic attitude toward drugs, one that amalgamates the overexuberant opinion of some with the nihilistic view of others—leading to a more balanced approach toward drug therapy.

As a result of the opinion by physicians that their emotionally stressed patients may be helped by drugs, in one recent year 50 million prescriptions were written for tranquilizers—just for ambulatory patients![2] I am aware of the fact that this statistic may represent not only an acceptance of drugs but also, more importantly, may indicate physicians' belief in the need for a drug or some therapeutic measure, simply administered, to help the emotionally disturbed patient.

Chemical attack upon brain disorders is not new. Only new are the types of chemicals made

* Director, Clinical Research, The Squibb Institute for Medical Research.

Presented at the Scientific Session, Indiana Academy of General Practice, Fort Wayne, Ind., Feb. 25, 1960.

CHARACTERISTICS OF "IDEAL" TRANQUILIZER

1. Rapid therapeutic response.
2. Effective in most patients.
3. Nonaddicting and nonhabituating.
4. Minimum toxicity in therapeutic range.
5. Low incidence of secondary side effects.
6. Absence of tolerance.
7. Adaptable to Out-Patients and In-Patients.
8. Does not dull senses, decrease perception, or interfere with mental acuity.
9. No impairment of voluntary motor movements.

Adapted from Farah, L.: *Internat. Rec. Med.* 169-379, 1956

TABLE I

available at an ever-increasing pace. In the past five years or so several new classes of drugs have been introduced that are loosely referred to as tranquilizers. Some appear not more than improvements on older types of sedatives, for example, meprobamate. Others—phenothiazine compounds—have entirely new and interesting neuropharmacologic actions. While these substances appear to act primarily on the central nervous system, the phenothiazines in particular are used also in medical conditions outside neuropsychiatry, *e.g.,* in surgery, obstetrics, and for nausea and vomiting.

Although phenothiazine itself is toxic, certain chemical substitutions on the phenothiazine nucleus have produced a group of rather remarkable compounds having the ability to tranquilize, *i.e.,* to act not upon higher cortical centers but rather at a subcortical level. This leads to a type of sedation without significant voluntary motor impairment. Tranquilization is accompanied by an inhibition of psychomotor hyperactivity, and by antihistaminic and local anesthetic properties. The therapeutic index of most of these compounds is unexpectedly high in view of the fact that all are capable to some degree of producing unwanted side effects, either as an extension of their pharmacologic activity or as an inherent property of the drug.

It might be well to ask if there is available today a so-called "ideal" tranquilizer. I have prepared a list, adapted from Farah,[3] of the characteristics of an "ideal" tranquilizer that might be used as a guide or reference against which to measure present-day tranquilizers (see Table I).

It is my belief that many of the tranquilizers available today come close to fulfilling these characteristics. In spite of this, the question "Which Tranquilizer?" was considered sufficiently pertinent to serve as the subject of this paper. Therefore, it is obvious that some, or perhaps all of the tranquilizers, under a particular circumstance must have failed to bring about the desired end-results.

Reasons for Failure

I think it would be well at this point to embark on an attempt to analyze why tranquilizers may apparently fail to bring about the desired results. I believe this apparent failure may reside in one or more reasons.

1. *Insufficient comprehensive knowledge about the drug itself.* In discussions I have had about tranquilizers, someone usually brings up the fact that he is confused about them. I am appreciative of the mental facility of today's physician who, in the face of an unrelenting avalanche of new drugs, is able to "roll with the punch" and fit many of these new drugs into his therapeutic attack upon patients' ills. However, I know from my own experience in practice that it is virtually impossible to learn all the facts there are to know about every new drug.

But, if one is not aware of all there is known about the difference between the limitations, side effects, toxicity, tolerance, therapeutic equivalents and therapeutic application of the major tranquilizers, particularly the phenothiazine derivatives, the desirable qualities of a particular drug looked for by each physician will not be found. This is especially true of the tranquilizers which, in addition, play a somewhat unique role in the physician's hand when compared with other classes of drugs, a point I would like to take up now as a second reason why tranquilizers may apparently fail.

2. *The philosophy of prescribing tranquilizers is unique.* Through our medical training we physicians have come to accept a classic concept of the use of drugs, as emphasized by Weidorn and Davis.[4] This concept implies that giving a drug to a patient leads to a definite physiologic effect in that patient: either a direct remission occurs as with digitalis, or remission is facilitated, as with an antibiotic. Such changes are physiologic within the patient's capacity to respond, irrespective of either the physician's active

role in the cure or his nonparticipating role in the patient's physiologic response. The physician assists the patient's physiologic repair by drugs and psychologic support but does not become a part either of the patient's disease or of the specific healing process.

In patients whose disease is primarily an emotional one, drugs exert a certain physiologic effect for the most part unknown, leading in some way to behavioral changes in the patient's interpersonal relationships. Tranquilizing drugs bring about a certain psychophysiologic change that increases the patient's receptiveness to his environment. Improvement takes place not only in the patient's physiologic realm but also in that extended area, past and present, of the patient's interpersonal relationships.

Thus, whenever a patient with an emotional illness is given an appropriate tranquilizer, the drug calls forth, with fair predictability, a physiologic response in the patient. However, one cannot with the same predictability know to what extent the patient's interpersonal relationships will improve. Change in this area depends upon the patient's past and present experiences.

Let me try to clarify this concept using alcohol as an example. Alcohol has a dual effect: (a) action on the central nervous system producing the typical slurred speech, blurred vision, and ataxia and (b) action on the personality of the individual.

Varied Results from One Drug

In devising a theoretic experiment, let us go to a nearby bar and select five male subjects who are, as far as we can tell, identical in appearance, body weight, build and emotional balance. Each man is asked to drink two ounces of bourbon rapidly. After allowing time for absorption to occur, observation of the subjects may show the following taking place: one man becomes quite aggressive, walks over to a stranger, starts to pick a fight, and eventually is escorted out of the bar. Another becomes extremely friendly, walks around, talks to everyone, sits down at tables, and generally causes no trouble. Another leans at the bar with his head in his hands, begins to get tears in his eyes, becomes extremely depressed. Another begins to feel ardent, becomes attentive to the waitress, and suddenly is smiling at all the women. The last subject becomes sleepy and passes out.

Therefore, in this theoretic experiment five distinctly different reactions occurred in spite of the fact that alcohol had a tranquilizing effect on each of them but each reacted in the way that his previous life experiences dictated. By this experiment one is able to demonstrate that varied results can occur from the action of the same tranquilizer.

When most of you prescribe a tranquilizer, you want to know what this drug will do to the patient's personality as well as to his psychomotor activity. Based upon the results of the experiment just outlined you can understand that while the tranquilizer may calm down the patient, the effect on his personality will be dependent upon his past experiences, not upon the drug used. Drugs cannot be made to do what they cannot do.

3. *Improper choice of patients for tranquilizers.* Tranquilizers, used properly, allow you to treat a certain segment of your practice more effectively than before. These drugs give you the means to decrease psychic suffering more quickly, to shorten the morbidity and to help lower the cost of mental disease. However, it is well to know that certain patients will not benefit from a tranquilizer and, used under these circumstances, the tranquilizer may be considered as having failed.

In general, such patients have been classified[2,5] as shown in Table II. While none of these are absolute contraindications to the use of tranquilizers, experience has shown that generally these patients do not respond well to such drugs. It is good policy always to ask a potential tranquilizer patient if he has had a tranquilizer before. If so, and he has had no benefit, his emotional illness probably is represented by one of these categories.

PATIENTS WITH POOR TRANQUILIZER RESPONSE[2,5]

a. Depressives
b. Hysterias
c. Obsessive-compulsives
d. Pseudo-neurotic schizophrenics
e. Life-long history of deviant behavior without anxiety
f. Hypochondriacs
g. Anxiety fixed to organ or situation
h. Anxiety giving secondary gain

TABLE II

POTENCY EQUIVALENTS OF PHENOTHIAZINES [6]

GENERIC NAME	TRADE NAME	Mg.	Times Potent as CPZ
Promazine	SPARINE	200	0.5
Mepazine	PACATAL	200	0.5
Chlorpromazine	THORAZINE	100	. .
Thioridazine	MELLARIL	100	0
Triflupromazine	VESPRIN	50	2
Prochlorperazine	COMPAZINE	25	4
Thiopropazate	DARTAL	15	7
Perphenazine	TRILAFON	8	12.5
Trifluoperazine	STELAZINE	5	20
Fluphenazine	PROLIXIN	2.5	40

TABLE III

4. *Dosage and administration of tranquilizers.* As with any medication intended for optimum therapeutic effect, dosage and administration are as important prerequisites to effective therapeutic response as is proper choice of patient. Failure to give both these aspects proper weight may lead to apparent failure of the tranquilizer. Previously I indicated that knowledge of potency equivalents with tranquilizers is extremely important. Such potency equivalents of phenothiazine derivatives, as suggested by Taylor,[6] are presented in Table III. Changing from one phenothiazine derivative to another can be done by using these data judiciously, as a rule-of-thumb.

Administering Phenothiazine

A few words about administration of phenothiazine tranquilizers are now pertinent. I am certain many of you have done as I did in practice. I selected a few drugs in each general class and learned them well in order to become familiar with their therapeutic effect, side effects, toxicity and dosage. I believe the same procedure applies to the phenothiazine tranquilizers. I suggest you select possibly two phenothiazines, one with more sedative action for nighttime use, and another, less sedative, for daytime use. Those selected should have enjoyed at your hands a respectable therapeutic effectiveness and a practical margin of safety between therapeutic and toxic doses or doses giving side effects. After making your selection, be guided by the following points that have been suggested:[5, 6]

a. The more acute the emotional problem, the more likely is the patient to benefit.
b. The more potent the drug, the smaller is the initial effective dose.
c. Neurotic, mildly disturbed psychotics and senile patients require smaller dosage; children tolerate relatively larger dosage.
d. Start with small doses and build up gradually; do not reverse this procedure under usual circumstances.
e. Should side effects occur, drop dosage somewhat and maintain patient at this level.
f. Do not switch drugs until the patient has been at the effective therapeutic dosage for several weeks to five to six months.
g. After improvement has been maintained several months, discontinue medication; if relapse occurs, restart the same drug.

By following these principles you may help your patient obtain as close to maximum benefit from tranquilizers as possible.

Two Types of Side Effects

5. *Side effects from tranquilizers.* Incomplete understanding of side effects that occasionally arise following tranquilizers can lead to apparent failure of the tranquilizer. Side effects of the phenothiazine derivatives are of two types: (a) Those that are a natural extension of the pharmacologic action of the drug and (b) Those caused by inherent properties of the drug. The first type includes the melange of symptoms arising from extrapyramidal sources and usually are referred to as extrapyramidal symptoms. This type may be divided into three sub-types:

(1) Akathisia. This apt word is derived from the Greek and means an inability to remain seated. Akathisia tends to come on after the patient has been on the drug a few days and is characterized by the patient's inability to sit still for any length of time. His legs are restless and he feels compelled to walk about. If lying, he cannot lie still or find a comfortable position but must move his legs or get up and walk. In contrast to other side effects akathisia is distinctly disturbing to the patient who begs for relief. Usually current anti-Parkinson drugs have only fair effect and decreasing or stopping dosage temporarily will lead to disappearance of symptoms. The practical point is that the patient with akathisia may, to the undiscerning eye, appear to call

for higher dosage of the tranquilizer in order to quiet him down. However, this will only exaggerate his complaint.

(2) Dyskinesia (dystonia). Perhaps no more severe but certainly more dramatic is the dyskinetic side effect, the second sub-type of extrapyramidal symptom. Most disturbing to the patient's family, even more so to his physician but surprisingly of relatively less concern to the patient, are the so-called dystonic symptoms. These consist of more or less continuous spasms of voluntary muscle groups. As a result one or more of the following may occur: torticollis; oculogyric crisis with eyes rolled up, lids open and retrocollis; opisthotonus; dysphagia: and protrusion of the tongue, to mention a few.

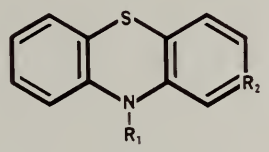
These usually are the earliest of the extrapyramidal symptoms, occurring within one to three days after initiating therapy. Such patients at times have been subjected to spinal puncture or tracheotomy before the physician became aware of the true diagnosis. Therapy consists of discontinuing the drug temporarily and administering one or two tablets of any one of the commonly available anti-Parkinson drugs. Parenterally administered Cogentin® may abort the attack in moments. Freyhan[7] has recommended caffeine sodium benzoate given parenterally as also effective. Symptoms have been completely reversible generally in 24-48 hours upon discontinuing the drug but recovery has been hastened by active therapy as mentioned.

(3) Parkinson-like symptoms are chronologically the last of the three sub-types of extrapyradmidal symptoms to occur and usually will do so before the end of 30 days of drug therapy. Symptoms are classic, being treated with anti-Parkinson drugs either concomitant with the tranquilizer or with its discontinuance.

The second type of undesirable side effect of tranquilizer administration includes such conditions as agranulocytosis, cholestatic-type jaundice, hypotension, photosensitivity, convulsions, and dermatologic complications. At this point I believe it advisable to present some chemical formulas in order to help you understand better how to choose a phenothiazine tranquilizer.

Chemists have continued to modify the original phenothiazine nucleus, having before them the

CHEMICAL STRUCTURE OF
REPRESENTATIVE PHENOTHIAZINE COMPOUNDS



Phenothiazine Nucleus

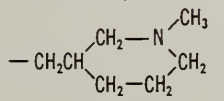
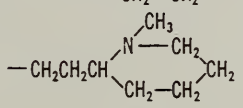
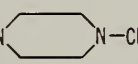
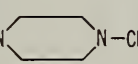
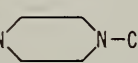
DRUG	POSITION R_1	POSITION R_2
Promazine (Sparine)	$-CH_2CH_2CH_2N(CH_3)_2$	—
Chlorpromazine (Thorazine)	$-CH_2CH_2CH_2N(CH_3)_2$	Cl
Trifluopromazine (Vesprin)	$-CH_2CH_2CH_2N(CH_3)_2$	CF_3
Mepazine (Pacatal)		—
Thioridazine (Mellaril)		—
Prochlorperazine (Compazine)	$-CH_2CH_2CH_2N$  $N-CH_3$	Cl
Trifluoperazine (Stelazine)	$-CH_2CH_2CH_2N$  $N-CH_3$	CF_3
Perphenazine (Trilafon)	$-CH_2CH_2CH_2N$  $N-CH_2CH_2OH$	Cl
Fluphenazine (Prolixin)	$-CH_2CH_2CH_2N$  $N-CH_2CH_2OH$	CF_3

FIGURE 1

constant goal of synthesizing modifications that would lead to lessening of side effects. Since in choosing a tranquilizer you are interested in selecting one with minimum side effects, I believe a few brief comments on the chemical structure of representative phenothiazines are in order (Figure 1). Since the phenothiazine nucleus itself was found too toxic, modification initially was made in two ways: chlorination at position R_2 and the introduction of an aliphatic or straight, 3-carbon chain at R_1.

Thus, chlorpromazine was born, having much less toxicity than the parent, unsubstituted phenothiazine nucleus. However, jaundice, occasional agranulocytosis and a not inconsiderable incidence of photosensitivity, dermatitis, and hypotension followed chlorpromazine administration. By removing the chlorine the chemists formed promazine. This modification resulted in

a loss of potency to about half that of chlorpromazine but did result in some decrease in side effects. Meanwhile, other possibilities were considered, based on precedence, of substituting another halogen—fluorine—for the chlorine. A CF_3 substitution was tried. This change produced trifluprom azine. Not only did this double the potency of the compound over chlorpromazine but also led to other significant changes: decrease in sedation and incidence of jaundice; virtual loss of agranulocytic action; lessening of hypotension, dermatitis, and photosensitivity and enhancement of antiemetic action. Here was definite proof that increasing the potency of a phenothiazine derivative by fluorination resulted in a lessened incidence of some side effects.

Modified Aliphatic Side Chain

But the chemists continued their modifications. Attention now turned to the aliphatic side chain and modification of it produced a piperidine (heterocyclic), ring-like structure. A representative of this group is mepazine. Certain pharmacologic differences became apparent. These included loss in potency of about 50% compared to chlorpromazine, marked decrease in antiemetic activity, a degree of agranulocytic potential equal to if not greater than that of chlorpromazine, but considerable lessening of extrapyramidal symptoms. A more recent piperidine-type modification (thioridazine) has a potency about equal to that of chlorpromazine, loss of antiemetic activity and a reported absence of extrapyramidal side effects.

I am sure it becomes obvious why so many phenothiazine-type tranquilizers are on the market—all representing attempts to decrease or modify side effects.

Still another major modification of the side chain was yet to occur. This was accomplished once more at the terminal nitrogen of the aliphatic side chain incorporating it into a six-sided piperazine ring. Several compounds having the piperazine modification in the side chain are on the market. Introduction of the piperazine modification has resulted in a considerable modification of action of the phenothiazine derivatives. These are: markedly increased potency, decrease in sedation and a considerable decrease in the incidence of hypotension, dermatitis, photosensitivity, agranulocytosis and jaundice. As may have been anticipated, fluorination of the piperazine derivatives further enhanced their potency.

To counterbalance but not outweigh the advantages of this modification arose an increased potential for causing extrapyramidal symptoms. This characteristic tends to lower the therapeutic index but careful adjustment of dosage will in most instances permit attainment of therapeutically effective levels without producing extrapyramidal symptoms.

To summarize the chemical aspects, phenothiazines have been modified by:

a. Adding or removing halogenation with resulting change in potency.
b. Fluorination with marked increase in potency.
c. Piperidine modification of the side chain leading to loss of or no gain in potency, loss of antiemetic action, decrease in extrapyramidal symptoms, and increase in some side effects.
d. Piperazine modification bringing about a marked decrease in all side effects, except for an increased incidence of extrapyramidal symptoms, increase in milligram potency and decrease in sedation and incidence of hypotension as modifications have continued.

A discussion of side effects and their relation to chemical structure is extremely pertinent because, in choosing a tranquilizer, awareness of its chemical structure and how it differs from others permits one to select a tranquilizer more likely to do what you ask of it. Because side effects, particularly extrapyramidal symptoms from phenothiazine derivatives, are dramatic even electrifying when unanticipated, many physicians after experiencing such an episode in a patient have tried to avoid similar future occurrences by one of the following methods:

a. Stopped using the drug.
b. Started giving subtherapeutic amounts of the drug.
c. Changed to a minor tranquilizer.

If we remember that extrapyramidal symptoms are an extension of the pharmacologic action of the drug much as "moon facies" may occur following too ambitious cortisone therapy, there seems little reason to abandon the drug since the drug did what it is capable of doing pharmacologically just as if one gave too zealously epinephrine, morphine or curare. Subtherapeutic doses avoid side effects nicely but also provide little or no therapeutic effect except for

the roughly 25% of patients—the placebo reactors—who will improve whether the drug is inert or given in subtherapeutic amounts. Substitution of a minor for a major tranquilizer I cannot quarrel with except that you may be sending a boy to do a man's job. Side effects from phenothiazines will usually occur within the first month of therapy. Close supervision of the patient during this interval will usually enable you to avoid occurrence of side effects or, if not, will allow you to have anticipated and treated them. Chronic administration of phenothiazine drugs appears to carry with it a decreasing incidence of extrapyramidal symptoms.

Conflicting Reports

6. *Variation in reported drug studies.* Probably no field of medicine today has a more difficult task than that presented by drug evaluation in emotional disease. Completely satisfactory methodology has not as yet been resolved. Meanwhile, equally competent clinical investigators may report diametrically opposed results whether these are in terms of therapeutic benefits, side effects, dosage or other facets of clinical observation. As a result, reports make their way into the literature attesting to the benefits of a given drug in emotional disease accompanied by reports, perhaps even in the same issue of a given journal, of ineffectiveness of the drug. As a result you are confused.

This problem is well appreciated by clinical investigators, all of whom are doing their best using clinical investigative designs that they, too, realize will one day be surpassed and supplanted by more definitive and objective means of evaluation. Apparent but not actual conflicting clinical reports on tranquilizers may in part result from the following:

a. Inadequate experimental design.
b. Lack of controlled observations.
c. Differences in patient populations and research environmental settings.
d. Differences in ratings used.
e. Impressionistic reports vs. those statistically valid.

7. *Time is essential.* The last reason why I think tranquilizers may appear to fail is because of an oversight in recognizing that time is just as essential in healing or ameliorating an emotional disorder as it is in improving or curing a physical one. You are quite familiar with how long it takes a wound to heal normally; how long it requires a patient with pneumonia to get well; and how many weeks the postpartum patient's uterus needs to return to its nonpregnant size. But are you just as certain how long it takes a patient with anxiety and tension, for example, to recover? Do we give time equal consideration in treating an emotionally disordered patient as we do one with a physical illness?

When we forget to appreciate that emotional disorders usually are slow to come on and equally slow to improve, and, if we have been prescribing a tranquilizer, conditions are ripe for that tranquilizer to appear to fail. We must not overlook in the recovery of the emotionally disturbed patient that not only do possible changes in environment, physical corrections where indicated and drug therapy play an important part but also does the requirement of time. If the physician occasionally overlooks the importance of ample time for improvement to occur, certainly the patient and/or his family almost always overlooks this pertinent element. In fact, so insistent may a family or patient be on rapid recovery that the physician may be goaded into expecting that same speedy recovery himself. Therefore, any approach less than one which recognizes time as essential in improving the patient will lead to another apparent failure laid at the tranquilizer's door.

Having presented a few reasons for the apparent failure of some tranquilizers, I will now turn to consideration of the ways in which you may answer the question, "Which Tranquilizer?"

There are two ways to do this. I could give you specific suggestions for drugs to use in office patients, hospitalized patients, psychoneurotics, psychotics, and others. I remind you that were I to give you such a list, it would be open to challenge almost immediately and rightfully so. One reason for this is that each physician ultimately bases his own selection upon the results of his own use of a drug.

Ways that Appear Successful

I believe that the better way to handle the matter of "Which Tranquilizer?" is to point out ways that appear to have been successful for most physicians consistently using tranquilizers. I would suggest the following:

1. Carefully evaluate on paper each new tranquilizer making its appearance. As considered previously, the philosophy behind the use of these drugs is different than with

usual medications, for in treating emotional ills the physician, too, is one of the active ingredients in the patient's getting well. Faith in the drug based not only on your own impressions of it but also on its background of clinical investigations is of known import in the success of any drug but particularly of tranquilizers.

2. Evaluate the clinical reports on the drug.

   a. Where were studies carried out—hospital? state institution? private practice? ambulatory or bed patients?

   b. How were results rated ("improved" vs. "unimproved"; "good" vs. "poor"; "discharged" vs. "nondischarged", etc.)

   c. What type patients were studied—acute, chronic, back ward, etc.?

   d. Does chemistry of drug suggest reconciliation with claims?

   e. Is the therapeutic index high or low?

3. Evaluate the authors of the reports.

4. Use the drug with a low reported incidence of side effects such as excessive sedation, agranulocytosis, jaundice, and the like. One can roughly judge this in phenothiazines by the chemical configuration.

5. Generally use the drug with a broad range between the therapeutically effective dose and the dose producing side effects. This does not mean that one should not use a drug having a narrow spread of dosage between these extremes. However, in the latter case, until one becomes acquainted with the drug's therapeutic range, there is less freedom of action in dosage.

6. Choose the drug—the phenothiazine—that suits you best. Do you prefer one drug? If so, do you prefer one with a little or a moderate amount of sedation? Perhaps you can use two such drugs generally: one for daytime use having little or no sedation accompanying its tranquilizing action; the other for nighttime use having both a sedative and tranquilizing component. Decide what you want in a tranquilizer for your emotionally upset patients and then select the drug or drugs that meet your requirements.

7. Try the drugs yourself and choose the one that works best for you. Two facts must be kept in mind when trying a new drug in private practice. These are: (a) Under varied conditions of private practice and regardless of the drugs given, particularly those used in emotionally tinged disorders, about 25% of patients may improve, regardless of what is done. These are the placebo reactors; (b) It is impossible for a physician to use a new drug in his private practice and obtain a truly objective, scientific evaluation of a drug's worth. This may sound harsh, but it is not meant to be.

   In private practice, except under those circumstances of a formal study set-up, the number of variables influencing the outcome are so great that the impact of each upon the total effect of the drug's action is impossible to assess. Therefore, in private practice under its uncontrolled circumstances one can arrive only at an impression. I emphasize this not because I oppose impressionistic studies or observations but because I want to point out the scientific limitations of impressionistic drug evaluations at the private practice level.

8. Lastly, no more than with any other drug should you expect 100% effectiveness from use of tranquilizers. The disease or disorder being treated is so variable, the patients themselves so hetergeneous, and the degree to which the physician himself enters into the therapeutic role so unique that to expect perhaps even the ordinary degree of effectiveness one experiences with most other drugs would not be realistic when applied to the effectiveness of tranquilizers.

If these points or suggestions are followed, I believe you will have far less difficulty deciding which tranquilizer suits you and ultimately your patients best.

Finally, I would like to emphasize an additional fact. Phenothiazine derivatives as well as other types of tranquilizers are not curative, one reason being that they do not attack the basic personality defect. Instead, these drugs relieve what have come to be called "target symptoms." These are such manifestations as anxiety, tension and psychomotor agitation. If the use of tranquilizers, particularly phenothiazine derivatives, is followed with this thought in mind, not only will you get more from the tranquilizer you choose but also will it then be less likely that at your hands the drug will fail.

REFERENCES

1. Blain, D.: GP 20:84, 1959.
2. Shaw, C. C., Felts, P. W.: Anesth. & Analg. 38:319, 1959.
3. Farah, L.: Internat. Rec. Med. 169:379, 1956.
4. Weidorn, Jr., W. S., Davis, F. H.: South. M. J. 52:419, 1959.
5. Ayd, F.: J. Ind. S. M. A. 52:516, 1959.
6. Taylor, I.: Rx Phenothiazine, Scientific Exhibit, presented at Annual Meeting American Psychiatric Association Inc., May 9-13, 1960, Atlantic City, N. J.
7. Freyhan, F.: Am. J. Psychiat. 115:577, 1959. ◄

The Journal of the Indiana State Medical Association

MEDICAL ESSAY CONTEST

for

Interns and Residents of Indiana Hospitals

During the intern and resident year of 1960-61 The Journal is sponsoring a medical essay contest open to interns and residents of hospitals in Indiana. The subject matter will be limited to clinical experience observed primarily in the teaching hospital of the author. Presentations may contain up to 4,000 words and preferably should be illustrated with clinical pictures, graphs or tables.

A first prize of $100.00, a second price of $75.00 and a third prize of $50.00 will be awarded. All entries are eligible for consideration for publication in The Journal.

Manuscripts will be judged by a prize award committee selected by the Editorial Board of The Journal and by the Dean, Indiana University School of Medicine.

Manuscripts should be prepared in accordance with the specifications outlined on the masthead page of The Journal.

Entries must be submitted prior to May 1, 1961.

The manuscript itself is to be identified only by the title. The author's name must not appear in the manuscript. Instead, a special title page bearing the title and the author's name and address should accompany the paper. Mail entries to Mr. James A. Waggener, 1021 Hume Mansur Bldg., Indianapolis 4.

Chest Injuries

*GEORGE D. BUCKNER, M.D.**

Fort Wayne

INJURIES OF THE CHEST are as common as injuries of the abdomen, but may be overlooked on first examination of the patient. If a serious chest injury is present, the signs of such damage may rapidly present themselves and should be recognized and the condition treated as soon as possible. Some chest injuries, such as cardiac contusion, are not readily apparent, but the possibility of such an occurence should not be overlooked.

Chest injuries may be classified into two main groups:

1) Open wounds
2) Closed wounds

Both of these categories may be broken down into their early and late effects. For example, an early effect of an open wound is collapse of the lung due to pneumothorax, while a late effect may be improper expansion due to fibrin formation and a resultant "captive lung." An early effect of closed injury may be collapse of the lung due to hemithorax and a late effect, again, captive lung or rupture of the heart from necrosis of previously contused areas in this organ. Both types of chest wounds may present the same immediate effects and both may present similar delayed or late effects. In some cases one hemithorax may show an open injury and the opposite side a closed-type injury.

Open wounds of the chest should be converted to closed wounds as rapidly as possible. An open wound may be treated by immediate debridement and suture closure, if the patient is in a facility where this is possible. If this is not the case, the wound should be closed with any material that is at hand in an attempt to make the dressing as airtight as possible, and debridement and suture done at a later date.

Wounds of the Thorax

Open wounds of the thorax may vary from small penetrating types to large gaping wounds. The large open wound in the chest is recognized easily and is given immediate treatment. The smaller penetrating wound may not be recognized as rapidly but it may be even more dangerous than the large injury. The reason for this is that the smaller openings sometimes allow air to enter the hemithorax, but not to leave, due to a valve type action. This results in a development of a positive pressure in the thorax which causes the mediastinum to push toward the unaffected side of the chest, thus affecting the function of the remaining lung.

Tension pneumothorax, as this is called, should be treated as soon as it is recognized. This can be done by aspiration of air with a syringe and needle, or by insertion of an inter-rib catheter and an underwater seal attachment. If all of the air in the pleural space has come through the opening in the chest wall and the opening is now closed air tight, aspiration of air until a negative pressure results should be sufficient to allow the lung to re-expand. If there is some lung damage and the lung itself is leaking some air into the pleural space, the use of inter-rib catheter and water seal attachment would be more efficacious than repeated aspirations via syringe.

The technic of aspiration of air from the chest is best done with the patient in a semi-erect posi-

* Presented at the Scientific Session, Indiana Academy of General Practice, Fort Wayne, Ind., Feb. 23, 1960.

tion with back-rest of the bed up about 45°, the site of aspiration being the second innerspace in the mid-clavicular line. Usual skin preparation and local anesthesia are used.

The insertion of inter-rib catheter is done in the same area and position as for thoracentesis. A cannula of a type from which the stylet may be removed and a French catheter about 16 F size passed through is passed between the ribs. The cannula is then removed over the catheter once it is in place, and the catheter is then sutured to the chest wall and attached to an underwater seal.

The resultant respiratory motions will cause air to be forced out of the pleural space through the catheter and bubbled out underwater. The water seal above the glass tube should be about two cm. After the lung has sealed so that it is no longer leaking air, the negative intra-thoracic pressure will be established and the lung will expand to fill the pleural space. At this time the catheter may be removed and the wound covered with vaseline gauze and dressing to prevent leakage of air back into the chest. Re-expansion of a collapsed lung is usually accomplished in 48-72 hours. If re-expansion has not occurred and air leak persists, this may be an indication for thoracotomy and suture of area of leak in the lung or bronchus.

Bilateral Injury

If bilateral chest injury has occurred, chest catheters with water seals may be used on both sides. If a lung is compressed by blood or fluid accumulation and not air, the site for insertion of the inter-rib catheter to effect drainage would be the seventh or eighth interspace in the anterior axillary line. The same type of water seal may be used or a second bottle, airtight, may be inserted in the line to collect drainage.

Patients may have injuries that necessitate insertion of two catheters into each chest, one high for air leaks and one low for drainage of blood or fluid accumulations.

In the management of chest injuries, the basic principle is to re-establish normal pulmonary function as soon as possible and as easily as possible. The use of inter-rib catheters is one way to do this. If, however, serious air leak or hemorrhage from the lung continues, open thoracotomy may afford the only chance of saving the patient. Therefore, using inter-rib catheters, the patient should be watched carefully and the chest checked frequently by x-ray and blood loss measured accurately.

Replacement of blood loss and treatment of shock should, of course, be carried out. Oxygen is of benefit for the patient during this stage and should be used either by intranasal catheter or oxygen tent.

Crushing injuries of the chest with resultant fractures of many ribs, some in several places, present a problem of poor exchange of air in the lungs, the reason for this being that during inspiration the size of the pleural cavity may actually be decreased and during expiration increased. Outside air pushes in on the unstable chest wall easier than it passes the glottis during inspiration and in expiratory phase air in the lung pushes the lung and chest wall out easier than to pass through the glottis.

This air in the lung then becomes O_2 poor and high in CO_2 and does not serve the purpose of O_2 and CO_2 exchange. The motion of the flail-like chest wall is paradoxical, *i.e.*, to collapse during inspiration and to expand during expiration. The treatment then is twofold, namely, stabilize the chest wall and reduce glottic resistance. The glottic resistance is overcome by tracheotomy.

The unstable chest wall is stabilized by external skeletal traction. This is accomplished by clamping towel clips in the second rib on each side of the sternum and suspending them by a rope through the handles over two pulleys and using 5-10 lbs. of weight, depending upon how much it takes to prevent paradoxical motion. This is a satisfactory way of immobilizing a chest wall, and usually the traction may be taken off at the third week and the tracheotomy tube removed a day or so later.

Respiratory Control—Good Prognosis

Other injuries to the chest include contusions to the heart, fractured ribs, ruptured diaphragm, ruptured esophagus, torn thoracic duct, tears in large blood vessels and, of course, contusions and lacerations to the chest wall itself. Management of these other conditions have to be individualized greatly. The cardiac contusion should be treated as a coronary artery disease and frequent ECG's should be made. The ruptured esophagus

and diaphragm are best treated by surgery. Rupture of a large vessel is usually not treatable, as the patient is gone before he can be treated.

As a generality, though, I think that most patients with chest injuries who survive the trip to the hospital, should be able to be controlled as to their respiratory mechanism and recover from their injuries. ◄

1003 Fullterton Street
Fort Wayne, Ind.

Physician Population Increases

The physician population of the United States and its possessions increased by some 4,769 in 1959, the Council on Medical Education and Hospitals of the American Medical Association reported recently.

This was an increase of 660 over the gain reported in the previous year, according to the council's report.

The increase of 4,769 results from the licensing of 8,269 new physicians minus approximately 3,500 physicians who died.

Of the 8,269 new physicians, 1,626 were foreign-trained.

The largest number of first licenses issued was 1,121 by New York. Three other states issued more than 500 first licenses—California 676, Illinois 521 and Pennsylvania 530.

The most notable increases, compared with 1958, were in Alabama, Connecticut, Illinois, New Jersey, Puerto Rico, South Carolina and Tennessee. There was no marked decrease evident in any state.—*Journal of the Medical Association of the State of Alabama,* June, 1960.

Ancient Precedent

It is well known that prepaid health insurance plans of one type or another date back 100 years or more, but Dr. Basil C. MacLean, Blue Cross Association president, tells of a prepayment arrangement on the North American continent that goes back more than 300 years.

Dated March 3, 1655, it is from the archives of the city of Montreal. It establishes, says Dr. MacLean in a new book, *The Health of People Who Work,* "a contract between 37 families and a 'Master Surgeon.' "

"It was a 'comprehensive' contract, for it excluded only smallpox, leprosy, epilepsy and 'cutting for the stone'—with no nonsense about income limits for service benefits."—*Medical News,* June 22, 1960.

Gonorrhea and Syphilis—A New Problem?

*ELMER HESS, M.D.**
RUSSELL B. ROTH, M.D.
ANTHONY KAMINSKY, M.D.
HAROLD McLAREN JR., M.D.
Erie, Pa.

YOU WILL NOTICE THAT I have a question mark after the title of my article, "a new problem." Many years ago I had a very warm argument with one of my dearest friends, the late Bishop of the Episcopal Diocese of Erie, John Ward. We were both speaking at a large meeting of lay people interested in the control of V.D. The Bishop's argument was that we should control V.D. via the moral teachings of Christianity and he was bitterly opposed to the dissemination of prophylactic education for the prevention of disease.

He felt that if you trained people, particularly young people, to prevent disease, you encouraged them to perform immoral sexual acts. I bitterly opposed his stand for the following reasons: that I did not believe that just moral preachment would prevent youngsters from sexual experimentation, and that as a physician, while interested in their morals, I was much more interested in the prevention of crippling and killing infections which could be visited upon them and be transmitted unto the third and fourth generation of them who came after.

When penicillin and the biochemical and antibiotic drugs (the so-called wonder drugs) became known for their ability to cure all and sundry infections, including the spirochete and the gonococcus, everyone thought we had the V.D. problem licked. However, the indiscriminate use of these drugs whether they were specifically indicated or not, created some new problems which are just today beginning to confront us. Now we are faced with an alarming increase in the incidence of both gonorrhea and syphilis in spite of all of our moral preachments and in spite of the free use of our wonder drugs. What has happened? Certainly the moral question is not new and certainly the record shows that moral issues have little or no effect upon the curiosity of our youth nor upon, unfortunately, some of the actions of our adult population.

Immunity Against Drugs

What then is wrong? Why the increase in these diseases? I mentioned a moment ago that the indiscriminate use of our wonder drugs might be the cause of our so-called new problem. The truth is that the various pathogenic and nonpathogenic organisms have at last built up a resistance to the wonder drugs and now, when we need them most, their efficiency has often been wasted upon a cold or other minor infection that could have easily been cured by some simpler therapy. We now have an alarming *new* problem with which to cope.

Our pharmaceutical friends are not only carrying on constant research for new combinations of known antibiotics and chemo-therapeutic agents but are forever searching for new agents to handle those organisms which have developed an immunity against the drug agents which we now possess. So we do have a new problem both in the comeback of the venereal diseases and in the search for new antibiotic and chemo-therapeutic agents to combat the increase in the disease incidence.

Let us look at the actual situation: In 1939 when the national venereal disease control program began, at least 14,500 persons died in the United States as a result of syphilis (11.1 per 100,000 population). In 1956, the most recent year for which complete mortality data is avail-

* From the Urological Clinic, St. Vincent Hospital, Erie, Pa.

Presented by Dr. Hess before a joint meeting of the Indiana Academy of General Practice and the I.U. School of Medicine, sponsored by Lederle laboratories, at Indianapolis, Ind., Sept. 30, 1959.

able, 3,860 syphilis-caused deaths were reported in the nation (2.3 per 100,000).

Similarly, first admissions of syphilitic psychotics to mental hospitals have declined from 7,800 in 1939 (5.5 per 100,000) to 1,663 in 1955 (1 per 100,000). Reported cases of infectious syphilis also declined consistently and significantly between the peak year of 1947 and 1954. Infant syphilitic deaths have declined from 1,300 per year to only 26.

But since 1954, the number of cases of infectious syphilis reported per year has leveled off and made a slight turn in an upward direction. Recently, increases in both early syphilis and gonorrhea have been reported by private physicians and by clinics and hospitals in all races and both sexes all across the United States.

Thirty of the 50 states reported statewide increases in lesion syphilis last year, and all but seven states have reported statewide increases in gonorrhea.

Between 1955 and 1958, reported primary and secondary syphilis, *i.e.,* infectious cases, increased to as much as 250% in such representative large cities as Boston, Chicago, Houston, San Francisco and Los Angeles. In the national capital, early lesion syphilis rose 194% over the identical period.

The fact most shocking in its implication is the increase in reported infectious venereal diseases among young people. In the 15-19 year age group alone, reported infectious venereal disease cases rose from 45,000 in 1957 to 49,500 in 1958. Today, 22% of all reported infectious venereal disease occurs in persons under 20 years of age.

Every day, 136 cases of venereal disease are reported among persons 19 years of age and younger in the United States. This is one teenage case every 11 minutes. If estimates are correct, the teenage infection rate alone may be closer to one per minute, every hour of every day and night. I think it is not only noteworthy but alarming to consider that more females are infected at the age of high school graduation than at any other age period.

The details of syphilis outbreaks in Kentucky, Iowa, West Virginia, Missouri, Virginia, Georgia, Massachusetts, Arkansas, Texas, California and other states are not apropos here except to point out that in each instance a large number of the persons involved were teenagers.

Considering that there is only one way, practically speaking, to transmit or contract venereal diseases, it is not surprising to find a high correlation between venereal disease, illegitimacy and other forms of delinquency and dependency.

Venereal disease statisticians now estimate the annual true incidence of syphilis in the United States at 60,000 cases and the incidence of gonorrhea in excess of one million.

Loss of Control Factor

I might mention that last year 19 cases of syphilis in later stages were treated and reported for every single case of early lesion syphilis which was reported, illustrating that we are losing much of our precious control factor—time.

The problem which faces us in the immediate future, particularly with regard to syphilis, concerns the hundreds of thousands of persons in this country needing treatment for syphilis *now.* If they are not found and treated, one in 200 will become blind, one in 50 will become paretic, one in 25 will become crippled or incapacitated to some extent and one in 15 will become a syphilitic heart victim.

Let us consider for a moment the costs of these diseases. It is very difficult to estimate the cost of gonorrhea except to say that it probably costs something in excess of 10 million dollars annually to treat. Although we are far from able to evaluate the total costs of syphilis, we do have a few good indicators. For example, syphilis still kills a minimum of 4,000 persons a year. These are just the known cases. How many syphilis-caused deaths are noted euphemistically as cardiovascular or neurological disease through diagnostic failure, oversight, concern for the family or for other reasons, we cannot even guess.

We do know that it costs 12 million dollars a year to maintain the syphilitic blind in this country; and loss of income by men with advanced syphilis is conservatively estimated at 100 million dollars a year.

We know definitely that it costs 48 million dollars a year just for hospitalization of syphilitic psychotics. Involved are about 33,000 persons, each of whom will spend about 10 years in institutions. Ultimately, these alone will cost at least one-half billion dollars more; and this is only the hard cash liability. (How are you going to balance governmental budgets with this sort of unnecessary expenditure?)

This one figure alone probably exceeds the total amount spent for venereal disease research and epidemiology by every country in the world in the past 400 years.

When you think that each of the 100,000 untreated syphilitics includes a potential 2,000 paretics who will cost several hundred millions of dollars more in hospitalization, the implication is staggering.

So this, then, is the general problem. What can we do about it? For one thing, it is pretty generally agreed that without vaccine, a venereal disease is eradicable only if every infectious case is located, diagnosed, treated and reported, its source ascertained and all contacts followed up to prevent further spread.

Let us examine each of these essential elements in turn to see where we might be missing the boat.

The important problem is how do we locate cases initially? Certainly a number of patients will discover symptoms and, suspecting venereal disease or not, will come to us for examination. When this happens, we ourselves must be alert to the possibilities of a venereal disease. We must forget that syphilis and gonorrhea are not confined to any race, sex, age, occupation or social group. Many epidemics reported recently involve large numbers of persons who might ordinarily be considered above suspicion. I have seen the disease take a judge off his bench, a bishop from his palace and a brilliant physician from his clinic.

Consider Many Symptoms

It is not sufficient to say that any genital lesion may mean syphilis. In addition, we must carefully consider the possibility of oral or anal lesions, mucous patches, lesions of fingers and breasts, macular or papular lesions either generalized or confined to the palms and soles, condylomata lata, regional or generalized lymph adenopathy, alopecia, or other more subtle signs of early syphilis.

As for gonorrhea, the purulent discharge from the penis makes one suspicious; but we must always remember that gonorrheal prostatitis, particularly its chronic form, may show nothing in a smear. We must remember the ever-present possibility of proctitis also, in far, far greater numbers than most people would believe and there have been many reports of buccal and ocular infections.

In the female, the identification of symptoms of either gonorrhea or syphilis may present real problems. The possibility of these diseases should never be far from mind; and in the absence of lesions or other salient symptoms, laboratory tests should be done whenever there is the least suspicion (and sometimes even when there is not).

Suppose we suspect a case of either syphilis or gonorrhea. What do we do? Certainly, because of the mental anguish suffered by so many persons when they find out they have a venereal disease, none of us wants to make such a diagnosis if there is a chance of error.

Perhaps this might influence some of us to take the easy way out and treat prophylactically. With suspected gonorrhea, this may be indicated. But with syphilis, such a procedure has a number of basic faults. One is that if we do treat on suspicion, and do not report a diagnosed case, we will have no way of knowing the incidence or the prevalence of the disease; and we will not know how or where to bring our control resources to bear.

A second reason is that treating a single person for a venereal disease without doing an epidemiologic work-up and examining contacts is like excising the original site of a metastatic cancer and not treating the metastasis.

A simple case in point is the male gonorrhea patient, at times the only means of diagnosis is the female. If he is not instrumental in getting both his source and spread contacts to treatment, they may never even suspect they are infected until they land in emergency with an acute PID.

Adequate Diagnosis Requisites

I think we should remember that an adequate diagnosis is arrived at only after we have a history and the laboratory findings as well as the results of a complete clinical examination.

Recently, I have heard many persons bring up questions concerning biologic false positivity. Now, granting such a phenomenon exists—and, as we know, it may be caused by a large number of known and unknown stimuli—it is perfectly true that as syphilis prevalence diminishes, a larger percentage of reactors will be non-syphilitic. This need not pose too great a problem, however.

On the basis of recent exhaustive studies, the better non-treponemal tests still are perfectly

acceptable and highly accurate diagnostic tools for syphilis—and they will be for some time to come. They are relatively inexpensive and easy to perform, and facilities for their performance are widespread and readily available.

Of course, there are those practitioners who will want to confirm findings by a treponemal antigen test in certain cases. The Treponema Pallidum Immobilization test (TPI) probably is the best known of these, but it is available only on a limited basis and is quite expensive. The Treponema Pallidum Complement Fixation test (TPCF 50) and the Fluorescein Treponemal Antibody test (FTA) hold good promise, but are not yet readily available. Probably the most practical and adequate confirmatory treponemal test is the Reiter Protein Complement Fixation test (RPCF), which is relatively cheap and easy to perform as well as being quite accurate.

In passing, I would like also to comment on the phenomenon of sero-fastness. Undoubtedly, some ex-syphilitics, having been adequately treated, will continue to have a positive or reactive serologic test for the rest of their lives. It is unfair and punitive, as well as senseless, to continue to administer therapy to these people. My own feeling in this matter is that if they have a history of adequate treatment with penicillin with no evidence of re-infection, they should be followed at rare intervals to observe any significant change in titer. If their treatment history is indefinite, one might judiciously administer a single adequate course of therapy and no more—following them as mentioned.

In males, of course, we may usually identify the gonococcus in the purulent discharge; but when a male without such a discharge comes to us out of self-suspicion asking for an examination for gonorrhea, we should take particular pains to get a good history and establish the basis for the suspicion. This done, a prostatic or a rectal culture often is indicated.

Gonorrhea as a rule cannot be diagnosed in the female either clinically or by means of a smear; and, in fact, even the laboratory culture procedure is so fraught with pitfalls that a single culture in the usual laboratory test may not be definitive. This is the reason, of course, for the recommendation of prophylactic treatment in the female gonorrhea suspects if there is the slightest suspicion.

Touching again on this matter of suspicion, I believe that in the interests of our patients we must perhaps be overly suspicious at times. I have heard of more than a few cases in which the physician ridiculed the idea of infection, particularly in younger girls, and made no honest attempt to diagnose because he had "known the patient all her life and felt that she was above suspicion."

In any case, I'm afraid I must report that with gonorrhea your best diagnostic efforts might be less than adequate, because to date, we have no adequate test for gonorrhea, particularly in the female. It may be that the fluorescein tagged antibody test for the gonococcus will be the answer. At present, researchers at the Venereal Disease Research Laboratory feel that a good fluorescent process will be available in less than a year. But we must continue for a while at least with the tools we have—forewarned and doubly cautious.

Treatment of Gonorrhea

Let us consider the treatment of gonorrhea and then proceed to the treatment of syphilis: You may very possibly have heard that certain strains of the gonococcus are beginning to show resistance to penicillin. While the demonstration of this proposition is not easy, particularly in this country so far, yet there is ample evidence that certain cases of gonorrhea, particularly in females, are requiring as much as 10 times the amount of penicillin to cure as we considered to be an adequate dosage only a few years ago.

Generally speaking, however, penicillin still is the drug of choice for all but a relatively few persons who cannot tolerate it. Most cases of gonorrhea in males still respond favorably to 600,000 units of either PAM or Benzathine Penicillin G and most cases in females will require no more than 1.8 million units of PAM. For those few who cannot tolerate penicillin, adequate cures may be effected with streptomycin, tetracycline, or other antibiotics.

Syphilis, thus far, has not exhibited any tendency toward resistance to penicillin, and so, barring the possibility of reaction, there is really no great problem in the treatment of this disease with either PAM or Benzathine Penicillin G. A total of 4.8 million units of PAM or 2.4 million units of Benzathine Penicillin G in almost any schedule should be sufficient for early cases, so

long as a therapeutic blood level is maintained over a period of about 12 days. Late syphilis usually should receive up to 10.8 million units of PAM. Persons who cannot take penicillin usually will respond to the tetracycline drugs (30-40 gms total), erythromycin (20-30 gms), or other antibiotics.

Must Report Diseases

Now, assuming we have diagnosed and treated a case of venereal disease—syphilis for example—certainly we cannot stop there. There are very good reasons behind the public health regulations in all states requiring the reporting of communicable diseases. That we often forget to comply with these regulations may be excused by our industriousness and overwork, but it cannot reflect favorably on our sense of responsibility.

Without doubt, adequate venereal disease epidemiology requires greater amounts of time than most of us can possibly devote to it; but this does not mean that we cannot take an active and purposeful part in the present program for the practical eradication of syphilis which is building up across the country. Public health people across the land have seen the handwriting on the wall. They realize that the time is at hand to reduce syphilis to its irreducible minimum if we are going to do it at all.

Penicillin, as we have mentioned, still is the drug of choice. But when and if this drug will be invalidated by problems of sensitivity and resistance is anybody's guess. Add to this the fact that as case loads are shifting from the public clinics to the offices of private practitioners, reported cases will tend to drop and will cease to reflect the true prevalence. As a result, our public health control mechanism will be cut and diluted to the point where it will be inadequate to continue the splendid work of epidemiology which has been carried out over the past 20 years.

More and more we private physicians must come to realize that this is our baby. We are seeing more of the cases and we must assume our share of the responsibility. The first step in this, of course, is to report our cases—which really is not asking a lot. The second step, I believe, is to make the fullest possible use of the trained epidemiologic assistance available to us through our local health departments.

Most local health departments have trained paramedical and nursing personnel available to assist us by interviewing patients for contacts and in tracing these contacts and bringing them to examination. These people are well aware of our problems and they have been trained to solve them with the least amount of fanfare. Their approach is highly ethical, always confidential, and with a great degree of understanding. In short, their attitude is professional in every sense of the word.

Recently, through cooperation of local health departments, certain rather isolated cases treated initially by private physicians have led to the uncovering of astounding chains of additional infections. One Midwestern case, followed out by city and state health workers, led to more than 180 additional cases.

By contrast to such positive results in isolated instances, however, consider the fact that during the five-year period in which the least progress has been made against syphilis, records show that of the 14,428 lesion syphilis cases actually reported by private physicians, only a mere 16.6% were interviewed by a trained venereal disease epidemiologist. These 2,400 private patients interviewed led to the examination of 8,016 contacts; but those not interviewed should have led to an additional 40,000.

In the light of national indexes, I am afraid we must confess that these 40,000 unfound contacts to private patients almost certainly included 2,900 cases of primary and secondary syphilis—infectious cases free by default to spread their disease until they were located by some other method, if ever.

Certainly this is an indefensible situation, and one which must be avoided in the future if we are to hope for real progress against syphilis.

Working together with public health people, I feel certain that we can accomplish what Dr. William J. Brown, Venereal Disease Program chief of the Public Health Service, calls "practical eradication"—the point where a case of syphilis will be at least as rare as a case of smallpox or malaria in this country.

I know that these public health people, federal, state and local, will gladly cooperate with us if we but give them the opportunity. And I believe we must do just that.

Luckily, we enjoy great freedom in this country; and one measure of this freedom is that each of us is free to practice medicine as he sees fit. But concomitant with such freedoms are responsibilities; and one of these responsibilities is

the control of our dread diseases in the interests of the whole people.

I do not think I am being overly optimistic when I say that given the tools we already have, I believe we can eradicate syphilis in the foreseeable future, and in its eradication build a lasting monument to the superiority of American medicine.

I wish to express my personal thanks to William J. Brown, M.D., Chief of Venereal Disease Branch in the Communicable Disease Section of the Public Health Service at Atlanta, and his associates, for the research necessary to present the facts on the new problem of Venereal Disease in this country. ◄

Automatic Thermometer

Designed by a British physician is an electronic clinical thermometer that permits a nurse to check temperatures of patients from her office.

Powered by a small battery and transistors, the apparatus consists of a meter, a switch and highly sensitive thermistors.

The apparatus can be strapped to a patient and connected by wires to the central temperature reading point. By flicking a switch the nurse can check the temperature at any time.

The thermistor probe could also be used to check separate parts of the body, where the impedence of blood flow might indicate a local obstruction. The apparatus was designed by Dr. D. C. Simpson of the medical physics unit of Edinburgh University. It is now in operation in a six-bed ward at the Edinburgh Royal Infirmary.—*MD Medical Newsmagazine,* Vol. 4, No. 6, 1960.

The Case of the Juvenile Jetsam

ARNOLD LIEBERMAN, M.D.
New York, N. Y.



"GIVE ME A BREAK, will yuh, huh?" This was my introduction to Thomas, age 13; place, outpatient clinic of Rush Medical College in Chicago; time, the early thirties—just as we were careening to the low point of the Great Depression.

Thomas spoke with a wheedling twang, redolent of the Deep South. He was a tall, gangling boy, terribly awkward with burgeoning adolescence and yet—subtly—repelling any sympathy instinctive toward the very young. The clothing was shabby, worn and dirty; the crinkly, unkempt hair was caked with filth; the broad, flat nose needed wiping; the thick, everted lips covered only partially his terribly maloccluded teeth; the jaw was weak and receding; the eyes were looking around furtively—one was reminded of a cornered ferret, ready to run or fight as the case might be. The absurdly long hands, dangling at his sides, protruded disconsolately from the cast-off jacket: a far too small hand-me-down. His opening gambit only helped confirm the impression of gutter gamin wisdom that lent a disharmonious note to the pediatric clinic where the student had taken me.

The future medico had gone over the patient quite thoroughly. There had been difficulty in getting a history out of Thomas. The boy was dull and apathetic; he appeared, to the student, to be retarded mentally. He was running a low-grade fever, was terribly underweight, anemic and had a definite sytolic murmur in the aortic region. The right knee joint seemed to be tender and somewhat swollen, thus giving the impression of some fluid being present within it. The tonsils were rather large but not inflamed. The student diagnosed rheumatic fever; he listed the other possibilities to be included within the differential diagnosis.

Won't Wanna Hurt Me . . .

Thomas had been shuffling his huge, knock-kneed legs back and forth while I had been absorbing the briefing by the student. The words had been away over his comprehension; all he wanted to find out was whether these incomprehensible white-coated white people were or were not going to do him harm. Tentatively, he stepped a bit forward turning to me, "Yuh won't wanna

One of a series of case reports; Dr. Lieberman formerly practiced in Lake County, Ind.



. . . his wife had acrimonious things to shrill — so he pushed her . . .

hurt me, huh?" The misfit, cast-off stockyard shoes encasing his feet had holes in their toes from which the bare toes protruded; a rank, totally unpleasant odor of manure and such things being spread by the filth encrusting and obscuring the frayed leather.

Being recently out of Cook County Hospital, I was rather inured to the odors, sights and sounds of this "back of the yards" clinic. I might have wrinkled my nose a bit—I did proceed to a careful examination of the patient. The referral had been from the school which Thomas had been attending whenever the truant officer could catch up with him. It was the school nurse who had taken his temperature and found 99.5° F (orally). The physical examination was about as the student had stated. The pediculosis corporis and the tinea versicolor did not seem contributory to the situation as such. However, there was some puffiness under the eyelids and some rather vague general muscular tenderness. The preliminary blood count showed not only a severe anemia but also an eosinophilia of four percent along with a marked leukocytosis.

Prodding Thomas' memory, we were able to satisfy ourselves that his father would bring—quite frequently—some uncooked ham from the Stock Yards where he worked. This was used to supplement the rations in the household. I ordered a muscle biopsy and felt quite pleased with myself as a sharp and rising clinician. I am sure the eight junior medical students, who were with me and to whom I gave an incisive (I hope) talk on trichinosis, were suitably impressed.

My joy was unconcealed when the biopsy proved positive. The x-rays of the chest and the EKG were quite within normal limits. The intestinal symptoms had been elicited by asking leading questions; in the intervening week, they had disappeared. No ova or parasites had been found in the stool specimen (not even hookworm) but this was explicable. The eosinophilia was not rising; in fact, it was stationary at four percent which did not bespeak an active trichinal infestation. The vague edema and muscular pains were really no longer there, although one could be imaginative. Such sepses as typhoid fever, undulant fever, the meningidites, pulmonary infections (including tbc) appeared to be ruled out. Yet, the sedimentation rate remained high as did the white blood count. The temperature was 100° orally at 11 a.m. that morning.

The boy was continuing dull and apathetic. The aspirin he had received during the week had not been of visible value. He flinched when the temporo-mandibular joint was palpated accidentally while were were looking in his throat. The urine report was a bit of a shock: there were shreds and mucus in the first glass; the second glass was clear. Urethral smear showed unmistakable gonococci! ! ! Of course, the lad had shown signs of beginning sexual maturation and we all know that erection is possible even before any outward signs of secondary development. Still, he had been asked the question routinely and had denied having had any outside physical contacts. The question was reworded and spelled out. The candid reply was direct and to the point.

"Oh, yes! Mary and I do it all the time; we sleep in the same bed; we've seen Aunt Jennie and Pappy do this lots of times."

This explained the gonorrheal urethritis and arthritis; it accounted also for the aortitis with vegetations on the aortic valve. Mary, the 11-year-old sister, was sent for post-haste. Examination of her was very conclusive of a specific Bartholinitis and endocervicitis. Very fortunately for her, because she was still pre-

pubertal, the internal organs remained uninvolved.

Streets not Paved with Gold

While Thomas and Mary were referred for treatment to the contagious ward of the Cook County Hospital (just across Harrison Street), social service was called in to make an investigation; quite obviously, the situation was beyond the capacities of the public schools and the truant officer. The facts were not hard to come by; they were grim and revealing. Thomas had been born in Mississippi into the usual sharecropper family. The father had been lured north by a hiring boss offering $3.90 a day—cash—for work at the stockyards. So he had come, bringing along his wife, baby Thomas and a newborn infant, Mary.

It turned out that Thomas' father had been one of thousands recruited to break a strike. The white strikers and the Negro strikebreakers had battled in ugly race riots that erupted all over the "back of the yards" district. The illiterate, totally naive sharecropper survived the violence and stayed on the job. Unions were institutions beyond his ken; to him, the cash income seemed fabulous.

However, Chicago was expensive and the slum they dwelt in began to wilt the health of his wife. With fading looks came a sharp tongue, so that it was really hard to blame her husband for seeking solace in a speak-easy presided over by a woman called Jennie. The needled hootch (courtesy of Al Capone) was cheap; Jennie also helped Thomas' father with her sympathy.

One night he came home late and more drunk than usual; his wife had acrimonious things to shrill; so he pushed her. He did not mean to shove her down the unrepaired, sagging cellar stairs; all the same, she received a nasty compound fracture of the ankle. She was taken to the hospital; it was the middle of the night and no one wanted the responsibility of doing an amputation without benefit of a consultant. Being a Sunday, it was late morning before she could be taken to surgery. The limb was not taken off high enough and so gas gangrene set in; in the pre-antibiotic days that was swift death.

. . . . Moved in with Jennie

Thomas' father moved in with Jennie. Welfare agencies began to become well acquainted with Thomas, his little sister, the father—and Jennie. As the years passed, both children were sent to school. Then it was the teachers' turn to learn both youngsters' names—well, even if unfavorably. The boy began hanging around pool rooms, running errands for mobsters, participating in minor thievery; in short, he was an increasing problem. His sister also promised to become a prime juvenile delinquent headache.

With all this information on hand, Thomas' father and Jennie were dragged into the clinic for a thorough examination. Incest can occur between different generations and the gonococcus inhabiting the children had to come from somewhere. . . . Well, surprisingly enough, neither one of the adults had any signs of active or chronic G.C. Very exhaustive, thorough testing revealed positive serology, true enough, but no G.C.

Very searching cross-examination of both the children and then the grown-ups finally unearthed the original focus. Some people hold the belief that, if one with a venereal disease spends a night with a virgin he will be cured. . . . Thomas' father was forced to confess that—for a consideration—he had made arrangements to have a certain "friend" spend a night testing this remedy.

Understandably, there was a big hullabaloo about the entire drab, unsavory mess; both Pappy and Jennie were hauled up for failing to give the children proper upbringing; they denied this vigorously. The charities took energetic (even if belated) steps, although publicity was shunned as the plague.

It was not too difficult to treat the sister; but in those pre-penicillin days Thomas was a tough medical problem. He was subjected to a lot of treatment; that helped but little. Time, good food, rest and such things were of more avail. Finally, both children were discharged to the supervision of the social services; medical inspection became periodic only.

The school took them both back (it had no recourse). Pappy and Jennie were instructed minutely; a separate bed was provided for sister; so the tavern was "home" again pending placement by social service.

Thomas began to look much better; the murmur over the aorta was barely audible and there was no evidence of embolic manifestations. To keep him out of mischief, he was clubbed into

accepting an after-school job as an errand boy for a neighboring grocery store. However, his sullen distaste for "home" continued undiminished; he still spent much time hanging around the pool rooms even while the blasé case worker continued a rather desultory search for an abode where Thomas and his sister could be placed, away from the charming pair that acted as their parents. Juvenile delinquency (however labeled) was hard to just shrug off; soliciting by little Mary was not to be countenanced, especially in the candy store across the street from the grammar school.

Altercation About a Skirt

While an acceptable solution was being sought, Thomas' problem was resolved with dramatic suddenness. One evening, after he had done his stint at the grocery store, Thomas—along with several other teenagers—was in the pool room of his choice. There was a flurry of altercation: apparently about a "skirt" although, later, no one was able to produce a rational account. Anyway, an ugly brawl erupted; knives flashed and fists were swung as the entire group of youngsters boiled out into the alley. By the time the police arrived, there was no one to identify anyone or anything. Nevertheless, Thomas was found lying sprawled on his face; a knife in his back preparing one for the lifeless corpse.

The coroner conducted the autopsy as a matter of form—maybe, also for practice. The tip of the blade had gone through the lung and lacerated the superior vena cava; the extensive hemorrhage from that lesion was the immediate cause of swift death. I was glad that the coroner's physician had seen my name on the boy's chart and so had done me the courtesy of calling up ahead of time. It was not too hard to persuade him to open the heart aseptically, observe the healed verrucous growths on the aortic cusps, and take blood for a culture. The original diagnosis of gonococcal valvulitis was thus proven beyond cavil even if the coccus itself was never cultured out.

Not long afterwards, Thomas' father wound up in the psycho ward with delirium tremens. He was committed for the developing general paresis; a fatal pneumonia supervened and saved the state a large bill for maintenance. Thomas' sister finally had to be expelled from school as a depraving influence; after all, soliciting and narcotics could not be tolerated—no matter the social worker. In view of her young years, she was placed in an institution for minors.



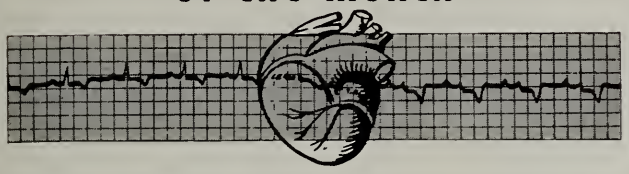
. . . knives flashed and fists were swung . . .

I was going to take copious notes in order to have the entire case presented at a clinico-pathological conference; my friend, the coroner's physician stopped me. "Remember Prof. Richard Jaffe and his famous English quotation, 'As less you write, as less is wrong!' Don't."

Still, my memory for remote events is fairly good; after a lapse of 30 years, the facts continue to be as outlined. In this tale of human *flotsam* and *jetsam* it may be difficult to know who was delinquent to whom; the answers remain moot. It is certain, however, that the labor recruiter who brought Thomas' family to Chicago never realized how heavy a financial burden the city of Chicago was to acquire or how unhappy the whole case was to become in the eyes of so many people. But, then, the decades have blurred the unpleasantness and the contemporary generation may learn from this tale that their fathers had problems of their own. ◄

1026 Sixth Ave.
New York, N. Y.

Electrocardiogram of the month



Presented as a regular feature of The JOURNAL, Electrocardiogram of the Month is a series of short talks on cardio-vascular diagnosis and treatment, edited by the staff of the Robert M. Moore Heart Clinic of the Marion County General Hospital, Indianapolis.

Abnormal Electrocardiogram and a Normal Heart

CHARLES FISCH, M.D.
Indianapolis

IN A PREVIOUS communication to this *Journal* (Condensed Cardiology: Normal Electrocardiogram in Angina Pectoris, August, 1959) the not infrequent coexistence of severe heart disease with a normal cardiogram was stressed. At this time we would like to present three conditions, rather common, in which the electrocardiogram *per se* is abnormal but the heart may be normal.

Case 1 (Figure 1)—A 33-year-old male was first examined on 3-22-55 and found to have an abnormal electrocardiogram. The abnormalities consisted of an M shaped and principally upright QRS in V1 associated with coving and inversion of T waves in leads II, III, V1, V2, V3, V4 and diphasic T waves in leads V5 and V6. The physical examination was negative. The patient was re-examined on 5-9-58, at which time the physical, fluoroscopic and x-ray examinations were again negative. The electrocardiogram remained unchanged. Repeat observation in 1960 disclosed an identical EKG pattern and a normal response to a Master two-step test.

The cardiogram in question suggests very strongly an antero-septal lesion and such a diagnosis would be imperative were serial tracings not available. Some have described this innocent pattern as "persistence of juvenile pattern." To attest to the occasional benign nature of this strikingly abnormal EKG, this patient was issued a large policy by one of our leading insurance companies.

Case 2 (Figure 2)—A 32-year-old woman hospitalized in a psychiatric institution, showed on a routine EKG an abnormal pattern with inversion of T waves in V3, V4, V5 and V6. The EKG was repeated after sedation and the T waves were found to be upright. This type of aberration has been described occasionally during sympathetic over-activity with outpouring of catecholamines and is commonly seen following hyperventilation. On the other hand identical abnormalities may be the only EKG sign of severe disease.

Case 3 (Figure 3)—A 22-year-old male showed on a routine pre-operative cardiogram an elevation of S-T segments in leads V2, V3, V4 and V5. There were no abnormal physical

* From the Robert M. Moore Heart Clinic, Marion County General Hospital, Indianapolis.

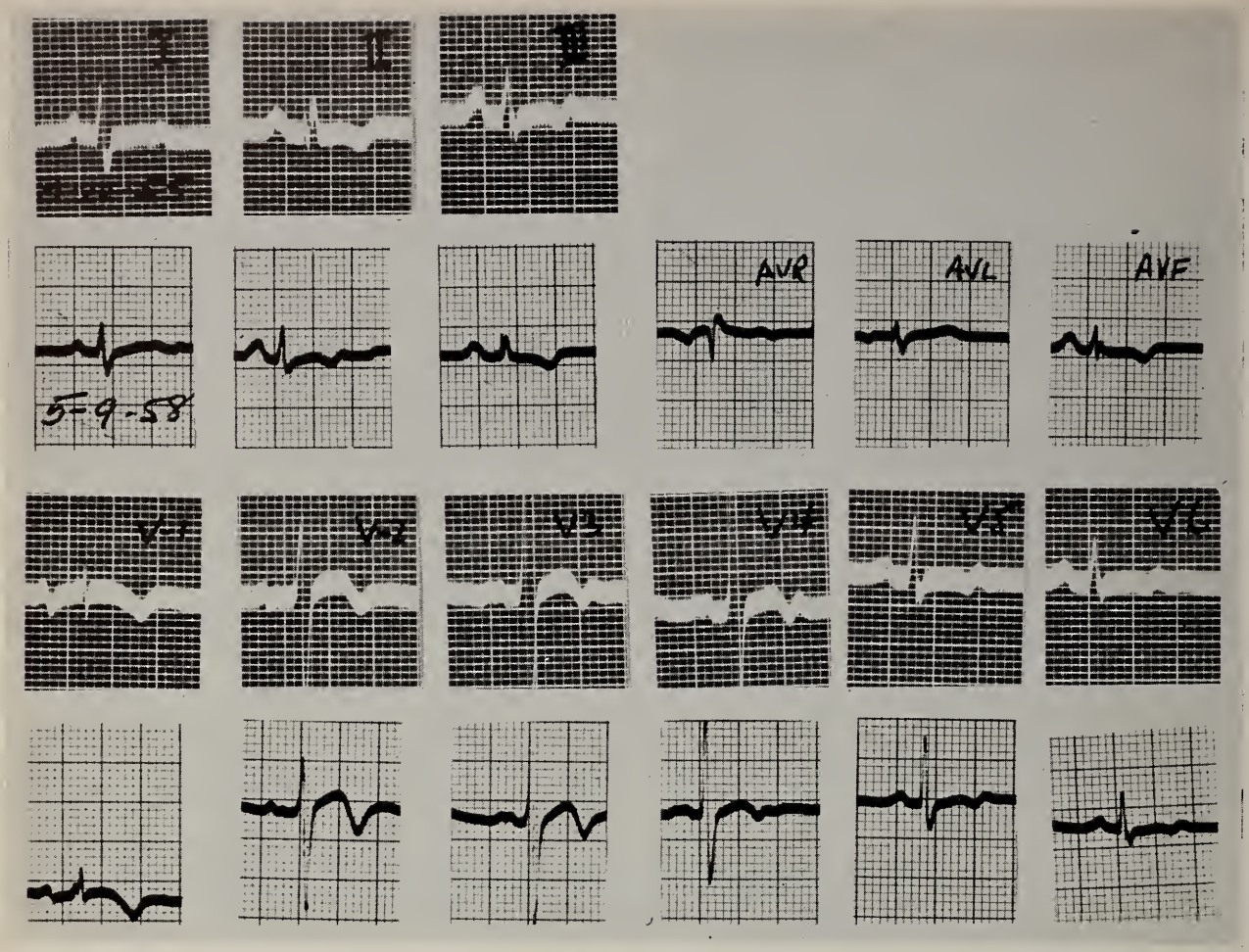


FIGURE 1

ROWS ONE AND THREE represent tracings taken on 3-22-55; rows two and four were obtained on 5-9-58. The abnormalities consist of an upright and splintered R in VI associated with inversion of T waves in leads 2, 3, V1, V2, V3, V4 and biphasic T in V5 and V6.

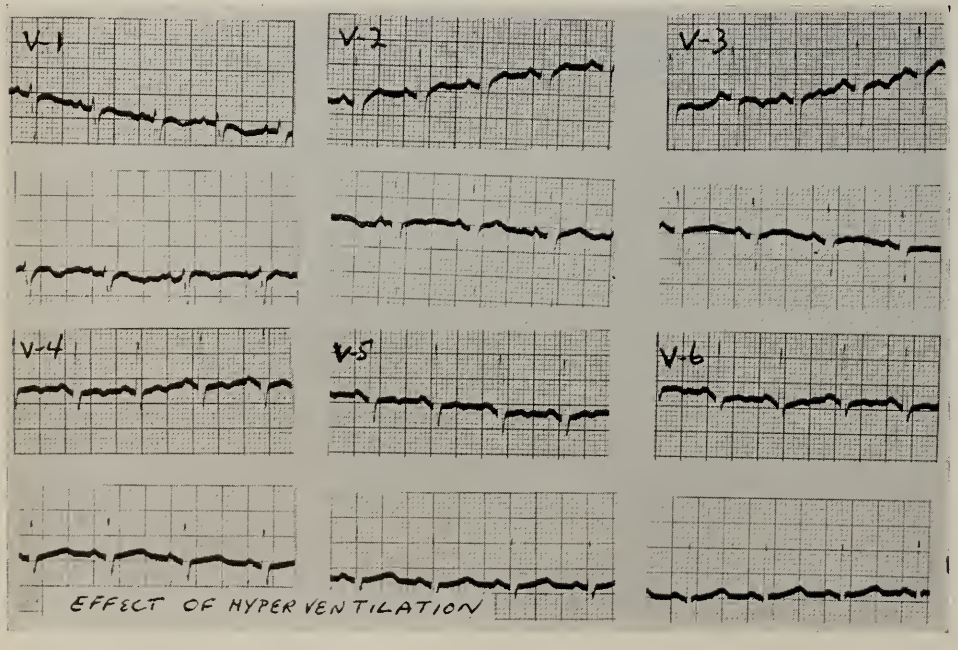


FIGURE 2

ROWS ONE AND THREE represent routine tracings, rows two and four represent the tracings taken after sedation. The first cardiogram shows inversion of T waves in leads V3, V4, V5 and V6, which after sedation, became upright.

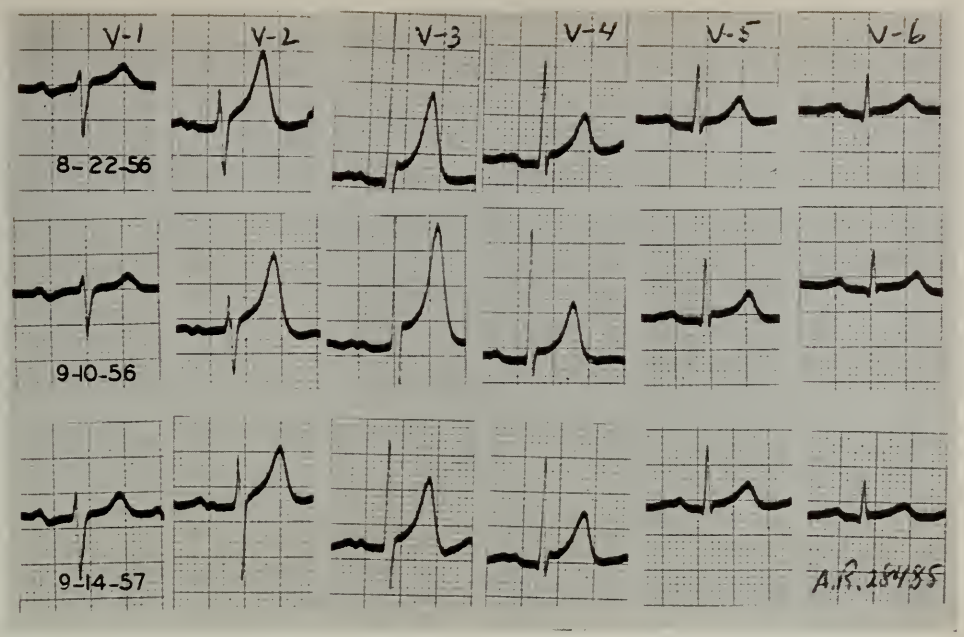


FIGURE 3

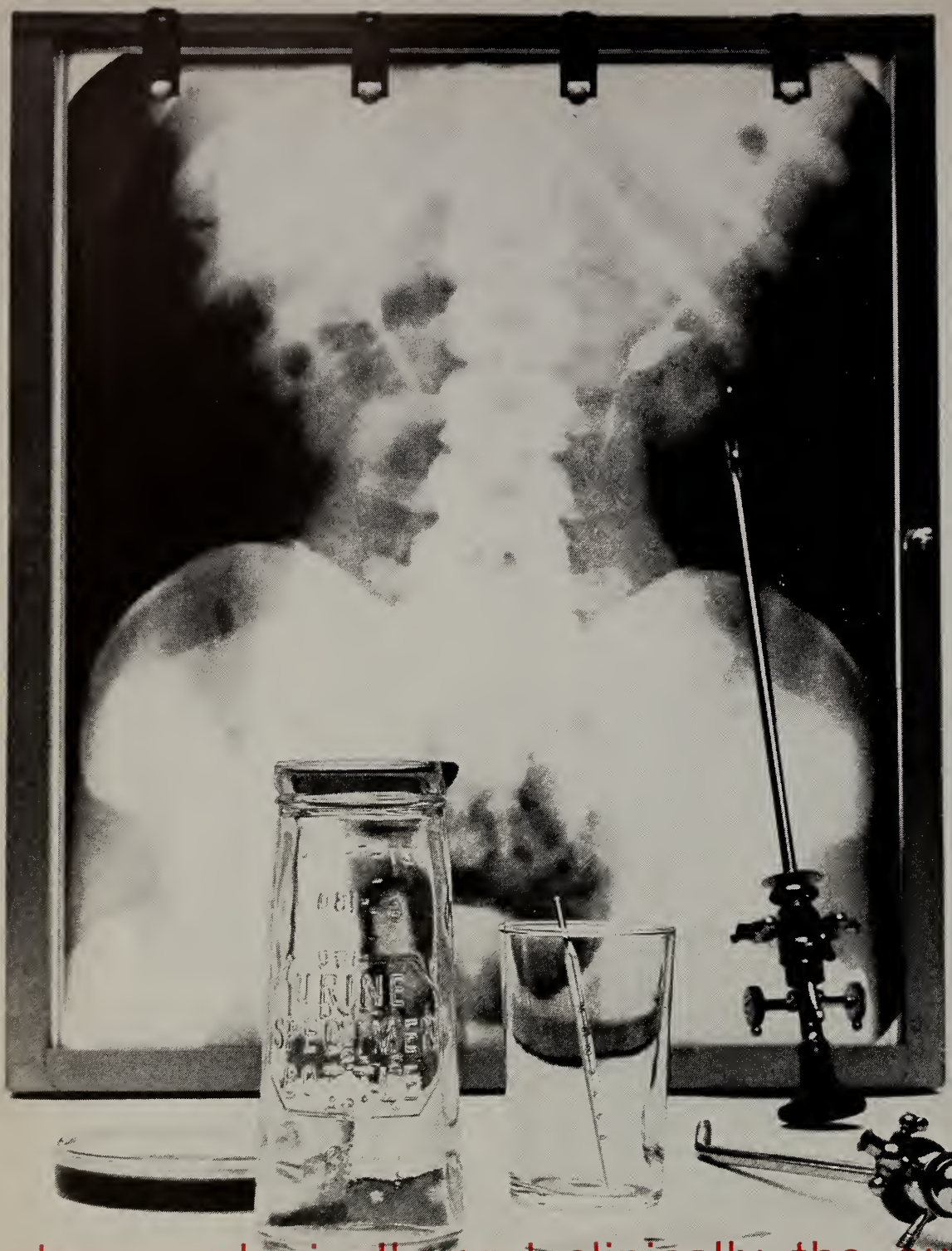
TRACINGS TAKEN on 8-22-56, 9-10-56 and 9-14-57 all show an elevation of the ST-T segment in V2, V3, V4, V5 and V6. Were this due to pericarditis or myocardial disease the S-T segment would not have persisted unchanged for such an extended period of time. The explanation for this pattern is that repolarization is of sufficient magnitude not only to inscribe the T wave but it is intense enough early during repolarization to elevate the S-T segment.

findings. Repeat EKG's approximately one month and one year later showed no essential change with elevation of S-T segment persisting. This type of elevation of S-T segment is often mistaken for acute pericarditis or early changes of myocardial infarction.

Comment

The three abnormal patterns described above may be static or due to temporary alteration of homeostasis, but they accompany anatomically normal hearts. Other causes for striking ST-T changes in presence of anatomically normal hearts are drugs, electrolytes, acid base balance, food, temperature, neurogenic stimuli, increased intracranial pressure, deformities of the chest and positional changes. It behooves all of us reading cardiograms to realize the non-specific nature of the ST-T segment changes and extreme caution in inferring an anatomical diagnosis. The unescapable fact remains that an EKG is basically a record of electrical potential traversing of the heart and not a microscopic slide.

Only after correlating thousands of tracings with autopsy material and animal experiments do we associate certain EKG patterns with particular anatomical changes. But even so this correlation is a statistical one, thus leaving considerable room for error. The occasional tragic errors may be averted only if the cardiogram is interpreted in light of clinical finding. The electrocardiographer not familiar with the clinical picture should simply describe the pattern, for anatomical, physiological and prognostic implications should be drawn only at the bedside with all the facts concerning the patient at hand. ◄



when sulfa is your plan of therapy..

pharmacologically and clinically the outstanding

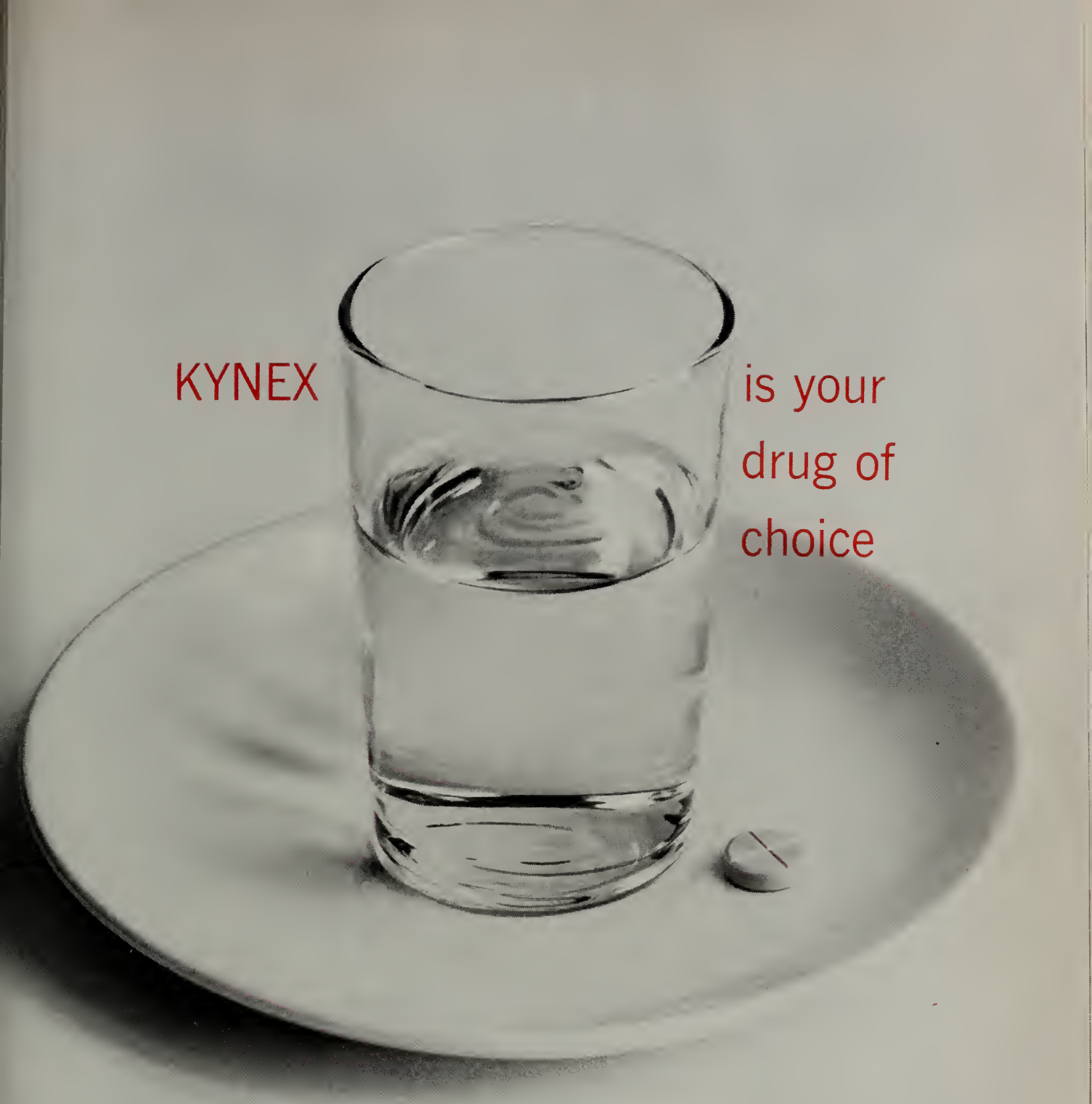
Rapid peak attainment — for early control — KYNEX® Sulfamethoxypyridazine reaches peak plasma levels in 1 to 2 hours[1,2] . . . or approximately one-half the time of other once-a-day sulfas.[2] Uninterrupted control is then sustained over 24 hours with the single daily dose . . . through slow excretion without renal alteration.

High free levels — for dependable control — More efficient absorption delivers a higher percentage of sulfamethoxypyridazine — averaging 20 per cent greater at respective peaks than glucuronide-conversion sulfas.[2] Of the total circulating levels, 95 per cent remains in the fully active, unconjugated form even after 24 hours.[3]

Extremely low toxicity[4] . . . only 2.7 per cent incidence in recommended dosage — Typical of KYNEX relative safety, toxicity studies[5] in 223 patients showed **TOTAL** side effects (both subjective and objective) in only six cases, all temporary and rapidly reversed. Another evaluation[4] in 110 patients confirmed the near-absence of reactions when given at the recommended dosage. High solubility of both free and conjugated product[6] obviates renal complications. No crystalluria has been reported.

Successful against these organisms: streptococci, staphylococci, E. coli, A. aerogenes, paracolon bacillus, Gram-negative rods, pneumococci, diphtheroids, Gram-positive cocci and others.

1. Boger, W. P.; Strickland, C. S., and Gylfe, J. M.: Antibiotic Med. & Clin. Ther. 3:378, (Nov.) 1956. 2. Boger, W. P.: Antibiotics Annual 1958-1959, New York, Medical Encyclopedia, Inc., 1959, p. 48. 3. Sheth, U. K.; Kulkarni, B. S., and Kamath, P. G.: Antibiotic Med. & Clin. Ther. 5:604 (Oct.) 1958. 4. Vinnicombe, J.: Ibid. 5:474 (July) 1958. 5. Anderson, P. C., and Wissinger, H. A.: U. S. Armed Forces M. J. 10:1051 (Sept.) 1959. 6. Roepke, R. R.; Maren, T. H., and Mayer, E.: Ann. New York Acad. Sc. 60:457 (Oct.) 1957.



once-a-day sulfa...

NOTE: Investigators note a tendency of some patients to misinterpret dosage instructions and take KYNEX on the familiar q.i.d. schedule. Since one KYNEX tablet is equivalent to eight to twelve tablets of other sulfas, even moderate overdosage may produce side effects. Thus, the single dose schedule must be stressed to the patient.

KYNEX Tablets, 0.5 Gm., bottles of 24 and 100. Dosage: Adults, 0.5 Gm. (1 tablet) daily, following an initial first day dose of 1 Gm. (2 tablets).

KYNEX Acetyl Pediatric Suspension, cherry-flavored, 250 mg. sulfamethoxypyridazine activity per teaspoonful (5 cc.). Bottles of 4 and 16 fl. oz. Recommended Dosage: Children under 80 lbs.: 1 teaspoonful (250 mg.) for each 20 lb. body weight, the first day, and ½ teaspoonful per 20 lb. per day thereafter. For children 80 lbs. and over: 4 teaspoonfuls (1.0 Gm.) initially and 2 teaspoonfuls daily thereafter. Give immediately after a meal.

KYNEX®

Sulfamethoxypyridazine Lederle

NEW—for acute G.U. infection AZO-KYNEX® Phenylazodiaminopyridine HCl—Sulfamethoxypyridazine Tablets, contains 125 mg. KYNEX in the shell with 150 mg. phenylazodiaminopyridine HCl in the core. Dosage: 2 tablets q.i.d. the first day; 1 tablet q.i.d. thereafter.

LEDERLE LABORATORIES, a Division of AMERICAN CYANAMID COMPANY, Pearl River, New York

Lederle

The Journal

of the INDIANA STATE MEDICAL ASSOCIATION

Devoted to the interests of the medical profession of Indiana

Editor: Frank B. Ramsey, M.D., 1802 North Illinois Street, Indianapolis 2, Indiana

Associate Editors: A. W. Cavins, M.D., 221 South Sixth Street, Terre Haute, Indiana; Lall G. Montgomery, M.D., Ball Memorial Hospital, Muncie, Indiana; David A. Bickel, M.D., 515 Odd Fellows Building, South Bend, Indiana; Stephen L. Johnson, M.D., 521 Sycamore Street, Evansville, Indiana.

Editorial Board: Term Expires

George M. Johnson, M.D., Richmond . . Dec. 31, 1960
Irvin W. Wilkens, M.D., Indianapolis . Dec. 31, 1960
Harold D. Lynch, M.D., Evansville . . Dec. 31, 1961
Jene R. Bennett, South Bend . . . . Dec. 31, 1961
Samuel R. Mercer M.D., Fort Wayne . Dec. 31, 1962
Franklin F. Premuda, M.D., Hammond . Dec. 31, 1962

Necrologist: James B. Maple, M.D., 117 West Washington Street, Sullivan, Indiana.

Assistant Editor: Sara M. Snyder

Business Manager: James A. Waggener

1019 Hume Mansur Building, Indianapolis 4, Indiana

Dangers of Mail-Order Dispensing

MAIL-ORDER DRUGS were the subject of critical discussion recently in the American Pharmaceutical Association's House of Delegates meeting in Washington, D. C.

AMA Trustee Dr. George M. Fister condemned the growing practice of obtaining drugs by mail, and labeled it as "one of the gravest problems" facing the health field today.

Dr. Fister pointed out that even in this day of automation, the personal relationship between the patient, his doctor and his pharmacist is highly essential. Such important items as the pharmacist's ability to check the prescription, verify the dosage and in the case of a refill to obtain the prescribing physician's approval are virtually impossible when the mail-order house is located miles away from the patient and doctor.

The physician, when confronted with such a setup, has no method of confirming the ethics, integrity and vigilance as to details of drug compounding in regard to the unknown individual who packages the drugs at the other end of the line. Indeed he has no assurance that a pharmacist is a part of the deal at all.

If the prescription is delayed in reaching the far distant drug house or the drug is delayed in delivery to the patient, serious results may ensue because of the remedy that wasn't there.

A mail-order drug house has no way of knowing whether a prescription is signed by an ethical practitioner. Any number of quacks or unscrupulous charlatans might, under this system, prescribe dangerous preparations. When the pharmacist and doctor live in the same community such miscarriages of medical service are not likely to occur.

The one thing that probably keeps such schemes going and makes them profitable enough to continue is that the prices imply cut-rates. Everyone likes a bargain, but it is better to limit bargains to merchandise whose quality can be checked by the purchaser. In the case of shoddy drugs, the purchaser will not know until it is too late.

"Nothing in this world was ever made or done so cheaply that someone else would not make it or do it for less," applies to drugs as well as anything else. All physicians should be informed on the mail-order drug "business," and should warn their patients.

Population on the Rise

A HIGH BIRTH RATE combined with a low death rate and a little migration is producing a population boom in the United States and Canada.

Births in the U. S. exceeded 4.1 million in six successive years during the 1950's. In every one of the 10 years starting with 1950 the birth rate was 24 per 1,000 or higher.

The general mortality rate decreased slightly in 1959, after remaining at a satisfactory low rate during the 50's. It was 9.5 per 1,000 in 1958, and fell to 9.4 per 1,000 in 1959. The all-time low was 9.2 per 1,000 in 1954.

Because of the increasing numbers of infants and very old people, the absolute number of deaths has increased for the past five years, although with the rapid gain in total population the rate remains low.

The United States, including the two new states, gained 2,900,000 residents in 1959, and 27.5 million since 1950. Our population is now estimated to be 179,250,000.

The growth is not at the same rate in all the states, and even varies markedly in the various geographic divisions. In three of the states, population figures declined in the past 10 years.

Study by the statisticians of the Metropolitan Life Insurance Company, as reported in their January 1960 *Bulletin*, shows the rate of population change in all states and by regions.

The country as a whole has had an average annual gain of 1.7% since 1950. The same percentage applies nationally to 1959. Indiana also had a 1.7% gain in 1959, but bettered the national average for the 10-year period with a gain of 1.8%.

All the geographic divisions recorded gains, but three states actually decreased in population. Vermont was minus .2% for the 10 years, but broke even in 1959. Arkansas was minus 1% both in '59 and during the 1950's. West Virginia was minus .2% both times. All other states gained during the decade by percentages ranging from a low of plus .2% to a high of plus 6.2%.

The 6.2% gain was Nevada. Florida chalked up 6% even for the 10-year period. The Pacific division was the fastest growing division with 3.1% annually for 10 years—with California at 3.6%, Hawaii at 3.0% (3.9% in the single year of 1959), and Alaska with a surprising average annual increase of 4.3% since 1950.

The Canadian population gain was also due to a high birth rate, up to a new high of 27.9 per 1,000 in 1959. Canada's mortality rate was at its low in 1958, with 7.9 per 1,000. Their 1959 mortality was 8.0; national population increase has averaged 2.7% for the 10 years.

Health vs Wealth

AMERICAN EXPENDITURES for medical care in 1958 added up to half the total spent for recreation, alcohol and tobacco.

The Health Insurance Institute has released the figures of the U. S. Department of Commerce concerning the personal expenditures in 1958.

Medical care in that year came to $16.4 billion or 5.8% of the total amount spent for personal needs. Recreational expenditures exceeded the medical bill slightly with a tab of $17 billion. The total for alcoholic beverages ($9.2 billion) and tobacco ($6.3 billion) almost duplicated the medical bill. The three together doubled the health expenditures.

The Newer Progestins

THERE IS PRESENTLY enthusiastic interest in the progestins as a group of therapeutic agents. It has long been known that progesterone, a steroid hormone elaborated by the corpus luteum, is essential for the implantation of the fertilized ovum and the maintenance of normal pregnancy. Rapid developments in biochemistry and newer experimental technics have advanced the knowledge of its physiological properties—the stimulation of growth of secretory, or pregravid endometrium and the inhibition of uterine mobility. The isolation of the natural endocrine

principle brought promise of an agent to control functional uterine hemorrhage, promote conception, prevent abortion, and to relieve dysmenorrhea and endometriosis. The use of the earlier preparations, which were relatively impotent, produced inconsistent responses and were often clinically disappointing.

But recently physiologically active and powerful steroid substances with progestational properties have been produced. Their effectiveness has been demonstrated both by a vast amount of research study, and by widespread clinical application. Some of these preparations are now being used extensively for various functional gynecologic and obstetric disorders.

While most of these substances represent a single hormone, one preparation (Enovid) is a combination of progestational and estrogenic substances. It is the 17 a-ethynyl-17-hydroxy-5 (10)-estren-3-one, brand of norethynodrel (9.85 mg) with 0.15 mg of ethynylestradiol 3-methyl ether. This substance has a broad field of activity and is recommended for any condition in which there is a need for stimulation of the secretory phase of the endometrium with an estrogenic effect. The priming effect of estrogen has been shown to be essential to the activity of all progesterone substances.

Other progestins depend on endogenous estrogen or estrogen administered separately. This combined preparation (Enovid) has been extensively used for amenorrhea, threatened and habitual abortion, endometriosis, dysmenorrhea, and functional uterine bleeding; and because of the potent estrogen component it acts also as a medical contraceptive by preventing ovulation. It will also delay the onset of menstruation. This substance is administered orally, but has the disadvantage that it frequently causes nausea and vomiting.

Hydroxyprogesterone Caproate (Delalutin) is an esterified derivative of the natural progestational hormone. It does not contain estrogenic or androgenic principles and is only available for intramuscular injection.

Norethindrone (Norluton) is the 17-a-ethynyl derivative of 19-nortestosterone. When given orally it has highly potent progestational activity. This substance does not cause nausea or vomiting, but because of its androgenic activity, masculinization of female fetuses has been reported following its prolonged administration during pregnancy.

The newcomer to this group of endocrine products is medroxyprogesterone acetate (Provera). Its manufacturer claims that it is four times as potent as norethindrone or norethyndrel. It is recommended for its progestational activity without androgenic or estrogenic effects.

The use of these potent progestational substances requires clinical judgment, some discernment and caution. They will all produce temporary aspermia in males. In any case of abnormal uterine bleeding, organic disease, particularly malignancy, should be ruled out by cytologic study, and curettage if necessary, before hormone treatment is instituted. Today progestational substances are most frequently used to control dysfunctional bleeding, increase fertility, and to prevent abortion. Like all new medical agents some claims have been made for the newer progestins that are premature and unwarranted. Many abortions are due to abnormal fetal development from unknown causes. Once an abortion is in progress the ability of any known medication to prevent it is open to question

These newer endocrine agents, in contrast to older preparations, are highly potent; they do control some dysfunctional bleeding, help some women get pregnant and prevent some abortions. But there is need for further clinical trial to clearly define their value in therapy of gynecologic and obstetric disorders. —D.A.B. ◄

Why do the prices of drugs in the United States differ from those sold elsewhere? Besides employment costs, what are some of the other factors involved in setting each country's level of drug prices?

Drug Prices . . . Here and Abroad*

IN THE WASHINGTON hearings, much has been made of the fact that a number of medicines cost far less in foreign countries than they do in the United States.

Nothing is less surprising than these price differences. Almost without exception, these drugs are not shipped from the United States but are manufactured abroad either by branches of U. S. companies or by foreign concerns. Their prices on the whole follow the pattern of employment costs—wages and salaries.

Obviously, the prices of any drug in the different countries of the world are the result of an enormous number of variable factors so complex that an analysis of the variations would require the services of an economist. Some of these factors are: currency exchange restrictions and the fluctuation of exchange rates; the progress of inflation within each country; drug-pricing control laws; taxes and tariffs; import regulations and restrictions; differing retail pricing practices; local wage scales and the great disparity in distribution and promotion methods.

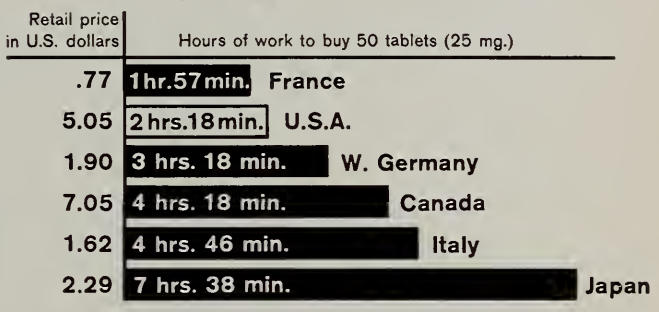
All of these factors combine with local competitive conditions to set the levels of drug prices in different countries.

However, and this must be emphasized, the most important single element is the vast difference in wages and salaries in countries around the world. As Roger Blough, Chairman of U. S. Steel, recently pointed out, employment costs—direct and indirect—represent more than three quarters of all costs in American industry.

A recent table in *Time* (December 28, 1959) gives the average hourly wages in manufacturing:

United States	$2.22
Great Britain	.67
Germany	.58
Mexico	.35
Japan	.30

Hours of Work Required To Buy Drugs in U.S.A. and Abroad



1959 Retail Prices of Chlorpromazine

Sources: Prices—Kefauver Committee, Exhibit 98, Jan. 21, P. 1544
Labor—Based on hourly earnings in manufacturing, *U. N. Monthly Bulletin of Statistics; Japan, Time Magazine* Dec. 28, 1959.

Roughly, United States wage costs are at least three times those in Europe, and even higher when compared to Mexico and Japan. For example, a secretary in Holland might get $112 a month in contrast to a secretary here who might earn $360 a month. The contrast in technical and administrative salaries is even more striking.

Under these circumstances, it is only natural that prices are lower elsewhere. For example, a one-pound loaf of white bread costs 20¢ in the U. S. It costs nine cents in Britain, eight cents in Ireland and Pakistan, and slightly less than two cents in Argentina, where the peso recently has been devalued.

You can have your hair cut in Dublin for 42¢ (including tip) and in Vienna for 31¢. In West Germany a glass of beer is eight cents, and you can have a good dinner in a London restaurant for $1.50. In Bolivia, you pay only $5.60 a day for complete care in a private room in a first-class hospital, and when you get out you can restore your strength with beefsteak at 31¢ a pound. Drug prices tend to follow this pattern.

Continued

* Comments by Smith Kline and French Laboratories, in "Drug Prices Around the World," May, 1960.

In certain U. S. industries such as heavy chemicals, it is possible to compensate for a 300% foreign labor cost differential by superior manufacturing methods or by mechanization. But the thinking of a biochemist in a pharmaceutical research laboratory cannot be mechanized.

The only method of bringing American drug prices into line with those in foreign countries is the unthinkable one of reducing our wage standards to those in foreign countries. This would mean that our standard of living—the highest in the world—also would be reduced, an equally unthinkable proposition.

Make Your Hotel Reservations Today!

111th Annual
ISMA CONVENTION

October 3-5

French Lick-Sheraton Hotel
French Lick, Ind.

★ Nationally and internationally-known doctors will bring you the latest developments in medicine at three scientific sessions.

★ Six hours of instructional courses, approved by IAGP Category I credit taught by outstanding Hoosier physicians.

★ Annual golf tournament and trap and skeet shoot.

★ Special dinner-entertainment-dancing on Monday evening, Oct. 3.

★ President's Reception, Annual Dinner and President's Night, Oct. 4.

President's Page

Another American Medical Association convention has come and gone. The setting was beautiful Miami Beach and the headquarters was the beautiful Americana Hotel.

One of the chief issues considered at this time had to do with physician-hospital relations; after long deliberation, the reference committee recommended to the House of Delegates that the guides for the conduct of physicians with institutions which were developed in 1951 be reaffirmed. This went into the record without debate on the floor.



However, the philosophy having to do with this relationship and the reaffirmation of the 1951 rules indicates the desire on the part of medicine that all elements stand together, for in so doing, strength can be preserved.

There was considerable discussion as to whether the AMA should get into the expensive operation of making a nation-wide study of the cost of medical care. Finally it was decided that this be done.

Considerable time was spent by the House of Delegates in discussion of activities in the field of aging. It was reassuring to learn how much expansion has occurred, in a short time, in Blue Shield plans and in private industry insurance plans for the care of these people. All the discussion, however, was directed toward the final conclusion that the care of the aged should be done at a local level and not become an element of the federal government's activity.

Interestingly enough it was resolved by the House of Delegates that the individual members of the American Medical Association as private citizens should take a more active part in the local, state and national government endeavoring to aid in the selection of qualified candidates for office regardless of party affiliation of such candidates, and that the individual members of the association work toward the creation of policies which preserve representative government, free enterprise, fiscal solvency and the integrity of the dollar.

Once again the House of Delegates voted against inclusion of physicians under social security. It was also further resolved that the American Medical Association should join other organizations in seeking reform of the federal tax structure so as to return to the states and their political subdivisions their traditional revenue sources and to allow American citizens to enjoy the fruits of their labor.

New rules were again laid down for the relations between physicians and allied health professions. The question on osteopathy received very little attention.

Various and sundry other issues were considered at the meeting. However, the general tenor of the meeting was not as vocal as others I have attended. I wonder if it could have been the tranquilizing effect of the geography in which the meeting occurred. I certainly hope it was not apathy on the part of the participants.

Earle W Arnold M.D.

The Women's Auxiliary

REPORTS TO ISMA

It is a story that can happen, and sad to say, still does happen occasionally—the medical school that loses a noted professor because of an inability to pay an adequate salary, the promising medical student that drops out of school because of financial difficulties, the university which cheats its students of a proper education because of outdated medical equipment and inadequate facilities. This has happened and is still happening in medical schools throughout the country.



There are two solutions to the problem. One is federally supported schools, and consequently "controlled" schools. The other, and certainly more desirable, is a free and unfettered system of medical education wherein the financial gap is filled by private donation, etc. Thus, "THE AMERICAN MEDICAL EDUCATION FOUNDATION."

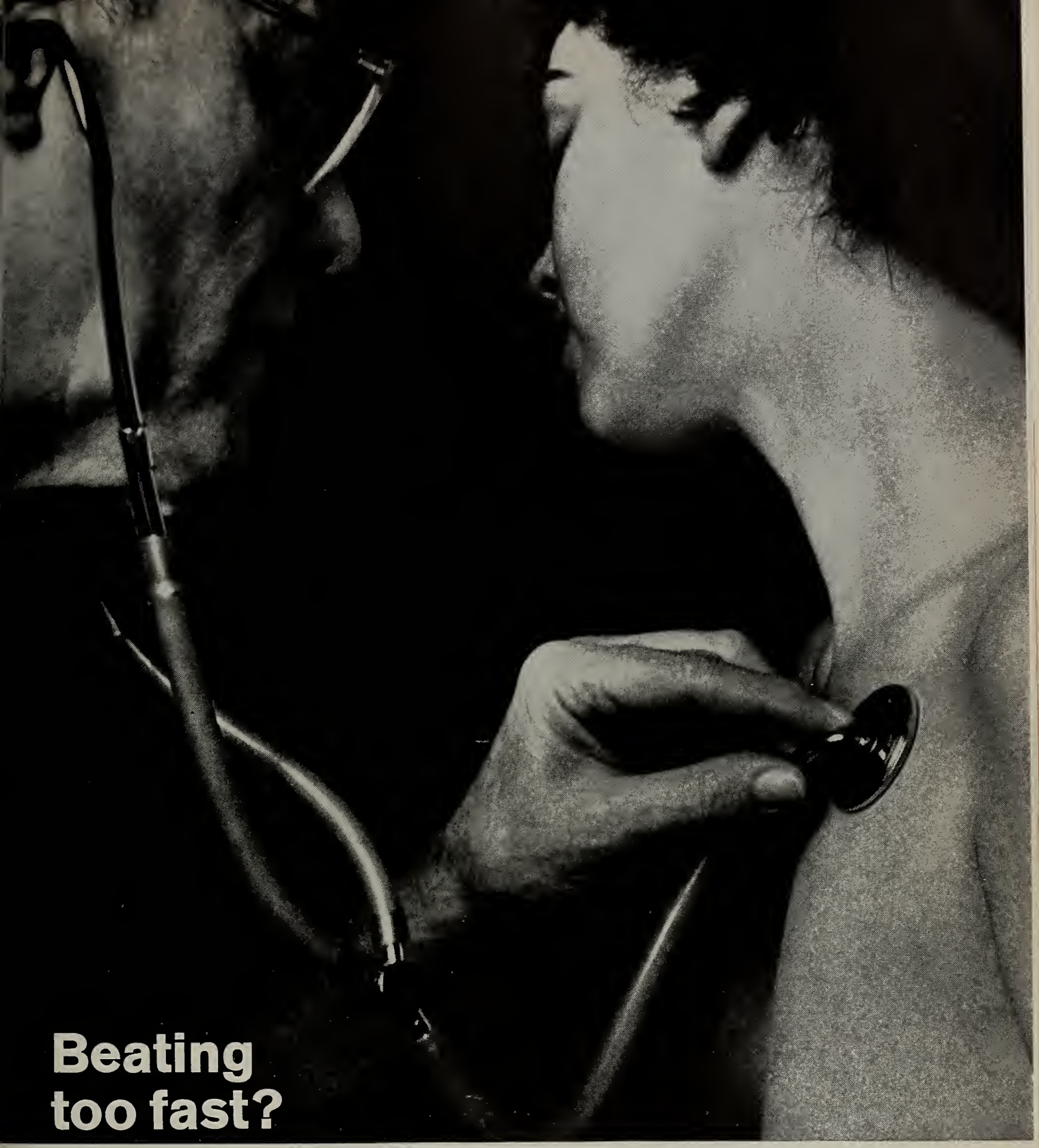
As an Auxiliary our support of A.M.E.F. has been constant but not adequate. We have finally achieved one of our "worked for" goals, that is, a contribution to the American Medical Education Foundation representing over $5.00 per member; but this can be only a beginning. The dream of organized medicine is that medical education can continue unhampered within the framework of freedom. Independent medical schools constitute the foundation of the free enterprise system of the private practice of medicine. Can we dare risk the consequences of not supporting A.M.E.F.?

Last year, the Auxiliary in the state of Indiana stood fifth in the highest per capita contribution to the A.M.E.F. This is a record to be proud of, but not one we should be content to stand on. Medical education has taken on new dimensions. The goals of today can no longer be based on the needs of yesterday. We must face the challenge which is looming over us.

We, as your Auxiliary leaders, have determined that each county auxiliary will have one program and at least one fund raising event for the support of A.M.E.F. Also, that each member will know what is at stake in the struggle of our medical schools to continue in the American tradition.

By your support of the American Medical Education Foundation, you not only serve the best interests of the medical profession, but you also serve American democracy.

Ina. Rigley



Beating too fast?

Slow it down with SERPASIL®

(reserpine CIBA)

Serpasil has proved effective as a heart-slowing agent in the following conditions: mitral disease; myocardial infarction; cardiac arrhythmias; neurocirculatory asthenia; thyroid toxicosis; excitement and effort syndromes; cardiac neurosis; congestive failure. Serpasil should be used with caution in patients receiving digitalis and quinidine. It is not indicated in cases of aortic insufficiency.

SUPPLIED: Tablets, 0.1 mg., 0.25 mg. (scored) and 1 mg. (scored). Complete information available on request.

CIBA

SUMMIT·NEW JERSEY

2/2819MB

A new approach to the betterment of expert testimony in personal injury cases: Systematic indoctrination in the proofs of science and the science of proof.

Law-Science Academy of America

*HUBERT WINSTON SMITH, LL.B., M.D.**

Austin, Texas

(Published concurrently in other medical and law journals as an interesting dissertation on an important subject. The opinions expressed do not necessarily correspond with the policies of the Indiana State Medical Association or *The Journal*.)

JUSTICE CAN ONLY be achieved in litigation, whether civil or criminal, if the facts found by judge or jury correspond with truth. There has been a constant search in this country for many years for solutions to the vexatious problems, multiple in nature, which spring from use of expert testimony. Thus, many states now permit by statute, or rule of court, appointment of impartial physicians or other experts, by the trial judge, to carry out impartial examinations of the claimant, in personal injury cases, of the accused claiming a mental defense in criminal cases, or of inanimate subject matter in some instances.

Accompanying these broad discovery provisions, which have been so effectual as a part of the Federal rules of civil procedure that they have been widely copied by the several states, have been liberal reforms, in most states, permitting the taking of depositions of parties and witnesses prior to trial. By thorough-going direct and cross-examination, qualified counsel can extract from treating and examining physicians, and other expert witnesses, the full facts as to what they did and found, and force into the open the medical contentions which will be made, at the same time crystallizing, defining and restricting the issues.

By assembling past medical and hospital records and taking depositions of all the treating or examining physicians, the parties can define and limit the medicolegal issues at an early stage of the litigation. Since the founding of the law-science movement in this country, which may reasonably be linked with the initiation of our law-science short courses at Tulane University in 1950, the percentage of personal injury cases disposed of by pre-trial compromise negotiation has risen from some 45% to close to 90%! Better counsel are now quite willing to concede that it is important to use the best available specialists, and necessarily to exchange freely medical reports without putting the opponent to the unnecessary trouble of taking depositions.

Quality of Testimony Varies

At the same time, there is a great unevenness in the quality of expert testimony in our trial courts, both in civil and in criminal cases. Only some six states of the Union require a physician to be a certified specialist in order to qualify him to testify on a specialty problem. The field of medicine has now broken down into some 35 recognized medical specialties and the judge who

* Professor of Law and Legal Medicine and Director, Law-Science Institute, University of Texas; Chancellor, Law-Science Academy of America.

permits the general practitioner to give opinion evidence on specialty subjects would be the first to take the train for the Mayo Clinic in event he had some serious health problem arise.

Some have assumed that the giving of unscientific medical evidence testimony is a badge of fraud, but it is my conviction, after studying the matter for many years, that ignorance is a greater foe of justice than misrepresentation. We need to tighten up our qualifications for expert witnesses, on *voir dire* (the qualifying) examination. While the treating physician should always be allowed to testify, whether he be a specialist or not, close control should be exercised to the end of determining important litigation, dependent upon advanced, skilled knowledge of a specialist, upon testimony of general practitioners.

As most readers will realize, the New York Academy of Medicine has recently cooperated with the trial courts of New York in supplying outstanding medical specialists, drawn from a rotating panel, to study particular cases in which the courts have applied for help. This is a step forward, and perhaps the gravest criticism which can be leveled at the plan is the fact that the trial judge customarily refers to this specially selected witness as the court's witness, thereby throwing the mantle of omniscience over him. This seems undesirable, and it would suffice if the court merely indicated that the expert witness had examined, without objection of the parties, with the understanding that both parties would be able to cross-examine him freely, permitting the jury to give his testimony the final weight they believe it to deserve.

Another solution which has been coming forward at intervals in recent years, is a suggestion for abolition of trial by jury, and even for abandonment of trial of these cases by judges without juries. The contention is sometimes made that an administrative tribunal, not bound by the common law rules of evidence, could gain a special skill in handling such cases, and dispatch claims more expeditiously and justly. After studying this matter for a number of years, we entertain grave doubts as to whether such a mechanism would improve the current level of practice.

Indeed, we are persuaded that adversary trial, when streamlined and speeded up, with full rights of direct and cross-examination of witnesses protected, makes for a more thorough preparation and presentation of evidence than any other known mechanism for determining disputed facts. These conclusions of ours, based upon many experimental trials where the proceedings and deliberations were tape-recorded, have been corroborated in recent months by research studies carried out by sociologists at the University of Chicago Law School, on trial by jury.

Need New Species of Lawyer

It is my belief that the need of the times is to train law-science advocates—a new species of trial lawyer who is deeply grounded in the proofs of science and the science of proof. Certainly, the whole trial process must move forward to a scientific level, if trial practice is to survive in an age which demands objectivity and speed.

If I may say so, with proper modesty, the Law-Science Institute of the University of Texas, the Law-Science Academy of America and the Law-Science Foundation of America have been the chief leaders in developing authoritative scientific instruction for trial lawyers in this country. Together, they have conducted during the past 10 years, more than 40 national institutes, or short courses. These were attended by more than 6,000 lawyers and physicians from all parts of the United States.

The Law-Science Institute of the University of Texas was the first such institute organized to carry out research and teaching between law and medicine. Indeed, its purposes are even broader, namely, to promote, by every proper measure, the integration of law with the physical, medical, psychological and social sciences.

The basic premise is that law cannot abandon its historical heritage, but must subject itself constantly to extrinsic criticism of other intellectual disciplines, insofar as these are relevant to fact-finding, or policy formation. The day of intellectual isolationism is gone. The great need of the time is for synthesis of knowledge, using a multi-dimensional approach and giving each distinct intellectual discipline which has a title to speak, an opportunity to be heard.

As we view the progress of human knowledge, we may divide research into two varieties. One is primary, analytical research, in which facts are broken down, or fragmented, into ever smaller facts, with the result that we pass from one universe of knowledge to another, constantly seeking final mechanisms, ultimate facts, or at

Law-Science

Continued

least controling basic principles. The other type of research, which has been much wanting on the American scene, involves the task of inter-relating bodies of knowledge. Such cooperation can result in improvement of justice, solution of many difficult problems which will not yield to the analysis of a single intellectual discipline and establishment of valued judgments based upon an integration of knowledge and culture. One line of research cannot take the place of the other, but both must proceed concurrently. By its very nature, since law must assume to regulate every activity of mankind, law has a capital opportunity to become a master social science, if you will, in this process of integration of knowledge.

Now this need for integration of knowledge is particularly keen when we come to complex catastrophic injuries. Such injuries usually involve more than one organ system of the body. They invoke the attention of several different types of specialists in order to arrive at any fair judgment as to the fact and degree of injury, and disability, and vexatious problems. As to whether the traumatic stimulus caused, aggravated or precipitated (or accelerated) the claimant's disease, or death, we may have to relate various doctrines of substantive law with the contributions of several medical and scientific specialties, including the work of such non-medical men as clinical psychologists and physicists.

The training given in American law schools today simply does not equip the oncoming young trial lawyer with the basic knowledge, or skills, to carry out this task of analysis and synthesis, which can only be met by a properly trained law-science advocate.

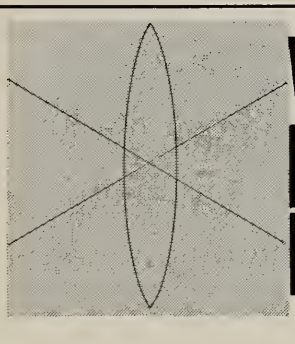
Meeting the Deficit

To meet this great deficit, two steps have been taken. The Law-Science Institute at the University of Texas, has introduced ambitious instruction in "Legal Medicine and Elements of Medicolegal Litigation" for law students interested in trial practice. This is a course which meets four hours each week, and it is not unusual, though it is an elective subject, for 75 to 100 of the students to take the course each year. Under our practice, the human body is divided into nine organ systems, the tenth area is reserved for medicolegal problems involving the total personality, and thus corresponding to psychiatry (and other behavioral sciences) and clinical psychology.

The eleventh area is reserved for "Medicolegal Trial Technique." Students are encouraged to do collateral research, both in the medical library, on select subjects, and in the law library, in an effort to inter-relate relevant materials. The institute has been instrumental, through the years, in developing more than 170 published studies on important, frequently recurring medicolegal problems, and these have appeared in leading law and medical journals, indicating that the goal of basic English has been reached, but without making the material so elementary that it is not acceptable to the scientific mind.

In recent years, the Law-Science Academy of America and the Law-Science Foundation of America have come to the aid of the Law-Science Institute in this tremendous undertaking which involves both continuing medicolegal education of practicing lawyers and physicians, as well as insurance company personnel and others

Continued on page 1518



VISION BEFORE PROGRESS

"Where there is no vision the people perish." The Bible tells us this, and its truth has never been more apparent than in the world today. Vision is a prerequisite to planning, but White-Haines has been planning for vision for more than a half-century. Fine ophthalmic craftsmanship, prompt service, your utter confidence in the exacting execution of the lens prescription you write . . . that's the credo of White Haines. It took vision to plan for that ultimate, too.

THE White-Haines OPTICAL COMPANY
34 Modern Laboratories
OHIO • PENNSYLVANIA • MARYLAND
KENTUCKY • W. VIRGINIA • INDIANA
MICHIGAN • ILLINOIS

Dietary Linoleic Acid and Linoleate—*Effects in Diabetic and Nondiabetic Subjects with and without Vascular Disease*

A paper by Laurance W. Kinsell, M.D., et al., excerpted from Diabetes—The Journal of the American Diabetes Association, May-June 1959

"*Linoleic acid as the major 'hypocholesterolemic agent' in vegetable fats.* The question has been raised as to the mechanism of lowering of the plasma lipids by a variety of vegetable fats. Among the entities present in or absent from vegetable fat which have been considered are: (a) the absence of cholesterol; (b) the presence of certain vegetable sterols; (c) the presence of certain vegetable phospholipids; (d) the nature of one or more of the fatty acids present; (e) the presence of trace materials.

in the diet

The absence of cholesterol has been excluded as a major factor.[5a] Phospholipids, if they contain a sufficient quantity of unsaturated fatty acids may produce a striking reduction. In our experience thus far saturated phospholipids fail to produce such an effect.[7]

Beveridge and his associates believe that vegetable sterols, particularly beta-sitosterol, are responsible to a significant degree for the cholesterol-lowering effect.[8] In our experience the vegetable sterols have a relatively weak and unpredictable effect of this sort.

Since the fatty acids of animal fats are predominantly saturated, and the fatty acids of most vegetable fats are predominantly polyunsaturated, with linoleic acid as the major component of the vegetable fats which lower cholesterol and other lipids, the question arises whether linoleic acid per se is capable of lowering plasma lipids. As reported previously[7] this is indeed the case. In a recent study in a young male with peripheral atherosclerosis in association with elevation of plasma cholesterol and of total lipids, ethyl linoleate produced a greater fall in the plasma lipid levels than had moderate amounts of natural sources of unsaturated fat. Linoleic acid, therefore, appears to be the most important single lipid-lowering component of vegetable fat.

* * *

Significantly higher levels of cholesterol were observed during oleate administration than during administration of equal amounts of linoleate. The relatively low cholesterol values during the second oleate period may have been related to linoleate stored in fat depots. The fatty acid composition of the cholesterol esters reflected the fat which was fed, i.e., the mono-enoic† acid content averaged more than 40 per cent during oleate feeding and less than 20 per cent during linoleate ingestion. Essentially, a mirror image of this resulted during linoleate feeding, at which time di-enoic acid predominated.

* * *

The data presented in this paper appear to establish that linoleic acid administered either as purified ethyl ester or as naturally occurring fat, in sufficient quantity, in properly constructed diets, will reduce plasma lipids to normal levels. The amount of linoleic acid required appears to bear a direct relationship to the amount of saturated fat included in the diet. Linoleic acid requirement may also bear a significant relationship to the amount of atherosclerosis present.

The transition from evaluation of the effect of dietary entities upon plasma lipids, to the evaluation of the effect of such materials upon vascular disease is difficult. However, such evaluation is not impossible. The requisites are adequate measuring sticks and well-controlled studies of sufficient duration. The duration of observation of effects of unsaturated fat in diabetic and nondiabetic patients with vascular disease is in no instance more than five years, and in the majority of instances, less than three. Our present impression is that improvement has occurred in some patients with atherosclerosis and with diabetic retinal and renal disease which was more than we would have anticipated in terms of the natural course of the disease. However, since it is well known that major fluctuations in these diseases can occur in individuals receiving no treatment, we believe it is appropriate at this time to say that no untoward effects appear to result when one prescribes diets containing large amounts of unsaturated fat for patients with such diseases, and it is not impossible that beneficial effects may be associated with such diets."

* * *

5a Kinsell, L.W., Partridge, J. W., Boling, L., Margen, S., and Michaels, G.D.: Dietary modification of serum cholesterol and phospholipid levels. J. Clin. Endocrinol and Met. 12:909, 1952.

7 Kinsell, L. W., Friskey, R., Splitter, S., Michaels, G. D.: Essential fatty acids, lipid metabolism, and atherosclerosis. Lancet 1:334, 1958.

8 Beveridge, J.M., Connell, W.F., Firstbrook, J. B., Mayer, G.A., and Wolfe, M.J.: Effects of certain vegetable and animal fats on plasma lipids of humans. J. Nutrition 56:311, 1955.

† Mono-enoic (mono-unsaturated) acid is presumably synonymous under these conditions with oleic acid and di-enoic (di-unsaturated) acid with linoleic acid

Where a vegetable (salad) oil is medically recommended for a cholesterol depressant regimen, Wesson is unsurpassed by any readily available brand.

WESSON'S IMPORTANT CONSTITUENTS

Wesson is 100% cottonseed oil . . . winterized and of selected quality	
Linoleic acid glycerides (poly-unsaturated)	50-55%
Oleic acid glycerides (mono-unsaturated)	16-20%
Total unsaturated	70-75%
Palmitic, stearic and myristic glycerides (saturated)	25-30%
Phytosterol (predominantly beta sitosterol)	0.3-0.5%
Total tocopherols	0.09-0.12%
Never hydrogenated—completely salt free	

Law-Science

Continued from page 1541

professionally concerned with medicolegal problems; also in developing ever-increasing instruction, in the way of seminars, for the undergraduate law students.

The Law-Science Academy of America and the Law-Science Foundation of America, are non-profit, charitable societies, so recognized by the Department of Internal Revenue, which are devoted to the same broad purposes as the Law-Science Institute, but specifically, at the moment, to furthering practical integrations of law with other fields of learning. The implications of this pragmatic movement can be tremendous. Obviously, there is a great need to integrate business practice with law, political theory and practice with law, economics with law, etc.

One of the more challenging areas involves integration of behavioral sciences with law. It is our contention that only behavioral sciences can explain human behavior, that only law can regulate it and that therein lies the basis of a necessary and enduring partnership. The whole reformation for our antiquated criminal law and penology depends on the rapid acceptation of these premises. It is interesting to me that lawyers everywhere seem enthusiastic, rather than resistive, in connection with the proposed infiltration of law with relevant scientific materials.

Recently, at one of our short courses held in New Orleans, the eminent neurosurgeon, Dr. James C. White, Prof. of Neurological Surgery at Harvard Medical School, stated that he found the lawyers to be more avid students of medicine than the medical students and doctors themselves. On all sides, we see a quickening of interest among lawyers in this trend toward a multi-dimensional approach to legal thought and action. Spearheading this national movement, has been the Law-Science Academy of America, which has advanced from a membership of 90, some two years ago, to some 700 leading lawyers and physicians in this country today. Every lawyer and physician in good standing, who is motivated toward the purposes of bettering social conditions, including the administration of justice, through cooperation of law and science, is eligible for membership. Various grades of membership exist, and various types of honors may be won on the basis of concrete achievement.

The current president of the Law-Science Academy of America is Dr. A. Earle Walker, Prof. and Chairman of Neurological Surgery at Johns Hopkins Medical School. He is generally recognized as one of the leading research men and clinicians in his field. Recently, he returned from London where he served for a month as Prof. of Neurological Surgery at Guys Hospital.

Current Chancellor of the Law-Science Foundation is Dr. Herbert C. Modlin, senior psychiatrist at Menninger Clinic and Foundation, a leader in the behavioral sciences, and generally accepted as one of the foremost exponents of integration of behavioral sciences and law. Dr. Hubert Winston Smith has been elected lifetime Chancellor of the Law-Science Academy and as lifetime president of the Law-Science Foundation, and gives administrative continuity, in conjunction with the boards of trustees, in development of the on-going programs of the two organizations.

Summer Instructional Program

In their determined efforts to hasten the training of an adequate, elite corps of law-science advocates in this country, the academy and foundation have established an unique summer instructional program in Crested Butte, Colo., 30 miles from Aspen. Crested Butte was once a bustling mining town, nestling high in the Rockies, on the western slope 27 miles north of Gunnison. When the Colorado Fuel and Iron Company closed its mines, in about 1953, the population dwindled markedly, and for a time, there was a real risk that the village might become a ghost town and undergo continuing dissolution.

Three years ago, however, the Law-Science Academy purchased old union hall, a large two-story structure in Crested Butte, and completely remodeled it, in keeping with the spirit of the town. Last summer, the academy held its first summer teaching effort there, offering four individual weeks of instruction, featuring top medical specialists and trial lawyers of this country. This year, the instruction was stepped up to nine weeks, and ran from June 13th through Aug. 12th, 1960. Each week of the instruction is a separate course unto itself, but there is an interlinking continuity which makes prolonged attendance highly beneficial to those who can stay for longer periods.

Continued on page 1524

stiffness and pain

"gratifying" *relief from stiffness and pain*

in 106-patient controlled study
(as reported in J.A.M.A., April 30, 1960)

"Particularly gratifying was the drug's [SOMA's] ability to relax muscular spasm, relieve pain, and restore normal movement . . . Its prompt action, ability to provide objective and subjective assistance, and freedom from undesirable effects recommend it for use as a muscle relaxant and analgesic drug of great benefit in the conservative management of the 'low back syndrome'."

Kestler, O.: Conservative Management of "Low Back Syndrome", J.A.M.A. 172: 2039 (April 30) 1960.

FASTER IMPROVEMENT—79% complete or marked improvement in 7 days (Kestler)

EASY TO USE—Usual adult dose is one 350 mg. tablet three times daily and at bedtime.

SUPPLIED: 350 mg., white tablets, bottles of 50.
For pediatric use, 250 mg., orange capsules, bottles of 50.

Literature and samples on request.

SOMA®
(CARISOPRODOL, WALLACE)

WALLACE LABORATORIES, CRANBURY, NEW JERSEY

Law-Science

Continued from page 1518

In keeping with the idealistic purposes of The Law-Science Academy and Foundation, printed announcements have been mailed to every law dean in America, indicating that carefully selected students will be eligible for scholarships at Crested Butte. It is hoped that a big brother relationship can be established between the distinguished visiting physicians and trial lawyers, on the lecturing staff, and the embryonic trial lawyers. It is possible, in the beautiful, restful setting of Crested Butte, to carry out instruction on an informal, seminar basis with maintenance of maximum arousal, interest and participation by both students and lecturers. A wealth of audio-visual material is used. On Tuesday and Wednesday evenings, the great trial lawyers of the country conduct three-hour seminars on "Medicolegal Trial Technique."

New Library Planned

Law-Science Academy has recently purchased an adjoining building which will be converted into an incomparable law-science library. The goal of the Law-Science Academy and Foundation extends even further than the mere integration of law and medicine. It is hoped that an unique cultural center can be established at Crested Butte, where unusual, creative individuals in all the arts and humanities, can spend time together and receive stimulation from fields other than their own.

Thus, it is anticipated that, eventually, those who come primarily for law-science training and incidental family vacation activities, will have a variety of choices in the late afternoons, or evenings, to attend such cultural activities as a great book series, teas devoted to discussion of literature, art and painting, politics, economics, art appreciation and a host of other subjects calculated to be of deep interest to the inquiring mind. The dream of Crested Butte, is not only to sharpen minds, but to broaden them. Situated in a valley surrounded by towering mountains, Crested Butte has been acclaimed as one of the most beautiful spots in North America. Both lawyers and physicians are diversified in their intellectual interests, with predilections toward various arts, sciences and humanities, and their preliminary preparation for their professional careers, so Crested Butte's guests are likely to have ranging interests.

Monograph to be Issued

Running concurrently with the teaching plans at Crested Butte, is an ambitious publications program, now in its formative stages, designed to create criteria of proof in respect to the relationship of trauma to injury and disease. These will involve participation by the most eminent living medical authorities, as well as distinguished trial lawyers, and are expected to issue in monograph form, beginning at an early date.

The hand of welcome and of brotherhood is out to every lawyer, every physician and every scientist or professional man who feels a natural sympathy to the objectives of the academy and would like to be identified with its on-going programs. ◄

The Norbury Sanatorium

Established 1901 — Incorporated
Licensed — Jacksonville, Illinois

FRANK GARM NORBURY, A.M., M.D., Medical Director
HENRY A. DOLLEAR, M.D., Superintendent
FRANK B. NORBURY, M.D., Physician

Operating

Maplecrest—

Restful, congenial, homelike surroundings are combined with the most modern diagnostic and therapeutic equipment.

Maplewood—

Most comfortable home for individuals requiring rest, scientific diagnosis and treatment. Fireproof construction.

A man took his Great Dane to a veterinarian.

"Doctor, you've got to do something. My dog does nothing but chase small sports cars," he said.

"Well, that's only natural. Most dogs chase cars," the vet replied.

"I know," the man agreed. "But mine catches them and buries them in the backyard."—*The Fifth Wheel.*

Squibb Announces Chemipen

Squibb Alpha-Phenoxyethyl Penicillin Potassium

new chemically improved penicillin which provides the highest blood levels that are obtainable with oral penicillin therapy



As a pioneer and leader in penicillin therapy for more than a decade, Squibb is pleased to make Chemipen, a new chemically improved oral penicillin, available for clinical use.

With Chemipen it becomes possible as well as convenient for the physician to achieve and maintain higher blood levels—with greater speed—than those produced with comparable therapeutic doses of potassium penicillin V. In fact, Chemipen is shown to have a 2:1 superiority in producing peak blood levels over potassium penicillin V.*

Extreme solubility may contribute to the higher blood levels that are so notable with Chemipen.* Equally notable is the remarkable resistance to acid decomposition (Chemipen is stable at 37°C. at pH 2 to pH 3), which in turn makes possible the convenience of oral treatment.

And the economy for your patients will be of particular interest—Chemipen costs no more than comparable penicillin V preparations.

Dosage: Doses of 125 mg. (200,000 u.) or 250 mg. (400,000 u.), t.i.d., depending on the severity of the infection. The usual precautions must be carefully observed with Chemipen, as with all penicillins. Detailed information is available on request from the Professional Service Department.

Supply: Chemipen Tablets of 125 mg. (200,000 u.) and 250 mg. (400,000 u.), bottles of 24 tablets. Chemipen Syrup (cherry-mint flavored, nonalcoholic), 125 mg. per 5 cc., 60 cc. bottles.

*Knudsen, E. T., and Rolinson, G. N.: Lancet 2:1105 (Dec. 19) 1959.

"CHEMIPEN" IS A SQUIBB TRADEMARK.

SQUIBB

Squibb Quality—the Priceless Ingredient

A summary of a statement on H.R. 7624 and S. 2197 before the House Committee on Interstate and Foreign Commerce, Feb. 11, 1960.

On Behalf of

I APPEAR BEFORE this committee as chairman of the Committee for the Study of Carcinogenic Substances of the American Pharmaceutical Association. My statement will be confined to a discussion of the implications of the so-called cancer clause, or Delaney amendment, of H. R. 7624 and the Food Additives Act of 1958. The Senate did not include this clause in similar color additives legislation which passed there (S. 2197).

The Delaney amendment imposes a flat prohibition on the use of any substance which can be made to produce cancer when ingested by animals, even if the dosage is a million times that for intended use in man or if experimental conditions are totally unrelated to actual use. We will demonstrate that such a clause is unscientific and works against the broad public interest. We will show the restrictions it imposes on agricultural progress through limitations of research and will suggest a slight modification in its wording which will protect the public health but permit the public to benefit from technological advances.

The essential purpose of color additives legislation now before this committee is to provide for the safe use of certain chemicals. Yet the proposed cancer clause imposes precisely the same absolute or *per se* doctrine which the legislation before you is designed to correct.

Let me demonstrate the dangers of such a clause using as an example the substance diethylstilbestrol. This chemical has been safely used in both human beings and animals for years. Yet, under the Delaney amendment, its present use cannot be extended and new uses are prohibited.

It is especially significant, then, that the Food and Drug Administration has examined scientific information about stilbestrol on six occasions and declared this chemical safe for six different uses. In 1941, the FDA, after examining clinical results with stilbestrol in 8,000 women, cleared this chemical as safe. It sanctioned the uses of stilbestrol in animals in 1947, 1954, 1955, 1957 and 1959.

Stilbestrol Used Widely

Stilbestrol is now administered to an estimated 300,000 women and 50,000 men per year in the United States. In addition, it is fed to some 75% of all beef cattle on feed in this country.

Many publications of outstanding authorities in the field of endocrinology have demonstrated that stilbestrol is safe as administered to human beings. Within the past three months, articles have appeared in the *Western Journal of Surgery* and two issues of the *Journal of the American Medical Association* pointing out that there is no danger of cancer production from estrogen treatment.

With respect to the use of stilbestrol in animal feeds, many scientists have reported on the lack of residue in meats produced. The Secretary of the Department of Health, Education and Welfare has also stated that no detectable residue remains in beef and sheep fed stilbestrol.

Stilbestrol faces a continuing problem because it can be made to produce cancer in guinea pigs, Syrian hamsters, a few strains of mice and a few strains of rats. Most work has been done with mice specially bred to develop spontaneous cancers.

It is interesting to note that no cancers have ever been produced with stilbestrol in most strains of mice and rats, monkeys, dogs, cats, goats, rabbits, pigs, many breeds of chickens,

Pharmaceutical Manufactures

DR. THOMAS P. CARNEY
American Pharmaceutical Association

turkeys and pheasants. Neither has cancer been reported in the millions of cattle and sheep to which stilbestrol has been fed.

Another example of problems arising when the Delaney amendment is applied can be seen in the case of arsenicals. Several of these chemicals are used in poultry and swine.

Delaney amendment provisions have prevented the further clearances of arsenicals in feeds, even though it has never been demonstrated that the organic forms cause cancer. Like stilbestrol, the arsenicals had received prior sanction by the FDA.

In considering the safe use of substances that cause cancer in animals, a point of disagreement has been whether or not threshold levels exist. A threshold level is one below which an animal does not get cancer but above which an animal does.

Many references in the scientific literature indicate that at low levels many chemicals do not produce cancer, but at higher levels they do. The Department of Health, Education and Welfare has also arbitrarily established safe levels for radiation and has altered these levels from time to time, thus employing scientific judgment in determining safe limits of a known carcinogen.

In August 1959, Arthur S. Flemming, Secretary of the Department of Health, Education and Welfare, reported that radiation levels in alfalfa hay samples in four states were well *above* maximum permissible levels. But he pointed out that milk from cows fed this hay would have much lower levels and, therefore, would not be a current threat to public health.

Flemming said in a statement issued January 26, 1960, that setting tolerance levels on carcinogens must rest on an evaluation of both risks and values. But he admitted that quantitative evaluation can be considered in setting tolerances.

Chemicals have had a dramatic impact upon our agricultural economy and its ability to meet the needs of a rapidly growing population.

One hundred years ago a farmer in this country produced enough food for himself and three others. Today he produces enough for 25 besides himself. Farm production has increased 33% with 33% fewer farmers, in the past 20 years.

Our record of improvement in agricultural production is due to (1) mechanization, (2) better strains and (3) chemicals. Representative Dixon (R.-Utah) estimates that 40 to 50% of farm productivity improvement since World War II resulted from agricultural chemicals.

It would be disastrous to remove any one of these methods to boost farm production at the same time that our population is increasing at its present rate. If, for instance, stilbestrol had not been on the market, the farmers of this country would have had to produce 360,000 more beef animals in 1959 to supply the amount of beef [possible] with stilbestrol. This is enough beef to feed 2½ million people for one year.

The Food Protection Board of the National Academy of Sciences-National Research Council said in 1956:

> No one knows exactly what would happen if the use of pesticidal chemicals on the farm should be abandoned, but it is safe to say that we could not commercially produce apples, peaches, potatoes, citrus, and tomatoes, to mention only a few crops; and yields of others would be drastically reduced.

Continued

Distinction Between Toxicity and Hazard

In the same report this board pointed out that in dealing with chemicals the distinction between toxicity and hazard should be recognized. *Toxicity* is the capacity of a substance to produce injury; *hazard* is the probability that injury will result from its proper use. A compound might be highly toxic, but used properly it would not be hazardous.

It should be obvious from previous discussion that a restriction such as the cancer clause affects the entire economy. It prevents the use of agricultural chemicals that have been highly important in improving both quantity and quality of food.

To use an example, stilbestrol is estimated to have saved the farmers of Iowa $15 million in 1959. Without stilbestrol, it either would have cost farmers more to produce the beef or cost the consumer more to buy this beef. Multiply this example by the thousands of useful chemicals involved and you arrive at the billions of dollars saved the economy yearly.

anorectic-ataractic

BAMADEX®

meprobamate 400 mg., with d-amphetamine sulfate 5 mg., Tablets

FOR THERAPY
OF OVERWEIGHT PATIENTS

- d-amphetamine depresses appetite and elevates mood
- meprobamate eases tensions of dieting (yet without overstimulation, insomnia or barbiturate hangover).

Dosage: One tablet one-half to one hour before each meal.

A LOGICAL COMBINATION
IN
APPETITE CONTROL

Lederle

The Delaney amendment also curtails progress in another way. From two to five years and $750,000 to several million dollars are needed to develop a new product in the pharmaceutical industry today. If there is a possibility that a useful new chemical might be kept off the market because of the inflexible cancer clause, then research on this chemical must be dropped.

We have stopped work on items of this kind in our company. I can tell you, too, that one major industrial company has discontinued operations at its agricultural research farm because of the uncertainty of the future in this field.

Prevents Use of Safe Drug

We believe that in enacting the Delaney amendment Congress made a sincere effort to write a law to protect the general health and welfare. But we do not feel that it was the intent of Congress to prevent uses of substances safe for their intended purposes.

We have no objection to retaining the Delaney amendment if the right of scientific judgment is returned in its administration. To accomplish this, we propose a change in the wording of this cancer clause to read in part:

> A color additive shall be deemed unsafe . . . if the additive is found *in amounts and under conditions reasonably related to the intended use* to induce cancer when ingested by man or animal. . . .

We also believe that a similar change should be made in the Food Additives Act.

This leaves some element of scientific judgment in the hands of the FDA—the agency well qualified to exercise its discretion in the best interests of the public. ◄

The young doctor was completely baffled by his first patient's rash. He went into his private study and consulted his medical books without success.

Finally he returned and asked: "Have you had this before?"

"Twice," the patient wailed.

"Well," the doctor said knowingly, "you've got it again!"

—*Capsuled Comments*, May, 1960.



Cartoon idea by pharmacist Emil Magdalener

Many of you may have seen a recent cartoon depicting a midnight scene in front of a pharmacy. A woman is pounding on the door and the pharmacist is leaning out the window of his apartment over the store. "Open up," shouts the woman. "My husband is sick and I need a stamp so I can send this prescription to the mail order house."

The drug that always fails is the drug that isn't there

Far-fetched? Perhaps, but there are those who would have us believe that our present system of drug distribution is inefficient and costly, and should be replaced by presumably more efficient and cheaper centralized or bureaucratic methods. Disregarding the probable political philosophy behind these suggestions, consider what a marvelously intricate and efficient system of drug distribution we have in this country. • From the laboratories of the manufacturers comes a steady stream of new and better drugs for your patients. Warehoused and stocked by drug wholesalers, these products are available in over 53,000 pharmacies scattered across the length and breadth of our land. And woe to the pharmacist who hasn't been provided with yesterday's laboratory discovery for your use in treating a patient today. • The economists speak of "utility of time" and "utility of place." We simply say that you can confidently prescribe *what* you choose, *when* it is needed, *wherever* your patient may be.

This message is brought to you by the producers of prescription drugs as a service to the medical profession. For additional information, please write Pharmaceutical Manufacturers Association, 1411 K Street, N.W., Washington 5, D.C.

ABSTRACTS

BOOK REVIEWS

THE RELUCTANT SURGEON, a Biography of John Hunter

By John Kobler, Cloth, 359 pp. including appendix, bibliography and index; Doubleday & Co., Inc., Garden City, N. Y., 1960.

John Kobler is a *Saturday Evening Post* editor who has written articles on science and medicine with a facility and grasp of these subjects unusual in a layman. This background he needed and used to the full in writing *The Reluctant Surgeon.*

This is highly recommended reading for the busy physician, for it is not a mere recital of John Hunter's accomplishments. All of the biographical data, in ample detail, are seen in relation to the matrix of life in those days, when Samuel Johnson, Joshua Reynolds and Benjamin Franklin were part of the scene.

Conversely, the shabby and even criminal side of London at that time is pictured in a vivid manner, from body-snatching to high crimes and executions. All this —together with an understanding description of the medicine, surgery, dentistry and quackery of those days —forms a background against which John Hunter stands out as "the founder of scientific surgery." Although he was ahead of his time, in many ways he blends with the background of his day, and so remains human.

The physician will find here many details of Hunter's work which are unfamiliar, but which augment progressively the esteem in which he is already held. As a sample, his ability as a teacher is emphasized and documented by the numerous students of his "anatomizing" who became so famous in their own rights that we forget to note their teacher.

Such a list includes Edward Jenner and Matthew Baillie; and from America, John Morgan, the first professor in America's first medical school, Philip Syng Physick, William Shippen, Richard Bayley, Philip Post and Benjamin Waterhouse. "It was fitting that the American Philosophical Society, at the urging of its president, Benjamin Franklin, should have elected John Hunter an honorary member."

Besides the Hunterian Museum there are many medical entities named from the great physician: The Hunterian Chancre, Hunter's Canal, Hunter's Operation for Aneurysm, for instance. For 12 years, he and his brother William performed many experiments and produced beautiful dissections, previously undreamed of, before they separated and John continued in research as well as practice. Their laboratories were built from scratch and were entirely a private undertaking.

The "reluctant" part of the book's title is explained on page 108: "He early recognized the body's ability to marshal its own defenses against attack, . . . and he grew to rely as much on this natural property as on medication and the knife—perhaps his greatest contribution to surgery. In an age when virtuosos of the scalpel performed with the bravura of actors, John regarded surgery as an admission of defeat. 'It is like an armed savage,' he said, 'who attempts to get that by force which a civilized man would get by stratagem.' "

There are, of course, instances where Kobler's medical exposition betrays the layman, but this is all the greater tribute to John Hunter—that a layman could be so much interested in his scientific pursuits and struggles, so many years ago. Hunter lived from 1728 to 1793.

A. W. Cavins, M.D.
Terre Haute

Editorial Note—John Hunter was interested in medical societies and founded more than one. If modern doctors feel pushed around by having to attend so many meetings, consider John's activities in 1785:

Friday evenings "from eight-thirty to eleven being taken up by the deliberations of the Lyceum Medicum Londinense, meeting in the museum. Sunday afternoons, in the Leicester Square building, John presided over informal *conversaziones.* On the first and second Wednesday of the month he joined his fellow members of the medical society at Old Slaughter's Coffee-House for a symposium on common diseases. Once a month the Society for the Improvement of Medical and Chirurgical Knowledge gathered at New Slaughter's. In addition there were frequent conventions of the Royal Society, the Royal Society of Medicine and the Physical Society." Quotation is from *The Reluctant Surgeon* by John Kobler—A.W.C.

CARDIOLOGY—An Encyclopedia of the Cardiovascular System

Aldo Luisada, editor; McGraw-Hill Co., New York; 3600 pages, 4 volumes, loose-leaf set; $100.00. NEW.

The logarithmic growth of knowledge has resulted in a fragmentation of the field of medicine so that, today, there are more than two score recognized specialty areas. For this very reason, the general practitioner as well as the internist require ever more urgently source references in which they can find—quickly—answers to specific questions.

Dr. Luisada and his formidable array of 250 recognized cardiologists have made the historic attempt to fill just that need. This encyclopedia is nothing less than a deliberate approach to a *codification* of all contemporary knowledge in the field of cardiology. In time and in its area, this may come to be as important a landmark as the famous Code of Hammurabi of antiquity.

Dr. Luisada "farmed out" all conceivable cardiological topics to the collaborators; then he performed the staggering task of editing and correlating the mountain of manuscripts thus obtained. The result is the present set of 3600 pages, profusely illustrated, gathered in four loose leaf volumes. Every conceivable topic is covered even if the indexing is not as complete as one would crave for quick reference.

The publishers have used splendid paper, the printing and illustrations are very clear and the tremendous price of the set seems actually very cheap for the value being furnished the reader.

Like all works by many authors working together, the labors are not of the same high quality throughout Possibly, this may be because the editor has had to condense, prune, and even delete much meritorious material for sheer lack of space. This is the reason why Dr. Luisada states in the preface that he expects to expand the set to five volumes and 5,000 pages as "optimal size" is attained. In meantime, this is the main adverse criticism.

Just spot checking and without making any invidious comparisons, I may be emboldened to say that the discussion on rheumatic fever, while good, is on the prosaic side. Again, spot checking a more restricted topic as Fiedler's Myocarditis, much recent good work (in my opinion) appears to have been either omitted or deleted.

Of course, the editor has to make the decisions on the space to be allotted each topic. This set is not as complete a handbook as say Beilstein's has been in chemistry. However, it is far more than a textbook; actually, it comes very close to its avowed goal of being a compendium of cardiology in all its ramifications. The few deficiencies observed will, undoubtedly, be overcome when the inevitable expansion and corrections will begin to be felt as new leaves will begin to reach the subscribers. The editor will have to make continuous decisions as to the quality of the indexing, size of individual chapters, additions, alterations, deletions, etc. This is what will (or will not) make this encyclopedia a living, reliable, continuously up to date, reference work.

Overall, Dr. Luisada is to be congratulated on having had the courage and unflagging zeal with which to pursue this immense undertaking from inception to publication. This digest and synthesis of the entire field of cardiology is a feat of monumental erudition combined with discriminating judgment; it is a must for every medical library. It should be digested assiduously by all internists and cardiologists; I am sure that many general practitioners will buy—and really read—this most useful and practical encyclopedia on cardiology.

Arnold Lieberman, M.D.
New York, N. Y.

THE HARDING SANITARIUM
WORTHINGTON
OHIO

For the Diagnosis and Treatment of Psychiatric Disorders
and with
Limited Facilities for the Aging

GEORGE T. HARDING, M.D.
HARRISON S. EVANS, M.D.
Medical Directors
CHARLES W. HARDING, M.D.
Clinical Director
DONALD H. BURK, M.D.
GEORGE T. HARDING, Jr., M.D.
HERNDON P. HARDING, M.D.
C. RICHARD JOHNSON, M.D.
ARNOLD L. NIELSEN, M.D.
R. EUGENE PROUT, M.D.

GRACE M. COLLET, Ph.D.
VERNON W. SHAFER, Ph.D.
Clinical Psychologists
MARY JANE McCONAUGHEY, M.S.W.
BENJAMIN E. WHEATLEY, M.S.W.
Psychiatric Social Workers
PAULINE L. TOOILL, R.R.L.
Medical Record Librarian
JAMES L. HAGLE, M.B.A.
Administrator
ESTHER L. SIMPSON, R.N.
Director of Nurses

Phone: Columbus TUXEDO 5-5381

Blue Cross—Blue Shield Program for Federal Employees

(One of a series of articles prepared by Blue Cross-Blue Shield)

During the month of June, some 32,000 Federal employees selected a health benefit program —a high or low level Blue Cross-Blue Shield program, or a high or low level commercial program.

By the time this article is published, we will be well into the job of processing claims payable under this coverage. Your Indiana Blue Cross-Blue Shield will administer both the high and the low level basic program. The high level basic program will pay the full cost of semi-private room, board and all other customary hospital services up to 120 days per admission. The program provides surgical and anesthesia indemnities according to a fee schedule which approximates our own Indiana Preferred Schedule. Also included are allowances for doctor's visits in the hospital for non-surgical cases up to a maximum of 120 days per admission at $15.00 for the first day, $10.00 for the second, $4.00 for the next eight days and $3.00 for each day thereafter.

The Blue Cross-Blue Shield low level plan will pay the cost of semi-private room, board and other customary hospital services up to 30 days per admission. This plan provides surgical and anesthesia indemnities which are roughly equivalent to Indiana's Standard Schedule of Indemnities. Also included are allowances for doctors' visits in the hospital for non-surgical cases up to 30 days per admission at $3.00 per day. Both the high and the low level programs also provide allowances for diagnostic x-rays within 72 hours of an accident, in the doctor's office or in the outpatient department of a hospital.

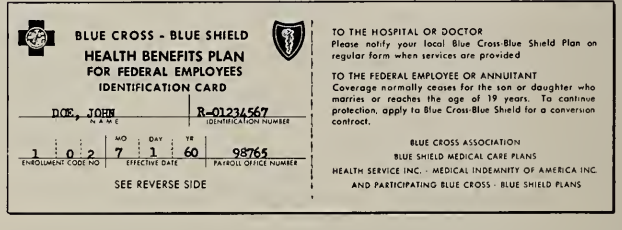
The Federal employee program also provides supplemental benefits covering such things as certain professional services not paid under the basic program, registered nurses, prescription drugs, x-ray and diagnostic laboratory procedures, braces, crutches, artificial limbs, etc. This part of the program is also on a high or low level option and, of course, must correspond with the selection of the basic plan.

The high option pays 80% of certain additional costs up to $20,000 after the member pays the first $100.00. The low level option covers supplemental benefits for long illnesses paying 75% of such additional costs up to $5,000 after the member pays the first $200.00.

The supplemental program as outlined above will be administered by the National Blue Cross and Blue Shield agencies and the local plan will not be directly involved.

Administration of the claims under the basic program will be conducted as in the past. For this program, doctors and hospitals will use the same claim reporting forms presently in use. Members participating in this program can be identified readily by the special Federal Employee Identification Card and by the prefix "R" in the Identification number. It will be necessary to have the identification number and the enrollment code number on all claims submitted. It is anticipated that there may be some member identification problems early in the program until all such members have received their new Identification Cards. With this exception the changeover should be a smooth one—since our basic administrative procedures will be much the same as the ones we are using now.

FEDERAL EMPLOYEE IDENTIFICATION CARD


BLUE CROSS - BLUE SHIELD
HEALTH BENEFITS PLAN
FOR FEDERAL EMPLOYEES
IDENTIFICATION CARD

DOE, JOHN
NAME

R-01234567
IDENTIFICATION NUMBER

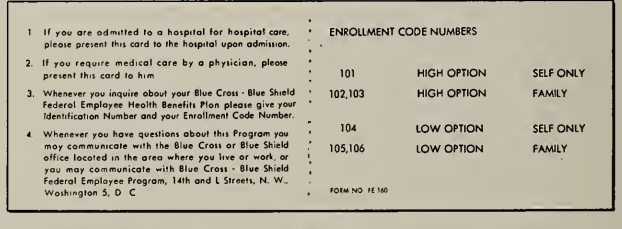
1 0 2	MO 7	DAY 1	YR 60	98765
ENROLLMENT CODE NO	EFFECTIVE DATE			PAYROLL OFFICE NUMBER

SEE REVERSE SIDE

TO THE HOSPITAL OR DOCTOR
Please notify your local Blue Cross-Blue Shield Plan on regular form when services are provided

TO THE FEDERAL EMPLOYEE OR ANNUITANT
Coverage normally ceases for the son or daughter who marries or reaches the age of 19 years. To continue protection, apply to Blue Cross-Blue Shield for a conversion contract.

BLUE CROSS ASSOCIATION
BLUE SHIELD MEDICAL CARE PLANS
HEALTH SERVICE INC. - MEDICAL INDEMNITY OF AMERICA INC.
AND PARTICIPATING BLUE CROSS - BLUE SHIELD PLANS


1. If you are admitted to a hospital for hospital care, please present this card to the hospital upon admission.
2. If you require medical care by a physician, please present this card to him
3. Whenever you inquire about your Blue Cross - Blue Shield Federal Employee Health Benefits Plan please give your Identification Number and your Enrollment Code Number.
4. Whenever you have questions about this Program you may communicate with the Blue Cross or Blue Shield office located in the area where you live or work, or you may communicate with Blue Cross - Blue Shield Federal Employee Program, 14th and L Streets, N. W., Washington 5, D. C.

ENROLLMENT CODE NUMBERS

101	HIGH OPTION	SELF ONLY
102,103	HIGH OPTION	FAMILY
104	LOW OPTION	SELF ONLY
105,106	LOW OPTION	FAMILY

FORM NO. FE 160

Identification Number and Enrollment Code Number must be entered on claim form. 101, 102, 103, 104, 105 and 106 are Blue Cross-Blue Shield Benefit Numbers.

W. C. Huddlestone
Public Relations Division ◄



GREETING GUESTS at a reception given by ISMA for Mrs. Ethel Gastineau, retiring president of the Woman's Auxiliary to the AMA were Mrs. Burton Kintner, Mrs. William Mackersie, Detroit, Michigan, who succeeds Mrs. Gastineau; Mrs. Gastineau, Dr. Earl W. Mericle, Mrs. Edward Rigley, Dr. Guy A. Owsley and Dr. and Mrs. Joseph Black.

Hoosiers Participate in AMA Miami Meeting; House of Delegates Actions Reported

TWENTY-NINE HOOSIERS traveled to Miami, Fla. as official delegates and as speakers, exhibitors and section delegates and officers for the 109th Annual Meeting of the American Medical Association, June 13-17.

ISMA House of Delegates members included Drs. Eli S. Jones, Hammond; Francis L. Land, Fort Wayne; Harold C. Ochsner, Indianapolis; Wendell C. Stover, Booneville and Gordon B. Wilder, Indianapolis.

Also attending were Drs. Earl Mericle, Indianapolis and Guy A. Owsley, Hartford City, president and vice-president, respectively, of ISMA; Mrs. Edward Rigley, South Bend, president of the Woman's Auxiliary to the ISMA; Dr. Cleon A. Nafe, Indianapolis, member of the AMA Board of Trustees; Mrs. Frank Gastineau, Indianapolis, president of the woman's auxiliary to AMA; Mrs. Joseph Black, Seymour, past-president of the Woman's Auxiliary to ISMA and Mr. James A. Waggener, ISMA executive secretary.

Representing the Section on General Practice was Dr. Lester Bibler, Indianapolis; Dr. Lall G. Montgomery, Muncie, was delegate from the section on Pathology and Physiology and also presented a scientific exhibit.

Hoosier officials of section organizations who attended the session were Dr. Charles L. Alvey, Muncie, vice-chairman, Section on General Practice and Dr. Myron Nourse, Indianapolis, assistant secretary of the Section on Urology.

Hoosier speakers and scientific exhibitors included Drs. Arthur J. Kuhn, Hammond; Leslie M. Bodnar, South Bend; Joseph B. Crowley, Notre Dame; John A. Campbell and Robert L. Campbell, Indianapolis; W. D. Snively, Jr., Evansville; D. C. Kohlstaedt, S. O. Waife and J. M. Mass, Indianapolis; Charles E. Jackson, Pierre C. Talbert and Harold D. Caylor, Bluffton and Ruth Drummond, Muncie.

Health care for the aged, pharmaceutical issues, occupational health programs, relations with allied health groups and relations with the National Foundation were among the major subjects involved in policy actions by the House of Delegates at the meeting.

Dr. Larson Named President Elect

Dr. Leonard W. Larson of Bismarck, N. D., former chairman of the AMA Board of Trustees and of the AMA Commission on Medical Care Plans, was named president-elect by unanimous vote. Dr. Larson will succeed Dr. E. Vincent Askey of Los Angeles as president at the Asso-

AMA Meeting

Continued

ciation's annual meeting in June, 1961, at New York City.

The AMA 1960 Distinguished Service Award, one of medicine's highest honors, was given to Dr. Charles A. Doan, who will retire next year as dean of the Ohio State University College of Medicine and director of the Health Center in Columbus, Ohio.

Total registration through Thursday, with half a day of the meeting still remaining, had reached 19,107, including 8,706 physicians.

Health Care For The Aged

After considering a variety of reports, resolutions and comments on the subject of health care for the aged, the House of Delegates adopted the following statement as official policy of the American Medical Association:

"Personal medical care is primarily the responsibility of the individual. When he is unable to provide this care for himself, the responsibility should properly pass to his family, the community, the county, the state, and only when all these fail, to the federal government, and then only in conjunction with the other levels of government, in the above order. The determination of medical need should be made by a physician and the determination of eligibility should be made at the local level with local administration and control. The principle of freedom of choice should be preserved. The use of tax funds under the above conditions to pay for such care, whether through the purchase of health insurance or by direct payment, provided local option is assured, is inherent in this concept and is not inconsistent with previous actions of the House of Delegates of the American Medical Association."

The House also urged the Board of Trustees "to initiate a nonpartisan open assembly to which all interested representative groups are invited for the purpose of developing the specifics of a sound approach to the health service and facilities needed by the aged, and that thereafter the American Medical Association present its findings and positive principles to the people."

In connection with an educational program regarding the aged, the House declared that "the American Medical Association increase its educational program regarding employment of those over 65, emphasizing voluntary, gradual and individualized retirement, thereby giving these individuals not only the right to work but the right to live in a free society with dignity and pride."

Earlier, at the opening session, Dr. Louis M. Orr, retiring AMA president, had asked the House to go on record favoring more jobs for the aged, voluntary retirement and a campaign against discrimination because of age, whether it be 40 or 65. The House also gave wholehearted approval to Dr. Askey's urging that state medical societies take an active part in state conferences and other planning activities preceding the January, 1961, White House Conference on Aging.

Pharmaceutical Issues

In the pharmaceutical area the House took two actions — one regarding mail order drug houses and the other involving the development and marketing of pharmaceutical products.

The House agreed with representatives of the pharmacy profession that the unorthodox practice of mail order filling of prescription drugs is not in the best interest of the patient, except where unavoidable because of geographic isolation of the patient. The statement pointed out that in this process the direct personal relationship, which exists between the patient-physician-pharmacist at the community level and which is essential to the public health and the welfare of patients, is lost.

The House also directed the Board of Trustees to request the Council on Drugs and other appropriate Association councils and committees "to study the pharmaceutical field in its relationship to medicine and the public, to correlate available material, and after consultation with the several branches of clinical medicine, clinical research, and medical education and other interested groups or agencies, submit an objective appraisal to the House of Delegates in June, 1961." The statement pointed out that certain proposals have been made which, if carried out, might impair the future of pharmaceutical research and development, thus retarding the progress of scientific therapy. It also said that the services of the pharmaceutical industry are so vital to the public and to the medical profession that an objective study should be made.

Occupational Health Programs

The House approved a revised statement on the "Scope, Objectives and Functions of Occu-

pational Health Programs," which was originally adopted in June, 1957. The new statement contains no fundamental alterations in AMA policy or ethical relationships, but it adds important new material on the following points:

1. Greater emphasis on the preventative and health maintenance concepts of occupational health programs.
2. A more positive statement of organized medicine's obligation to provide leadership in improving occupational health services by part-time physicians in small industry.
3. Increased emphasis on rehabilitation of the occupationally ill and injured.
4. Inclusion of the proper use of immunization procedures for employes, as approved by the House in 1959.
5. A more adequate statement on the need for teamwork with lay industrial hygienists in tailoring each occupational health program to the particular employe group involved.

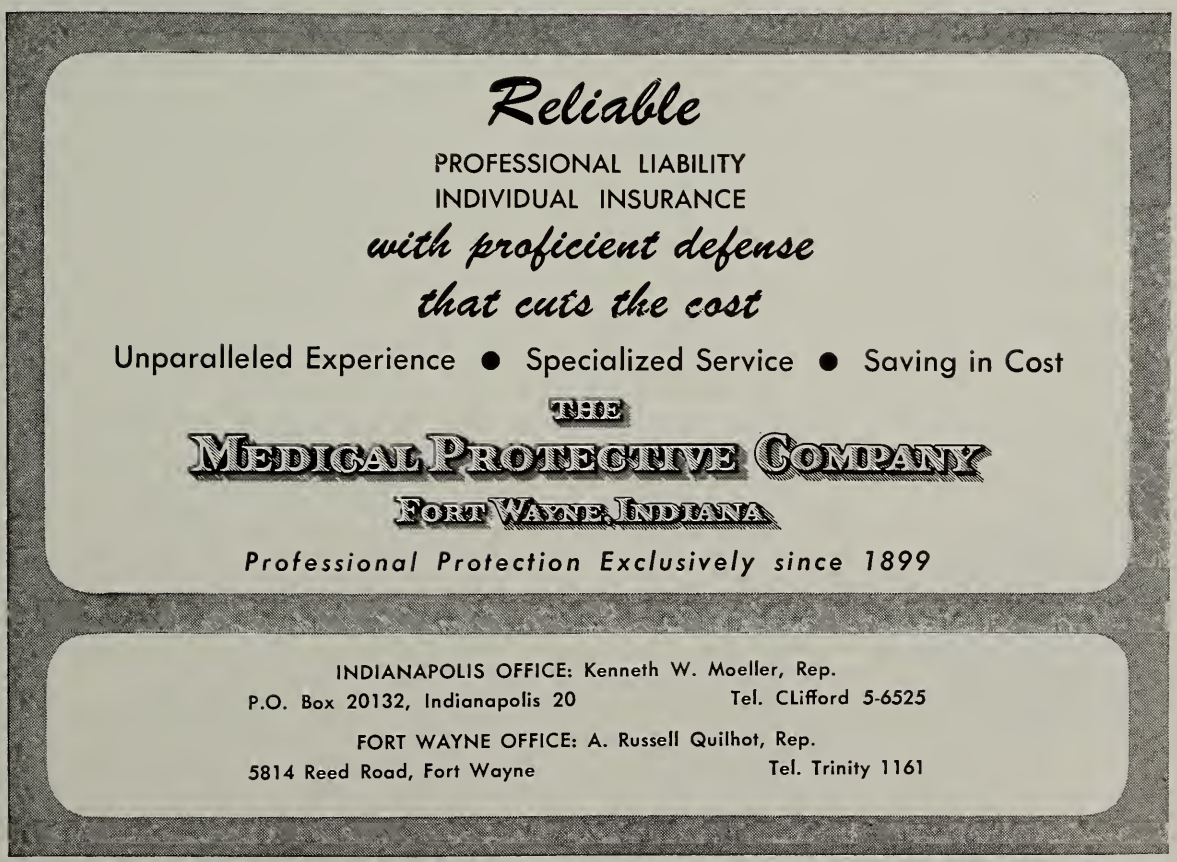
In approving the revised guides for occupational health programs, the House also accepted a suggestion that the AMA Council on Occupational Health undertake a project to study and encourage the employment of the physically handicapped.

Allied Health Groups

The House approved the final report of the Committee to Study the Relationships of Medicine with Allied Health Professions and Services and commended it as "a monumental work." The report covers the present situation, future implications and recommendations, including guiding principles and approaches to activate physician leadership. The House strongly recommended that AMA activity in this vitally important area be continued and it approved the appointment of a Board of Trustees committee to carry on the work.

To develop physician leadership in promoting cooperative efforts with allied health professions and services, the report suggested the following AMA activities:

1. A general conference should be held with allied scientists in the basic medical sciences and related disciplines for discussion of matters of common concern related to the creation of permanent, cooperative activities.
2. Specific exploratory conferences should be held with members of segments of science allied to a given area of medical practice



with the national medical organizations concerned.

3. General and specific conferences should be held with professional and technical assistants on education, recruitment and coordination of contributions.
4. Through meetings and publications, reciprocal exchange of information should be provided between physicians and allied scientists and members of health professions.
5. Effective, continuing liaison should be established between AMA representatives and professional and technical personnel.

National Foundation

The House took two actions involving relations between the medical profession and the National Foundation. It adopted a statement of policies for the guidance of state medical associations and recommended that they be adopted by all component medical societies. These policies cover such subjects as membership of medical advisory committees at the chapter level, the function of these committees, and basic principles concerning financial assistance for medical care, payment for physicians' services and physicians' responsibilities for constructive leadership in medical advisory activities.

In another action the House directed the Board of Trustees to authorize further conferences with leaders in the National Foundation on the problem of poliomyelitis as it relates to the betterment of the public health and to consider further joint action toward the eradication of polio. The House commended the National Foundation for its outstanding service in the attack against polio, but pointed out that much work remains to be done in public education, vaccination, continuing assistance for polio victims and continued research.

Miscellaneous Actions

In dealing with reports and resolutions on a wide variety of other subjects, the House also:

Strongly reaffirmed its support of the Blue Shield concept in voluntary health insurance and approved specific recommendations concerning AMA-Blue Shield relationships, including the addition of two members to the Board of Directors of the National Association of Blue Shield Plans. The new AMA board appointees would be selected from the Council on Medical Service and would serve in addition to the three AMA appointed members of the Blue Shield Board.

Approved a contingent appointment of not more than six months for foreign medical school graduates who have been accepted for the September, 1960, qualification examination;

Agreed that the American Medical Association should sponsor a second National Congress on prepaid health insurance;

Approved a Board of Trustees request to the Postmaster General for a stamp commemorating the Mayo Brothers;

Decided that the establishment of a home for aged and retired physicians is not warranted at this time.

Approved the establishment of a new "Scientific Achievement Award" to be given to a non-physician scientist on special occasions for outstanding work;

Approved the following schedule for future annual meetings: Atlantic City, 1963; San Francisco, 1964, and New York City, 1965;

Approved the objectives of the AMA Commission on the Cost of Medical Care established



by the Board of Trustees and headed by Dr. Louis M. Orr, immediate past president of the Association;

Urged individual members of the Association to take a greater interest and more active part in public affairs on all levels;

Reaffirmed its opposition to compulsory inclusion of physicians under Title II of the Social Security Act and recommended immediate action by all AMA members who agree with that position;

Called for a review of existing and proposed legislation pertaining to food and color additives, with the object of supporting appropriate measures which are in the public interest;

Urged reform of the federal tax structure so as to return to the states and their political subdivisions, their traditional revenue sources;

Asked state and county medical societies to make greater use of AMA recruitment materials in presenting medicine's story to the nation's high schools;

Requested the Board of Trustees to initiate a study of present policy regarding the required content and method of preparing hospital records;

Commended the Department of Defense and the Air Force for establishing and operating the Aeromedical Transport Service and urged that it be maintained at optimum efficiency;

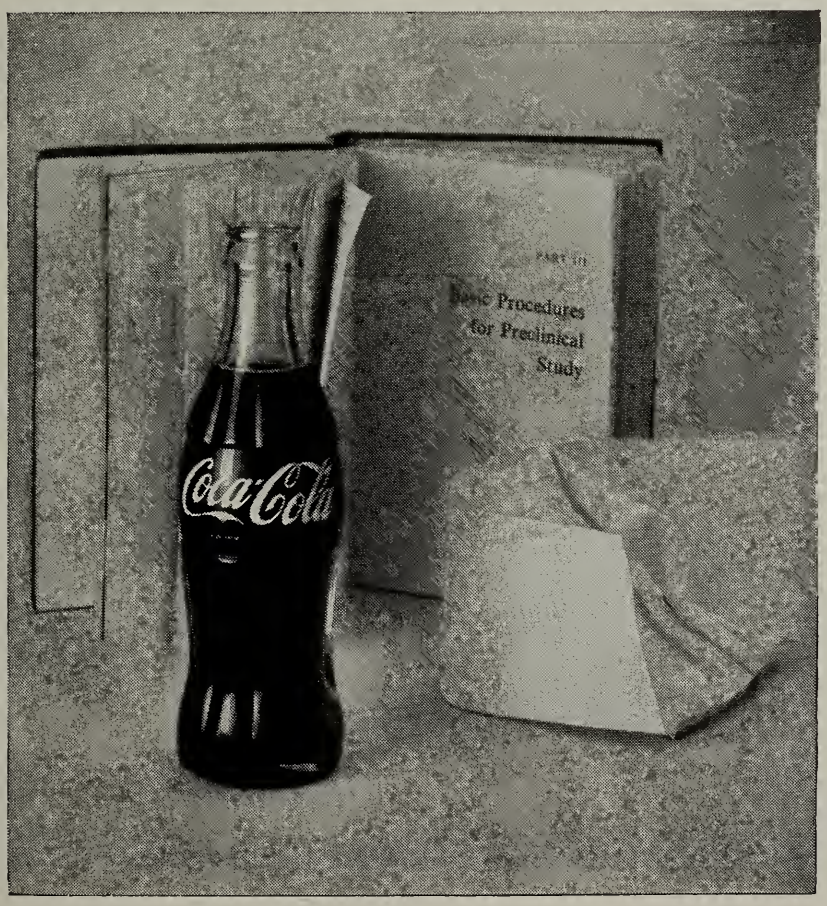
Directed the Board of Trustees to develop group annuity and group disability insurance programs for Association members; and

Expressed grave concern over the indiscriminate use of contact lenses.

Addresses and Awards

Dr. Orr, in his final report to the House at the opening session, urged medical societies to "adopt" rural villages, cities and regions in underdeveloped parts of the world and to send them medical, clinical and hospital supplies.

Dr. Askey, in his inaugural address Tuesday night, declared that medicine faces its greatest challenge in the decade ahead, adding that physicians must prove the effectiveness of medicine practiced in a free society. Dr. John S. Millis (PhD), president of Western Reserve University, Cleveland, Ohio, and guest speaker at the inaugural ceremonies, said the human dilemma of the sixties is an increasing desire for security and authority with a diminishing desire for responsibility.



When too many tasks
seem to crowd
the unyielding hours,
a welcome
"pause that refreshes"
with ice-cold Coca-Cola
often puts things
into manageable order.

DRINK
Coca-Cola
REG. U.S. PAT. OFF.

AMA Meeting

Continued

At the Wednesday session of the House, Dr. Askey urged intensified, accelerated effort in five areas—medical education, preparations for the White House Conference on Aging next January, health insurance and third party relationships, mental health, and membership relations.

The Goldberger Award in Nutrition was presented to Dr. Richard Vilter of the University of Cincinnati. The Boy Scouts of America, celebrating its golden jubilee, presented the AMA with a citation in appreciation of the medical profession's help and support. Dr. B. E. Pickett of Carrizo Springs, Texas, retiring chairman of the Council on Constitution and Bylaws, received an award in recognition of his long service.

Election of Officers

In addition to Dr. Larson, the new president-elect, the following officers were named at the Thursday session:

Dr. William F. Costello of Dover, N. J., vice president; Dr. Norman A. Welch of Boston, re-elected speaker of the House, and Dr. Milford O. Rouse of Dallas, Texas, re-elected vice speaker.

Dr. Gerald D. Dorman of New York City was elected to the Board of Trustees to succeed Dr. Larson, and Dr. James Z. Appel of Lancaster, Pa., was re-elected to the Board.

Elected to the Judicial Council, to succeed Dr. Louis A. Buie of Rochester, Minn., was Dr. James H. Berge of Seattle, Wash.

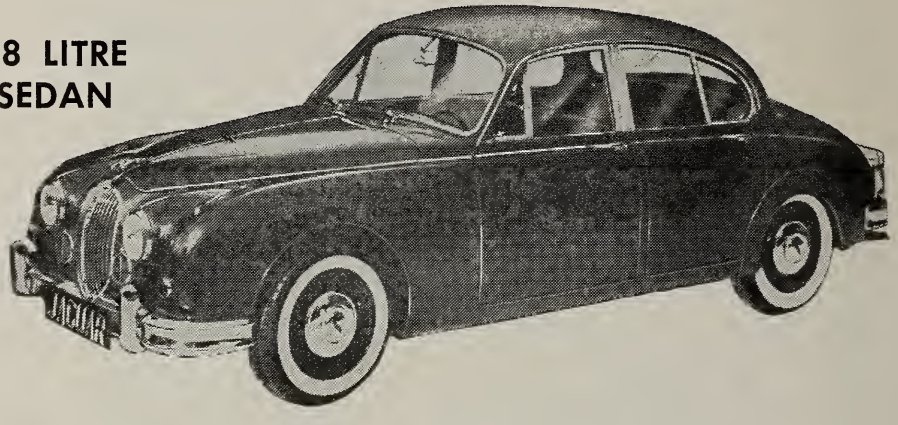
Named to the Council on Medical Education and Hospitals were Dr. William R. Willard of Lexington, Ky., succeeding Dr. James M. Faulkner of Cambridge, Mass., and Dr. Harlan English of Danville, Ill., who was re-elected.

On the Council on Medical Service, the House re-elected Dr. Russell B. Roth of Erie, Pa., and Dr. Hoyt B. Woolley of Idaho Falls.

Dr. George D. Johnson of Spartanburg, S. C., was named to succeed Dr. Pickett on the Council on Constitution and Bylaws. ◄

House of Delegates actions are listed as reported by Dr. F. J. L. Blasingame, AMA Executive Vice President.

NEW JAGUAR 3.8 LITRE FAMILY SPORTS SEDAN



The only car in the world that unites the vitality and spirit of a sports car with the roominess and comfort of a family sedan!

The Jaguar 3.8 sedan is a supreme achievement in performance, comfort and modern, functional styling in the highest Jaguar tradition. Full competition sports car power COMBINED with 5-passenger sedan luxury and comfort. Blazing acceleration and speed, with the famous Jaguar XK engine that has won countless trophies round the globe. Maximum safety with road-race-proved disc brakes. Greater visibility with wrap-around windows, thinner pillars. New high-output heating and defrosting system. Automatic transmission and power steering are optional. Also see the luxurious Mark IX sedan and the classic XK 150 sports models. Convenient terms!

JAGUAR
2330 NORTH MERIDIAN STREET

MIDWEST DISTRIBUTORS, Inc.
• INDIANAPOLIS



6-10 HOURS
SUSTAINED THERAPY

ONE and only ONE
Timed AMO*dex* CAPSULE
PER DAY will economically

control appetite in weight reduction or relieve the nervous symptoms of anxiety and the underlying depression.

Timed AMO*dex CAPSULES* (Testagar) furnish a controlled uniform action. The medications provide prolonged, continuous therapeutic effect from active ingredients over a period of 6 to 10 hours.

Following ingestion of one *Timed* AMO*dex CAPSULE*, small amounts of the medication are released immediately.

Each *Timed* AMO*dex CAPSULE* contains a daily therapeutic dose of:

Dextro-amphetamine hydrochloride	15 mg.,
Amobarbital	60 mg.

AMO*dex* ADVANTAGES

- HIGH-LEVEL ANOREXIGENIC ACTIVITY WITHOUT NERVOUS EXCITATION
- SMOOTH, UNIFORM ACTION
- THERAPEUTIC EFFECT LASTING 6 TO 10 HOURS
- ONLY ONE DOSE DAILY
- CLINICALLY ECONOMICAL TO THE PATIENT

PROTRACTED THERAPEUTIC EFFECT

Before the development of *Timed* AMO*dex* (Testagar) the usual dose of Dextro-amphetamine hydrochloride, for the control of appetite, was one 5 mg. tablet two or three times a day. The usual dose of Amobarbital ranged from 20 to 40 mg., two or three times a day. On such a dosage regimen the absorption of the drugs, after ingestion, takes place quite rapidly. The therapeutic activity occurs within one-half to one hour. When the therapeutic peak is reached, a gradual decline takes place. At this point, the patient should receive another dose of medication . . . the cycle is then repeated.

Patients frequently fail to follow the physician's instructions. They take medication at irregular intervals. When this occurs with drugs such as dextro-amphetamine sulfate, phosphate or hydrochloride, excitation may result. A balanced combination of Dextro-amphetamine hydrochloride, **the preferred salt,** plus a balanced daily dose of Amobarbital will give the expected therapeutic results *without* excitation.

Timed AMO*dex*, after ingestion, releases Dextro-amphetamine Hydrochloride and Amobarbital steadily and uniformly over a period of 6 to 10 hours. Therefore, the physician may dispense with the usual dosage schedule thereby *attaining better control of therapy*. The patient will receive the benefits of even and sustained therapeutic effects. Side reactions such as anxiety and excitation are greatly minimized.

ACTION AND USES

Timed AMO*dex CAPSULES* (Testagar) supply the antidepressant and mood-elevating effects of Dextro-amphetamine hydrochloride and the calming action of Amobarbital. *Timed* AMO*dex* elevates the mood, relieves nervous tension, restores emotional stability and the capacity for mental and physical effort.

Timed AMO*dex CAPSULES* are manufactured under these patent numbers:
2,736,682 — 2,809,916
2,809,917 — 2,809,918
Which provide prolonged, continuous therapeutic effect over a period of 6-10 hours

INDICATIONS

Timed AMO*dex* is the preferred treatment in anxiety states and in the management of obesity. *Timed* AMO*dex* may also be used in the treatment of Depressive states, Alcoholism, Nausea and Vomiting of Pregnancy.

DOSAGE The Daily Dose of *Timed* AMO*dex* (Testagar) IS ONE CAPSULE ON ARISING OR AT BREAKFAST.

SUPPLIED Bottles of 100 and 1000 capsules, available at all pharmacies. Also supplied in half strength as *Timed* AMO*dex*, Jr.

SAMPLES AND LITERATURE UPON REQUEST

Testagar & co., inc. 1354 W. Lafayette Blvd. Detroit 26, Michigan



I. U. Lists 36 Promotions In School of Medicine

Forty members of the instructional and research staffs of Indianapolis divisions of Indiana University received promotions July 1 by action of the University's Board of Trustees.

The University's annual list of faculty promotions, announced in Bloomington by Ralph L. Collins, vice-president and dean of faculties, includes 36 in the School of Medicine.

The promotions of full-time staff in the School of Medicine and their new ranks are as follows:

Professor—Drs. Arthur L. Drew, Ralph M. Reitan and Frank Vellios.

Associate Professor—Drs. Morris H. Aprison, William H. Bond, Carl W. Fuller, Alvin S. Levine, Harold Persky, James C. Shanks, Jr. and Francis L. Sonday.

Assistant Professor—Drs. Robert M. Armer, Edith Haynes, Ralph B. Lingeman, Jr., Bernard Lubin and Jack D. Summerlin.

Part-time members of the faculty of the medical school will move up to new ranks as follows:

Associate Professors — Drs. DeWitt W. Brown, Charles Fisch, P. D. Genovese, John Kooiker, Earl W. Mericle and Harvey W. Sigmond.

Assistant Professors—Drs. Thomas A. Brady, Robert B. Failey, J. Walter Kinzel, Joseph C. Ross, Sydney L. Stevens and Charles J. Van Tassel.

Instructors—Drs. William L. Franklin, James B. Hammond, Robert J. Healey and Arvine G. Popplewell.

Associates—Drs. Max Bartley, Charles Cure, Paul Merrell, I. E. Michael and Edward Schaffer.

Two Hoosiers to Speak At Postgraduate Meeting

Two Indianapolis physicians have been listed as speakers at the 45th scientific assembly of the Interstate Postgraduate Medical Association, Oct. 31-Nov. 3, at the Pittsburgh Hilton Hotel, Pittsburgh, Pa.

Dr. R. S. Griffith will discuss "Use and Abuse of Antibiotics," and Dr. Kenneth G. Kohlstaedt will speak on "Newer Concepts on Hypertension." The program provides Category I credit for A.A.G.P. members.

Additional information about the meeting can be obtained from the Association's central office, Box 1109, Madison 1, Wis.

Four Hill-Burton Projects Approved During April and May

The department of Health, Education and Welfare has reported status of Hill-Burton Indiana grants for the months of April and May to be as follows:

As of April 30, projects approved included Lafayette Home Hospital, Lafayette, $2,810,950, with federal share of $853,650, for 134 additional beds; St. Elizabeth Hospital, Lafayette, a $3,107,920 project, federal share being $850,640; and St. Anthony Hospital, Terre Haute, a $514,682 project with federal share amounting to $171,561.

On that date there were 67 projects completed and in operation, at a total cost of $71,917,484, with a $23,576,458 federal contribution and supplying 3,138 additional beds. Twenty-two projects were under construction, at a total cost of $22,880,221; federal contribution for these is $5,849,687; 825 additional beds will be provided.

Five projects were approved but not yet under construction as of April 30. They will supply

307 additional beds, at a total cost of $8,649,002, with a $2,603,184 federal share.

One project, at a total cost of $1,019,525 was approved during May for Mary Sherman Hospital, Sullivan. The federal share will be $332,-333; it will supply 43 additional beds.

As of May 31, 68 projects were completed and in operation, at a total cost of $72,673,838, including a $23,816,458 federal share and supplying 3,166 additional beds.

Also as of May 31, 23 projects, costing $24,-392,550, with a $6,333,914 federal share, and supplying 852 additional beds, were under construction.

Approved but not yet under construction were four projects, costing $7,453,077, including a $2,208,184 federal share and supplying 285 additional beds.

Dr. Eldred F. Hardtke, Indiana University psychiatrist and former president of the Owen-Monroe Medical Society, was recently installed as president of the Indiana Neuropsychiatric Association. Dr. George Rader, Indianapolis, is the new president- elect.

Allergists to Meet

Plans are being made for the annual meeting of the Midwest Allergy Forum, to be held at the Penn Sheraton Hotel, Pittsburgh, Pa., Oct. 22 and 23.

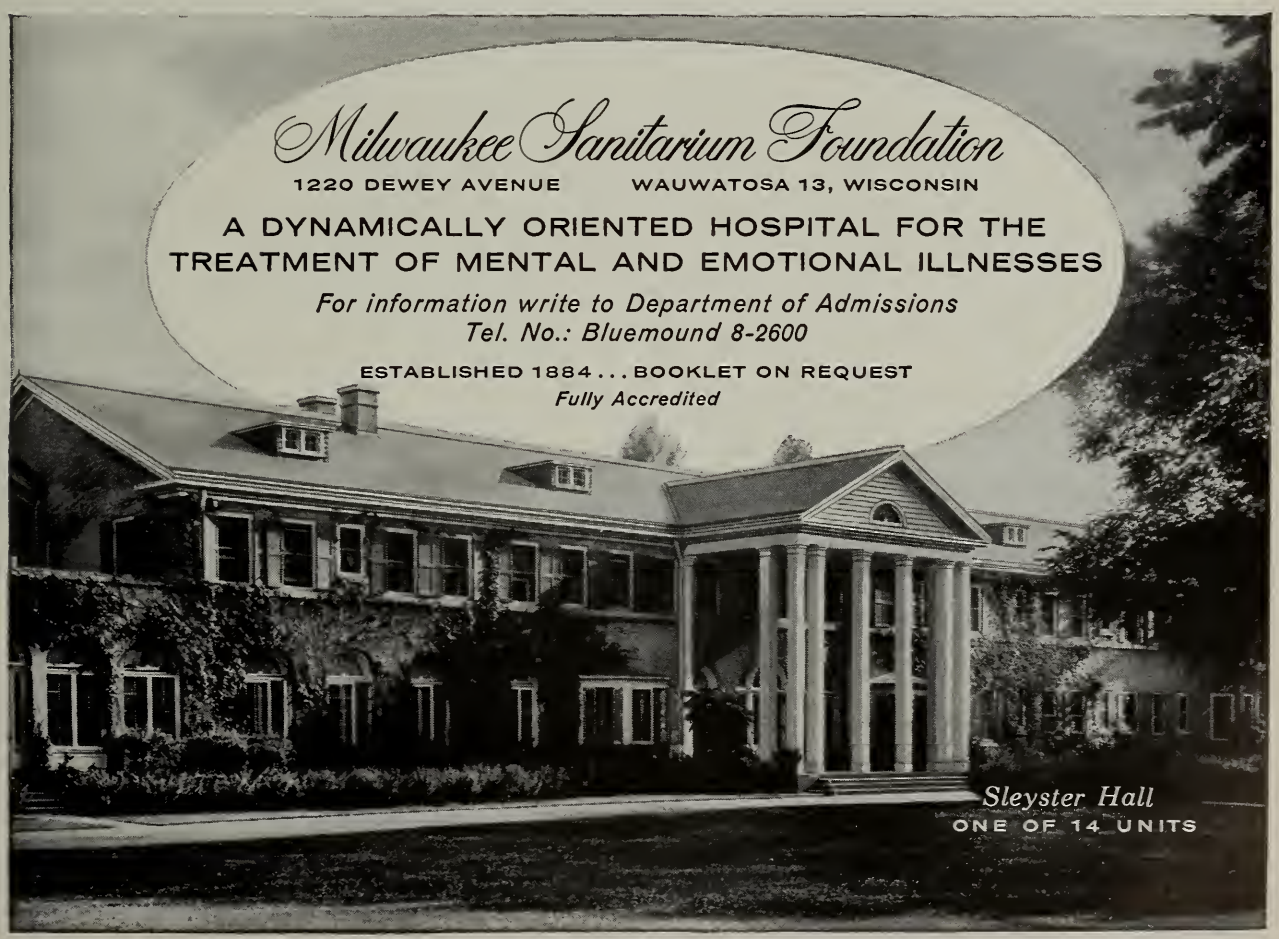
The program will include a panel discussion on chronic urticartic, drug allergy and repository therapy in addition to presentations on bronchial asthma.

Urological Association Offers Awards

The American Urological Association is currently offering awards totaling $1,000 for essays on the result of clinical or laboratory research in urology. First prize will be $500; second, $300 and third, $200.

Competition is limited to urologists who have been graduated not more than 10 years, and to hospital interns and residents doing research work in urology.

For additional information, write Mr. William P. Didusch, executive secretary, 1120 N. Charles St., Baltimore, Md. Essays are due before Dec. 1, 1960.

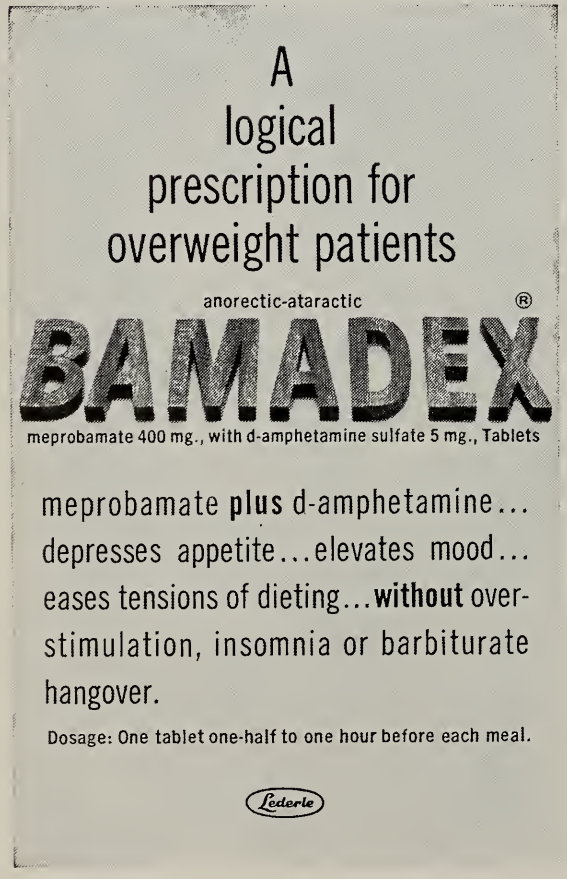


Surgeons-Anesthesiologists Program Features 14 Hoosier Physicians

Fourteen Indiana physicians took part in the scientific program at the annual meeting of the Indiana and Kentucky chapters of the American College of Surgeons and the Indiana and Kentucky societies of Anesthesiologists at French Lick, Ind., June 17-18.

An Indianapolis surgeon and editor of *The Journal,* Dr. Frank B. Ramsey, was chosen president-elect of the Indiana Chapter of the American College of Surgeons. Current president of the group is Dr. Harold Trusler, Indianapolis.

Hoosiers taking part in the scientific program were Drs. Willis D. Gatch, Indianapolis, "Care of the Terminal Cancer Patient;" Thomas Bauer, Indianapolis, "Burn Scar Deformities;" Stanley Battersby, Indianapolis, "Traumatic Injuries and Lacerations of the Trachea and Major Bronchi;" Harold Trusler, "The Control of Surgery" and Harold H. Davidson, Evansville, "Sin, Sex and Segregation."



Also Drs. David Bickel, South Bend, "Cause and Control of Hemorrhage in the Immediate Postoperative Period in Gynecologic Patients;" Mell B. Welborn, Evansville, "Management of Malignancies of the Rectum and Rectosigmoid Colon in Elderly Patients;" James McIntire, Indianapolis, "The Technic of Hemorrhoidectomy;" John Combs, Evansville, "Combination of Spinal and Endotracheal Inhalation Anesthesia for Upper Abdominal Surgery" and R. E. Lempke, Indianapolis, "The Problem of Mesenteric Vascular Thrombosis."

Others who presented papers were Drs. Richard H. Stein, Vincennes, "Paravertebral Sympathetic Block;" Thomas C. Moore, Muncie, "Predisposing Factors to Thrombo-Embolic Disease," and William Sholtz, Lafayette and Jack E. Pilcher, Indianapolis, panel discussion entitled "The Legal Aspects of Surgery and Anesthesia Problems."

Attending the program were two American College of Surgeons officials, Dr. Paul R. Hawley, retiring Director and Dr. John Paul North, who will take Dr. Hawley's place.

Special speaker at the annual banquet was Dr. Bell I Wiley, Professor at Emory University, on the topic, "Dear Folks."

Rhinologic Society Announces Plans For Sixth Annual Meeting at Chicago

The American Rhinologic Society has announced plans for its sixth annual meeting, at the Belmont Hotel, Chicago, Oct. 8.

Guest of honor and one of the speakers will be Dr. Henry L. Williams, Mayo Clinic, "Thirty Years of Experience in Rhinology."

A two-day surgical seminar in the Illinois Masonic Hospital, Chicago, will precede the meeting.

For information, write to Dr. Robert M. Hansen, Secretary, American Rhinologic Society, 1735 N. Wheeler Ave., Portland 17, Ore.

The medical section of the National Tuberculosis Association announced recently that it has changed its name from the American Trudeau Society to the American Thoracic Society.

Clinical results with *Trancopal*®[1]

	Excellent	Good	Fair	Poor	Total
LOW BACK SYNDROMES					
Acute low back strain	25	19	8	6	58
Chronic low back strain	11	5	1	1	18
"Porters' syndrome"*	21	5	1	1	28
Pelvic fractures	2	1	—	—	3
NECK SYNDROMES					
Whiplash injuries	12	6	2	1	21
Torticollis, chronic	6	2	3	2	13
OTHER MUSCLE SPASM					
Spasm related to trauma	15	6	1	—	22
Rheumatoid arthritis	—	18	2	1	21
Bursitis	2	6	1	—	9
TENSION STATES	18	2	4	3	27
TOTALS	112 (51%)	70 (32%)	23 (10%)	15 (7%)	220 (100%)

*Over-reaching in lifting heavy bags resulting in sprain of upper, middle, and lower back muscles.

Dosage: **Adults, 200 or 100 mg. orally three or four times daily.**
Relief of symptoms occurs in from fifteen to thirty minutes and lasts from four to six hours.

How Supplied: Trancopal Caplets®
200 mg. (green colored, scored), bottles of 100.
100 mg. (peach colored, scored), bottles of 100.

1. Kearney, R. D.: *Current Therap. Res.* 2:127, April, 1960.

1506M Trancopal (brand of chlormezanone) and Caplets, trademarks reg. U. S. Pat. Off.

Winthrop LABORATORIES, New York 18, N. Y.

Assistants Meet at Richmond, Mrs. Blance is New President

Wayne and Union county medical assistants were hosts to 160 members of the Indiana State Association of Medical Assistants at that group's fourth annual convention, April 30-May 1, at Richmond.



Mrs. Blance

Officers installed for the 1960-61 year are Mrs. Jean Blance, Fort Wayne, president; Evelyn Montgomery, Shelbyville, president-elect; Mary Jo Scott, Evansville, treasurer and Carolyn Appleby, Richmond, recording secretary.

Speakers for the convention included Grimsley T. Hobbs, Professor of Philosophy at Earlham College, "The Whys of Medical Morals," and Dr. Landrum Bolling, Earlham president, "World of Turmoil—the 1960's."

Those attending were guests at an "Oasis Party" and banquet, at a breakfast given by the Wayne-Union Medical Society and a Sunday Luncheon, with "Hawaii" as the theme. Charles Matthews, Earlham professor, presented a program on "After Luncheon Laughter."

The group is planning to hold its fifth annual convention at South Bend next year.

Heart Association Now Accepting Applications for Support of Studies

Applications from research investigators for support of studies to be conducted during the fiscal year beginning July 1, 1961 are now being accepted by the American Heart Association.

Announcement was made by officials of the Indiana Heart Association, affiliated with the AHA, who pointed out that the deadline for applying for research fellowships and established investigatorships is Sept. 15, 1960. Applications for grants-in-aid must be received by Nov. 1, 1960.

Further information and application forms regarding research awards may be obtained from the Assistant Medical Director for Research, American Heart Association, 44 East 23rd Street, New York 10, New York.

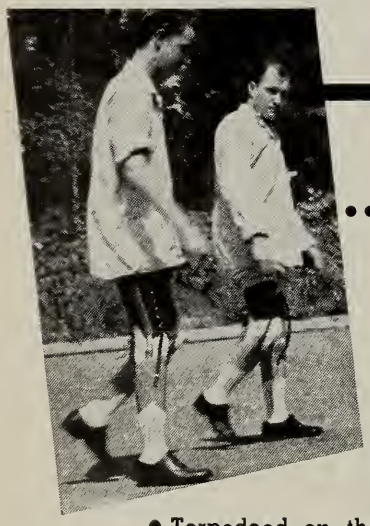
Stipends in all categories have been increased this year based on rising costs of living according to the Association.

The next scheduled examination, Part 1, written, of the American Board of Obstetrics and Gynecology, will be held in various U. S. cities, Canada and military centers outside continental U. S. on Jan. 13, 1961.

Candidates applying are not required to submit case reports, as previously required; they are required, instead, to keep in their files a duplicate list of hospital admissions as submitted with their application, for submittal at the annual meeting should they be eligible to take Part 2, oral, examinations.

Reopened candidates are required to submit case reports for review 30 days after notification of eligibility. Scheduled Part 1 and candidates resubmitting case reports are required to submit case reports prior to Aug. 1 each year.

Current bulletins are available by writing to Dr. Robert L. Faulkner, executive secretary, 2105 Adelbert Rd., Cleveland 6, Ohio.



...THEY CAN WALK AGAIN

• Torpedoed on the Murmansk run —nearly frozen to death in an open boat—both legs lost below the knee—ex-Merchant Marines Michael McCormick and William Morris walked unaided in three weeks. They could look forward with certainty to leading a normal life again. To these men, as to thousands of other Hanger wearers, the phrase "Hanger is a symbol of help and hope" is a concrete truth proven by every day of their future lives.

Hanger PROSTHESES

Air-Conditioned Offices

1529-33 N. Illinois St., Indianapolis 2, Ind.
3108 Burnet Avenue, Cincinnati 29, Ohio
Fairfield at Pontiac, Fort Wayne, Ind.
418 N. Main St., Evansville, Ind.

INDIANA STATE BOARD OF HEALTH

Monthly Report—June, 1960

Disease	June 1960	May 1960	Apr. 1960	June 1959	June 1958
Animal Bites	918	667	633	1264	831
Chickenpox	335	467	548	142	165
Conjunctivitis	155	153	130	68	65
Diphtheria	0	1	0	0	2
Dysentery, Unspecified	10	10	25	7	11
Impetigo	86	90	84	69	37
Infectious Hepatitis	28	58	77	19	10
Infectious Mononucleosis	16	30	20	8	20
Influenza	393	437	781	217	100
Measles (Rubeola-Rubella)	1514	1984	2028	582	1667
Meningitis, Meningococcal	6	2	5	2	1
Meningitis, Other	13	16	12	6	8
Mumps	473	445	441	248	323
Pertussis	21	37	38	44	139
Pneumonia	189	175	159	106	111
Poliomyelitis	2	0	1	7	0
Streptococcal Infections	429	692	1098	285	275
Tinea Capitis	33	43	39	7	8

OVER 80 YEARS' SPECIALIZED EXPERIENCE IN THE RESTORATIVE TREATMENT OF

"THE PROBLEM DRINKER"

At The Keeley Institute your patients are assured of receiving:

- the most modern, coordinated, comprehensive, rehabilitative regimen
- in addition to medical, nutritional and physiotherapeutic treatment, we also offer psychiatric diagnosis and psychotherapy
- full cooperation throughout with the referring physician
- in addition to the care of the alcoholic we also treat narcotic and drug addiction
- surprisingly low cost—to cover all medical care, medicines, laboratory work, room and excellent cuisine

You can obtain more detailed information by writing us direct.

WE WELCOME YOUR REFERRALS...

THE KEELEY INSTITUTE
DWIGHT, ILLINOIS

Member American Haspital Assaciation, Member Illinois Hospital Assaciatian. Licensed by the Department of Public Health, State of Illinais.

A LOGICAL ADJUNCT TO THE WEIGHT-REDUCING REGIMEN

meprobamate **plus** d-amphetamine... reduces appetite...elevates mood...eases tensions of dieting...**without** overstimulation, insomnia or barbiturate hangover.

Dosage: One tablet one-half to one hour before each meal.

anorectic-ataractic

BAMADEX®

meprobamate 400 mg., with d-amphetamine sulfate 5 mg., Tablets

Lederle

Deaths . . .

Marvin Sandorf, M.D.

An Indianapolis physician, attorney and civic leader, Dr. Marvin Sandorf, died May 31 in an Indianapolis hospital at the age of 57. He had maintained an office on the south side of Indianapolis for 20 years.

Dr. Sandorf was a graduate of Northwestern University and Loyola University School of Medicine, and took his residency at Cook County Hospital, Chicago. He also held a law degree from East Tennessee Law School, Knoxville, but was not a practicing attorney.

Active in civic affairs, Dr. Sandorf was a Mason, a member of the Unitarian church and belonged to the Indiana State Bar Association.

Leonard F. Swihart, M.D.

An Elkhart, Ind., ophthalmologist, Dr. Leonard F. (Jack) Swihart died May 28 at the age of 61.

He was a graduate of the Indiana University School of Medicine, took his internship at the University of Nebraska Hospital, and was in residency in Vienna, Austria before establishing practice in Elkhart.

Dr. Swihart had served on the Elkhart School Board as treasurer for nine years; he was a World War I Army veteran.

George A. Vail, M.D.

Dr. George Vail, 45-year-old Lawrenceburg physician, died June 3 at North Bend, Chio, in a boating accident.

A 1941 graduate of the Indiana University School of Medicine, Dr. Vail was on active duty as a medical officer from 1941-48.

He was on the staffs of Margaret-Mary Hospital, Batesville, Ind.; Good Samaritan Hospital, Cincinnati and Dearborn County Hospital.

Arthur J. Whallon, M.D.

A former president of the Reid Memorial Hospital Staff, Richmond, Dr. Arthur J. Whallon, died June 1 at the age of 73. He had held the office of president for five years, beginning in 1940.

Dr. Whallon was a 1911 graduate of the University of Cincinnati; he served his internship and residency at Cincinnati General Hospital.

Dr. Whallon served in the Army Medical Corps from 1917 to 1919 and was stationed in Europe for 15 months. ◄

District, County News



DR. FRANK LYMAN (left) opens one of a series of medical television panels presented in Evansville by the Vanderburgh County Medical Society this past spring. Pictured with Dr. Lyman are Drs. Robert Beck, Maurice FitzGerald and James Matthews.

The society has been invited to continue with the series next year. One moderator served throughout the past series; each program, however, had different panel personnel.

Clay

Dr. Jack R. Glosson, Clay City, has been named secretary-treasurer of the Clay County Medical Society. He succeeds Dr. Robert K. Webster.

Floyd

Twenty-one members of the Floyd County Medical Society met at New Albany June 6 to view the Parke-Davis film, "Sex Hormones."

Montgomery

Dr. Samuel C. Millis spoke on "Calculation of Fluids and Electrolytes" at the June 16 meeting of the Montgomery County Medical Society at Crawfordsville. Twenty-three doctors attended.

Eighth District

Newly-elected officers of the eighth District Medical Society are Drs. Stanley W. Burwell, president; Leland G. Brown, secretary; Gordon B. Wilder, councilor and Irwin S. Hostetter, alternate councilor. ◄



Carrying on congestion-free with fast-acting

NTZ® NASAL SPRAY

At the first allergic sneeze, two inhalations from the **NTZ** Nasal Spray act speedily to bring exceptional relief of symptoms. The first spray shrinks the turbinates and enables the patient to breathe through his nose again. The second spray, a few minutes later, opens sinus ostia for essential ventilation and drainage. Excessive rhinorrhea is reduced. **NTZ** is well tolerated and provides safe "inner space" without causing chemical harm to the respiratory tissues.

NTZ is a balanced combination of three thoroughly evaluated compounds:

- (N) **eo-Synephrine® HCl, 0.5%** to shrink nasal membranes and sinus ostia and provide inner space
- (T) **henfadil® HCl, 0.1%** to provide powerful topical antiallergic action and lessen rhinorrhea
- (Z) **ephiran® Cl, 1:5000** (antibacterial wetting agent and preservative) to promote spread and penetration of the formula to less accessible nasal areas

NTZ is supplied in leakproof, pocket size, squeeze bottles of 20 cc. and in bottles of 30 cc. with dropper.

QUICK SYMPTOMATIC RELIEF OF HAY FEVER OR PERENNIAL RHINITIS

Winthrop LABORATORIES New York 18, N. Y.

NTz, Neo-Synephrine (brand of phenylephrine), Thenfadil (brand of thenyldiamine) and Zephiran (brand of benzalkonium, as chloride, refined), trademarks reg. U. S. Pat. Off.

Commission Meetings

Constitution and Bylaws

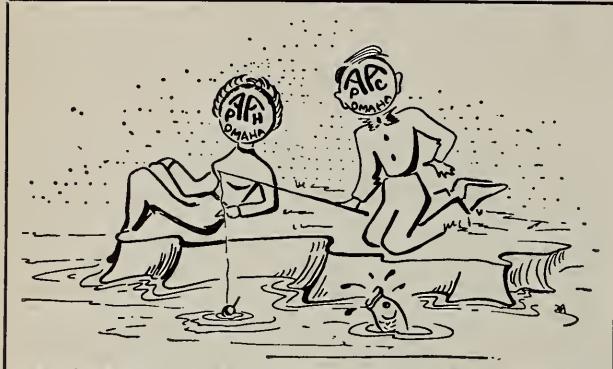
June 19, 1960

The Commission on Constitution and Bylaws of the Indiana State Medical Association met in a conference room of the Student Union Building of the Indiana University Medical Center in Indianapolis, at 1:55 p.m., June 19, 1960; Dr. Charles A. Jones, chairman, presiding.

The following commissioners were present: Drs. Lowell J. Hillis, John B. Cleveland, William B. Challman, A. W. Cavins, Truman E. Caylor, G. O. Larson and Robert M. Hansell. The following commissioners were absent: Drs. Dillon Geiger, Richard H. Woolery, Gordon Fessler, Howard E. Sweet, Irwin S. Hostetter, William M. Sholty and Philip J. Rosenbloom.

The minutes of the meeting held on April 24, 1960, were read and approved as corrected.

Dr. Cavins moved that the wording of the proposed amendment of the Bylaws be changed so that in Section 7 of Chapter XXV, the word, "transfer" replace the word, "membership." The motion was seconded, voted upon, and passed. Dr. Cavins moved that the word, "such" be interpolated between the word, "every" and the word, "physician," in the proposed amendment to Section 4, Chapter XXV, of the Bylaws of the Indiana State Medical Association. This motion was seconded, and passed.



PROTECTION AGAINST LOSS OF INCOME FROM ACCIDENT & SICKNESS AS WELL AS HOSPITAL EXPENSE BENEFITS FOR YOU AND ALL YOUR ELIGIBLE DEPENDENTS

ALL PREMIUMS COME FROM

PHYSICIANS SURGEONS DENTISTS

ALL BENEFITS GO TO

PHYSICIANS CASUALTY & HEALTH ASSOCIATIONS

OMAHA 31, NEBRASKA

Since 1902

Handsome Professional Appointment Book Sent to you FREE upon request.

Model Constitution and Bylaws

Dr. Cleveland presented a resume of the matter of developing a model constitution and bylaws under the aegis of Indiana State Medical Association for the information and convenience of any county medical society which may wish to have the assistance of such a compilation. In June, 1957, the Law Department of the American Medical Association prepared a model constitution and bylaws which was made available to Indiana State Medical Association, and which served as a basis for the preparation of a draft by a subcommittee of this commission for discussion and possible adoption by the commission as a model for use in this State.

Dr. Cavins stated that the Vigo County Medical Society had already availed itself of the American Medical Association version and had adapted it to the needs of that county society, and commented upon the extent of revision deemed desirable, despite the excellence of the American Medical Association preparation.

Dr. Challman moved that the draft prepared by a sub-committee of this commission be recommended to the county medical societies and those who are in conflict with it change their present constitution to conform with it or to adopt this model for their county society. Dr. Larson seconded this motion. Dr. Cleveland suggested that a detailed consideration be given to numerous provisions presented in the draft before any vote for adoption was taken. Dr. Challman then withdrew his motion; Dr. Larson concurring.

Dr. Cleveland requested a change in the order of business to consider a letter from the St. Joseph County Medical Society regarding the remission of dues to Indiana State Medical Association. After discussion, Dr. Cavins moved that the secretary of the commission be directed to answer the letter and state that the commission had previously considered this matter thoroughly before coming to its conclusion; that we were quite willing to consider the question further; that the commission would like for the society to enumerate the causes they think are, "good causes" in addition to, "financial hardship." Dr. Hillis seconded this motion. Motion carried. The secretary was further instructed to emphasize the time element involved in this connection because of the requirement of submission of final report of the commission by July 15.

The secretary of the commission then proceeded to read paragraph by paragraph the draft of a constitution and bylaws for a hypothetical and typical county medical society, which draft had been prepared by a subcommittee of this commission. Numerous changes were considered and many changes were decided upon; Dr. Cavins then moved that the commission approve for publication the model constitution and bylaws, as changed. This motion was seconded by Dr. Larson, voted upon and passed.

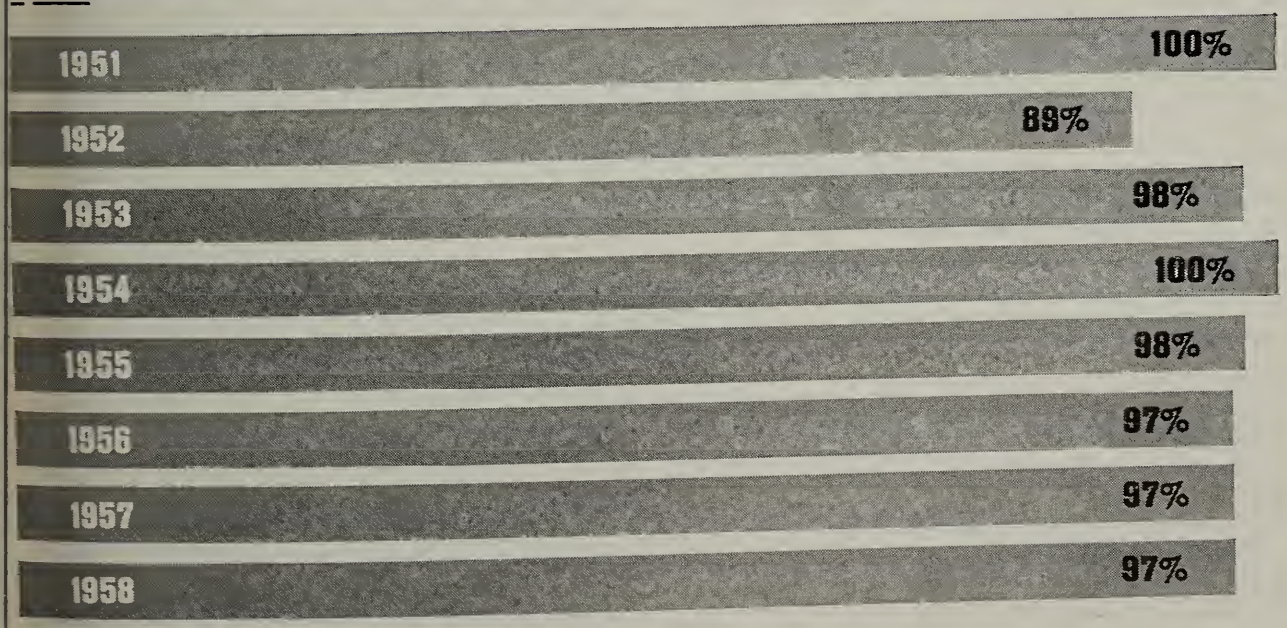
Dr. Larson moved that the commission commend the subcommittee which drafted this model constitution and bylaws for a county society. Dr. Cavins seconded the motion. Motion passed.

The meeting adjourned *sine die* at 4:45 p.m.

John B. Cleveland, M.D.
Secretary ◄



IN VITRO SENSITIVITY OF PYOGENIC STRAINS OF STAPHYLOCOCCI TO CHLOROMYCETIN OVER A PERIOD OF EIGHT YEARS*



Statistics were gathered over almost a decade on 329 children with staphylococcal pneumonia; 1,663 sensitivity tests were performed.

*Adapted from Rebhan & Edwards.[2]

10850

PARKE, DAVIS & COMPANY Detroit 32, Michigan PARKE-DAVIS

The Journal

September 1960

of the INDIANA STATE MEDICAL ASSOCIATION

Office of Publication:
1019 Hume Mansur Building, Indianapolis, Indiana

$1.00 per copy
except Yearbook
$5.00 per year

Contents

SCIENTIFIC

Reiter's Syndrome, Jack W. Hickam, M.D., Richard H. Childress, M.D., Indianapolis 1599
Cobalt-60 Therapy in Mammary Cancer, James C. Katterjohn, M.D., Indianapolis 1606
Postoperative Radiation for Carcinoma of the Breast, John W. Beeler, M.D., Indianapolis 1614
The Tuberculin Test, Edward W. Custer, M.D., South Bend 1618
The Case of the Changing Personality, Arnold Lieberman, M.D., New York, N. Y. 1623
Electrocardiogram of the Month: Diagnosis of Ventricular Tachycardia, Charles Fisch, M.D., Indianapolis 1629

EDITORIALS

Voluntary Plans Grow in Coverage, Benefits 1634
Complex—Controversial—Costly 1635
Foreign Medics Must Meet Standards 1636
Youngsters Are Safest 1637

SPECIAL FEATURE

Wings Over the World, John H. Furbay, Ph.D., New York, N. Y. 1648

CONVENTION SECTION

Section Begins 1725
Table of Contents to Special Convention Section 1790

REGULAR FEATURES

Month in Washington 1580
Fourth Estate 1588
Journal Medical Essay Contest 1622
Journal Offers $5 for Medical Anecdotes 1637
President's Page 1638
Woman's Auxiliary Reports to ISMA 1644
New Light on 'Over 65' Protection (one of a series) 1680
News Notes 1684
FDA Proposes Regulations on New Drugs 1684
New Amendments Rescind Several Civil Air Standards 1688
Board of Health Report 1694

BUSINESS

Executive Committee, July 9, 1960 1696
Budget Committee, July 9, 1960 1700
The Council, July 10, 1960 1700

EDITORIAL AND ADVERTISING INFORMATION

All articles must be typewritten, double-spaced with margins of one inch.

Photographs should be printed on glossy paper. Negatives cannot be used.

Illustrations are desirable. Selection of illustrations submitted at discretion of editor and editorial board members. Cost of color illustrations must be shared by the author.

Contributors are responsible for all statements made in their articles. The editors and editorial board members may not be in agreement with all views expressed by authors, but it is desired to give all authors as great latitude as possible. However, the right is reserved to reduce in length or reject any article.

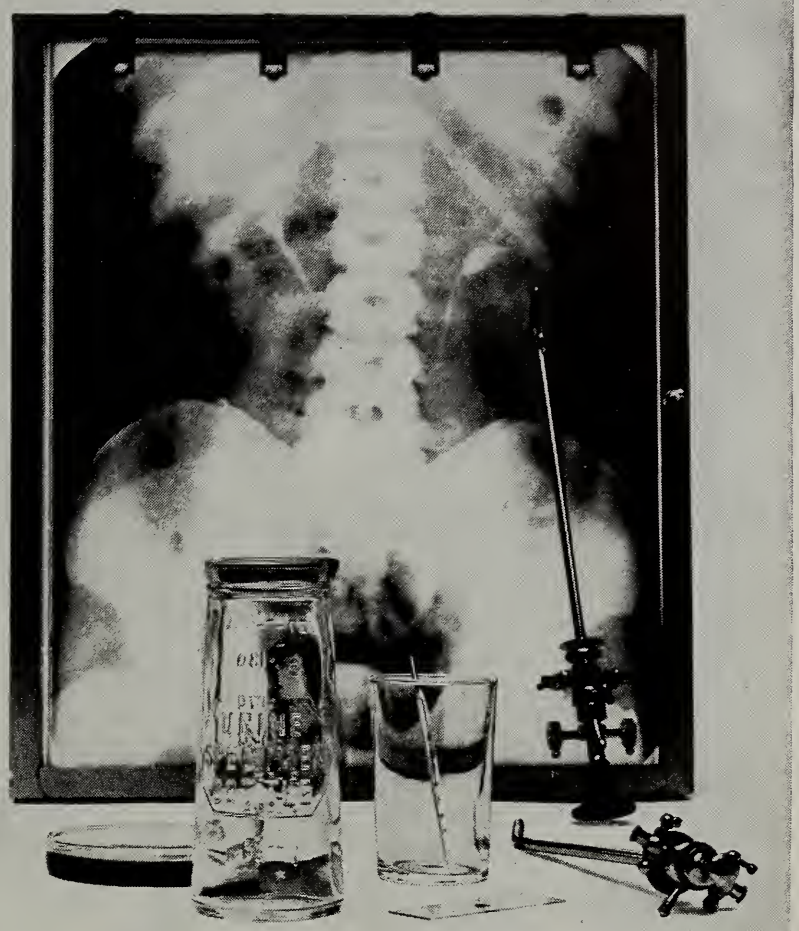
Articles are accepted for publication with the understanding that they are submitted for exclusive publication in THE JOURNAL of the Indiana State Medical Association.

Communications dealing with editorial matter should be sent to Frank B. Ramsey, M.D., Editor, 1802 North Illinois Street, Indianapolis 2, Indiana. All other communications should be sent to THE JOURNAL of the Indiana State Medical Association, 1019 Hume Mansur Building, Indianapolis 4, Indiana.

Advertising rates will be furnished on request. Copy must be received by the 5th of the month preceding month of issue. (Scientific manuscripts must be received at least two weeks earlier if geared for a specific issue.)

Entered as second class matter January 25, 1933, at the Postoffice at Indianapolis, Indiana. Copyright, 1960, by the Indiana State Medical Association. Published monthly at 1019 Hume Mansur Bldg., Indianapolis 4, Indiana.

when sulfa is your plan of therapy...



KYNEX®

Sulfamethoxypyridazine Lederle

OUTSTANDING 1-DOSE-A-DAY SULFA

Rapid peak attainment in 1 to 2 hours[1,2] . . . approximately one-half the time of other single-daily dose sulfas.[2] *High free levels*—as much as 95 per cent of circulating levels remaining in fully active unconjugated forms.[3] *Extremely low 2.7 per cent incidence of side effects* in toxicity studies on 223 patients.[4] Includes *total* reactions (subjective and objective), all temporary and rapidly reversed. No crystalluria reported.

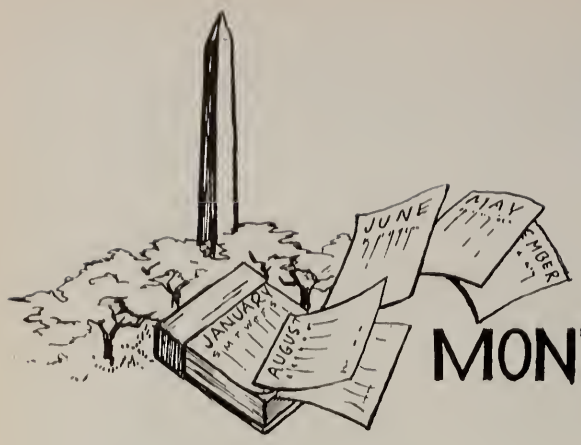
KYNEX TABLETS, 0.5 Gm., bottles of 24 and 100. Dosage: Adults, 0.5 Gm. (1 tablet) daily following an initial first day dose of 1 Gm. (2 tablets).
KYNEX ACETYL PEDIATRIC SUSPENSION, cherry-flavored, 250 mg. sulfamethoxypyridazine activity per tsp. (5 cc.). Bottles of 4 and 16 fl. oz.
New **KYNEX** ACETYL PEDIATRIC DROPS, cherry-flavored, 125 mg. sulfamethoxypyridazine activity per cc. In 10 cc. squeeze bottle.
New for acute G. U. infection **AZO KYNEX** TABLETS (for q. i. d. dosage), 125 mg., **KYNEX** Sulfamethoxypyridazine in the shell with 150 mg. phenylazodiaminopyridine HCl in the core.

Precautions: Usual sulfonamide precautions apply.

1. Boger, W. P.; Strickland, C. S., and Gylfe, J. M.: *Antibiotic Med. & Clin. Ther.* 3:378 (Nov.) 1956. 2. Boger, W. P.: In: *Antibiotics Annual* 1958-1959, New York, Medical Encyclopedia, Inc., 1959, p. 48. 3. Sheth, U. K.; Kulkarni, B. S., and Kamath, P. G.: *Antibiotic Med. & Clin. Ther.* 5:604 (Oct.) 1958. 4. Anderson, P. C., and Wissinger, H. A.: *U. S. Armed Forces M. J.* 10:1051 (Sept.) 1959.

LEDERLE LABORATORIES, a Division of AMERICAN CYANAMID COMPANY, Pearl River, New York

Lederle



This summary of what is happening in Washington is prepared by A.M.A.'s Capital office and airmailed to *The Journal* on the ninth of each month preceding month of issue.

MONTH IN WASHINGTON

WASHINGTON, D.C.--Democrats and Republicans are campaigning on opposing planks on the issue of health care for the aged. The Democratic party advocates the Social Security approach; the Republican party favors federal aid in the field, but outside the Social Security system.

The GOP plank pledged:

"Development of a health program that will provide the aged needing it, on a sound fiscal basis and through a contributory system, protection against burdensome costs of health care. Such a program should:

"--Provide the beneficiaries with the option of purchasing private health insurance -- a vital distinction between our approach and Democratic proposals in that it would encourage commercial carriers and voluntary insurance organizations to continue their efforts to develop sound coverage plans for the senior population.

"--Protect the personal relationship of patient and physician.

"--Include state participation."

The key paragraph of the Democratic plank stated:

"The most practicable way to provide health protection for older people is to use the contributory machinery of the Social Security system for insurance covering hospital bills and other high cost medical services. For those relatively few of our older people who have never been eligible for Social Security coverage, we shall provide corresponding benefits by appropriations from the general revenue."

Charles H. Percy, Chairman of the GOP Platform Committee, stated that the reference to a "contributory system" in the Republican plank did not mean a Social Security tax.

BOTH CANDIDATES SUPPORT HEALTH CARE FOR AGED

Presidential and Vice Presidential candidates of both parties went into the election campaigns pledged to support the health-care-for-the-aged planks adopted by their respective conventions. Vice President Richard M. Nixon, the GOP Presidential nominee, already was on record as unalterably opposed to any program of national compulsory health insurance. The long-established position of Sen. John F. Kennedy of Massachusetts, the Democratic Presidential candidate, has been "that only by use of the Social Security system can we have true health insurance."

Speaking for the American Medical Association, Dr. Edward R. Annis of Miami, Fla., appeared before the platform-drafting committee of the

Continued on page 1584



SALUTENSIN™

Hydroflumethiazide • Reserpine • Protoveratrine A

An integrated multi-therapeutic antihypertensive, that combines in balanced proportions three clinically proven antihypertensives.

In each **SALUTENSIN** Tablet:

Saluron® (hydroflumethiazide)— a saluretic-antihypertensive	50 mg.
Reserpine—a tranquilizing drug with peripheral vasorelaxant effects	0.125 mg.
Protoveratrine A—a centrally mediated vasorelaxant	0.2 mg.

Comprehensive information on dosage and precautions in official package circular or available on request.

BRISTOL LABORATORIES • Syracuse, New York

Continued from page 1580

Democratic convention at Los Angeles, and Dr. Leonard W. Larson, AMA President-elect, before the Republican policy group at Chicago.

The AMA spokesmen warned both parties that a program following the Social Security approach "would be unpredictably costly; it would unnecessarily cover millions of people; it would substitute service benefits for cash benefits; it would lead to poorer--not better-- quality of medical care; it would overcrowd our hospitals; it would lead to the decline, if not the demise, of private health insurance; and it would interfere dangerously with the doctor-patient relationship, which is the solid foundation upon which effective medicine must be based."

URGE SUPPORT OF MILLS PLAN

Dr. Annis also urged support of the House-approved Mills plan to provide health care for the needy aged who need help with the federal government and the states sharing the costs outside the Social Security mechanism.

In an advertisement run in some large daily newspapers in mid-August, the AMA outlined its reasons for supporting the Mills plan. The ad said, in part:

"The AMA believes our nation, as well as its senior citizens, will best be served by a locally administered health aid program designed TO HELP THOSE WHO NEED HELP...

"...We are equally sincere in our opposition to legislative measures that approach the problem on a shotgun basis--with the idea of increasing repeatedly the Social Security tax in order to finance health benefits for EVERYONE who is covered by the old age, survivors and disability insurance program, regardless of their need.

"There are many serious hazards in using the Social Security approach to finance medical and hospital care for our older citizens. When government starts telling the doctor how to practice medicine; telling the nurses how to nurse; telling the hospital how to handle its patients, the quality of medical care is sure to decline. The cost of such a program eventually would be staggering, and would make a serious dent in the pay envelopes of millions of Americans covered by Social Security. Private, voluntary health insurance, which has been doing such a magnificent job, would be undermined and, in time, destroyed.

"Most important, perhaps, is the fact that such an approach would just be the beginning of compulsory, government-run medical care for every man, woman and child in the United States. For it wouldn't be long before the Federal Government would be lowering the age at which people would be eligible, and adding one costly service after another to a program that would place your health care under the Federal Government's thumb. And let's not forget that our present health care is recognized to be the world's finest." ◄

-pain due to
or associated with
-spasm of skeletal muscle

a new muscle relaxant-analgesic

Robaxisal®

ROBAXIN® WITH ASPIRIN

Many conditions, painful in themselves, often give rise to spasm of skeletal muscles. ROBAXISAL, the new dual-acting muscle relaxant-analgesic, treats both the pain and the spasm with marked success: In clinical studies on 311 patients, 12 investigators[1] reported satisfactory results in 86.5%. Each ROBAXISAL Tablet contains:

- A relaxant component—Robaxin*—widely recognized for its prompt, long-lasting relief of painful skeletal muscle spasm, with unusual freedom from undesired side effects. . . . . 400 mg.

*Methocarbamol Robins U.S. Pat. No. 2770619

- An analgesic component—aspirin—whose pain-relieving effect is markedly enhanced by Robaxin, and which has added value as an anti-inflammatory and anti-rheumatic agent. . . . (5 gr.) 325 mg.

INDICATIONS: ROBAXISAL is indicated when analgesic as well as relaxant action is desired in the treatment of skeletal muscle spasm and severe concurrent pain. Typical conditions are disorders of the back, whiplash and other traumatic injuries, myositis, and pain and spasm associated with arthritis.

SUPPLY: ROBAXISAL Tablets (pink-and-white, laminated) in bottles of 100 and 500.

Also available: ROBAXIN Injectable, 1.0 Gm. in 10-cc. ampul. ROBAXIN Tablets, 0.5 Gm. (white, scored) in bottles of 50 and 500.

[1]Clinical reports in files of A. H. Robins Co., Inc., from: J. Allen, Madison, Wisc., B. Billow, New York, N. Y., B. Decker, Richmond, Va., C. Freeman, Jr., Augusta, Ga., R. B. Gordon, New York, N. Y., J. E. Holmblad, Schenectady, N. Y., L. Levy, New York, N. Y., N. LoBue, Chicago Heights, Ill., H. Nachman, Richmond, Va., A. Poindexter, Los Angeles, Cal., E. Rogers, Brooklyn, N. Y., K. H. Strong, Fairfield, Ia.

Additional information available upon request.

A. H. ROBINS CO., INC., Richmond 20, Virginia

Making today's medicines with integrity . . . seeking tomorrow's with persistence



LOOKS AT MEDICINE

This section of THE JOURNAL is devoted to the presentation of opinions which appear on the editorial pages of the public press, and which are of interest to the medical profession. Its function is to review comments which may be favorable or unfavorable to medicine. Members are invited to submit editorial clippings for this column.

More Than Medicine

An honest, clear look at America's elderly citizen can be the most instructive and constructive result of the current discussion of plans to provide government-aided health insurance for the aged.

What does the aged person expect of life in the U. S. A.? What does society today expect from the elderly citizen? What, really, is the problem faced by these older men and women of America?

Insofar as the immediate issue is concerned, it will be well to inquire now whether an extensive health program, however paid for and handled, would meet "the problem" of old age. The impression is being created that America's elderly people would be happy if they no longer had to worry over the financial cares connected with illness, medical treatment and hospitalization.

Relief from the anxiety of paying medical bills is important to the older citizens. Yet, they must realize and the public must understand that easing that painful situation will by no means resolve the central problem.

The real crux of the matter is that the elderly citizen is generally shunted aside once he crosses the artificial age limit of 65 years. His status changes abruptly from that of a productive member of his community to that of an idle one, often a dependent.

While the policy isn't spelled out that way, the country now operates on the basic premise that a man or woman over 65 "just isn't any good any more."

The elderly citizen knows this isn't so. But he stands alone against the pressures of government, the practice of industry and individual concepts. The older citizen is a worthwhile person, capable of making worthwhile contributions to society, but he is actively discouraged from such a role.

The real problem is that America's elderly citizens are denied the belief that they are doing something worthwhile for themselves and for others. The American accent on youth should at least be balanced with respectful attention for age, and its advantages.

The United States may have to educate itself once more to the fact that wisdom comes with years, and abilities accumulated over a lifetime are not to be lightly laid aside. The older citizen should retain a sense of personal importance.

Medical care is but a minor part of this very real, central problem. A man can be lonely and unhappy in spite of the best hospital treatment on earth.

The United States needs to establish a place of honor in its society for its elderly citizens, and this involves much more than money, laws and politics. America should apply fully the spirit of the Commandment which says, "Honor thy father and thy mother."

Indianapolis Star
April 4, 1960

Health Plans Lack Facts

Raymond Moley

With only weeks left of this session of Congress, there is small chance of any legislation for the medical needs of the elderly being passed and approved. If Congress passes the jerry-built plan introduced by Kennedy, Humphrey, Symington and McNamara, the President is certain to veto it. And Congress certainly will not pass the administration measure.

Continued



What's she doing that's of medical interest?

She's drinking a glass of pure Florida orange juice. And that's important to her physician for several reasons.

How your patients obtain their vitamins or any of the other nutrients found in citrus fruits is of great medical interest—considering the fact there are so many wrong ways of doing it, so many substitutes and imitations for the real thing.

Actually, there's no better way for this young lady to obtain her vitamin C than by doing just what she is doing, for there's no better source than oranges and grapefruit ripened in the Florida sunshine. There's no substitute for the result of nature's own mysterious chemistry, flourishing in the warmth of this luxurious peninsula.

An obvious truth, you might say, but not so obvious to the parents of many teen-agers.

We know that a tall glass of orange juice is just about the best thing they can reach for when they raid the refrigerator. We also know that if you encourage this refreshing and healthful habit among your young patients — and for that matter, your patients of any age — you'll be helping them to the finest between-meals drink there is.

Nothing has ever matched the quality of Florida citrus—watched over as it is by a State Commission that enforces the world's highest standards for quality in fresh, frozen, canned or cartoned citrus fruits and juices.

That's why the young lady's activities are of medical interest.

© Florida Citrus Commission, Lakeland, Florida



prescribe

NIPHYLLINE

the unique specific

This exclusive development is neutral in action, and ***specific in prophylaxis and treatment of angina pectoris.*** It is effective orally in about thirty minutes, for periods of 7 to 8 hours . . . and, even when given routinely, does not cause nausea or gastric upset. Niphylline is an efficient vasodilator and diuretic combining the effectiveness of Neothylline (soluble, neutral, stable derivative of theophylline) and pentaerythritol tetranitrate, substantially more effective than mannitol hexanitrate. Thus, the patient receives the benefits of both drugs without any annoying side effects.

Niphylline is safe, and well tolerated . . . exerts strengthening effect on heart muscles, and acts synergistically, remarkably reducing severity and frequency of cardiac attacks.

Indications: Relief and control of angina pectoris, cardiovascular symptoms, asthenia, coronary spasm with myocardial pain, prophylaxis and treatment of left ventricular insufficiency, cardiac dyspnea and oliguresis.

Dosage: One or two tablets, 3 or 4 times daily, or as directed by physician.

Supplied: Bottles of 100 and 1000 tablets.

Each tablet contains: Pentaerythritol tetranitrate, 10 mg., and Neothylline (dihydroxypropyl theophylline), 100 mg.

PM **PAUL MANEY**
LABORATORIES, INC.
Cedar Rapids, Iowa

Fourth Estate

Continued

The need for something is real, but it might be just as well to have it go over to the new Congress, when there will be less confusion and less political competition for votes. Meanwhile, it is very important that both the President and Congress devise some orderly way to explore the subject and bring in some vital facts.

Prepaid Illusion

Obviously, the administration's plan is the result of a compromise and hasty improvisation. For according to reports, Secretary Flemming wanted a different sort of bill and so did his more conservative brethren.

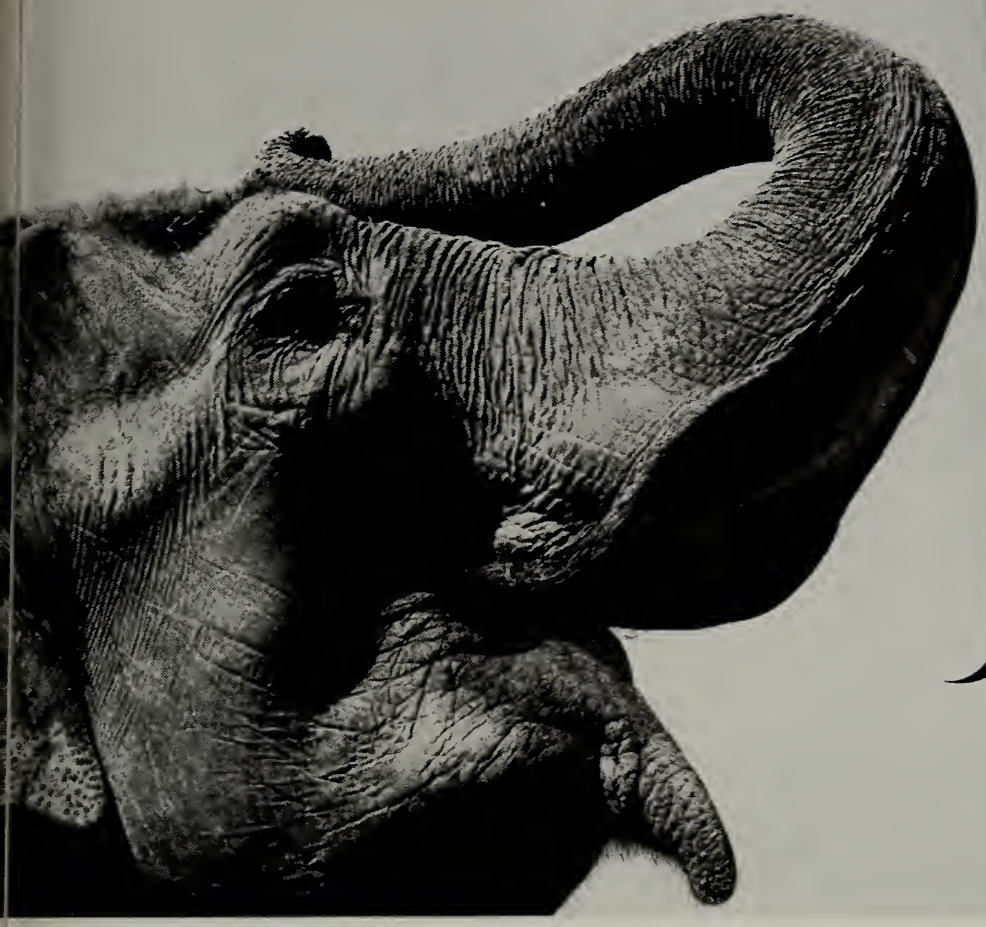
Any television viewer who saw and heard Sen. McNamara—whose subcommittee has traveled far and wide gathering information on the problems of the aged—expound his conclusions must have been shocked at his naïveté. He kept repeating that what his bill and the Forand bill seek is "prepaid" health insurance. The political purpose of this claim is to reassure those millions under 65 that the money taken in additional social security taxes is buying them something in the future, as well as providing for people who are now over 65. This idea of "prepayment" for security in old age was a major argument when the Social Security Act was passed in 1935 and which went into effect in 1937. But consider what those who were taxed then got in "prepayment." The dollars they then put into their so-called equity in the trust fund are now worth 52 cents.

I wish that the "Mr. 42" of 1937 might talk to the man who is "Mr. 42" today. He would tell him of the bitter disappointment he suffered as he saw inflation eat away the value of his savings as well as his equity in social security. What assurance could the man of 42 now have that this promise of "prepaid" health insurance would not prove to be another illusion, especially since the Forand bill and other spending proposals of the "liberals" would certainly keep the cycle of inflation moving?

There are other unanswered questions. Why not consider several forms of tax deductions, which so far as I have seen are ignored in all bills on medical care before Congress?

How about a tax deduction for children who want to buy insurance for their aged parents or contribute to the cost of the care themselves?

Continued



"Sometimes, when I have a running nose, I'd like to clear it with TRIAMINIC®— just to check out that systemic absorption business.

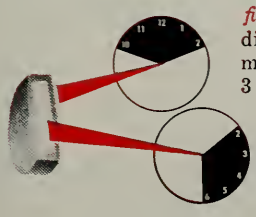
Reaches all nasal and paranasal membranes, huh?"

...and for humans with RUNNING NOSES...

You can't reach the entire nasal and paranasal mucosa by putting medication in a man's nostrils — any more than you could by trying to pour it down an elephant's trunk. TRIAMINIC, by contrast, reaches *all* respiratory membranes *systemically* to provide more effective, longer-lasting relief. And TRIAMINIC avoids topical medication hazards such as ciliary inhibition, rebound congestion, and "nose drop addiction."

Indications: nasal and paranasal congestion, sinusitis, postnasal drip, upper respiratory allergy.

Relief is prompt and prolonged because of this special timed-release action:



first—the outer layer dissolves within minutes to produce 3 to 4 hours of relief

then—the core disintegrates to give 3 to 4 *more* hours of relief

Each Triaminic timed-release Tablet provides:

Phenylpropanolamine HCl.....50 mg.
Pheniramine maleate.....25 mg.
Pyrilamine maleate.....25 mg.

Dosage: 1 tablet in the morning, midafternoon and at bedtime. In postnasal drip, 1 tablet at bedtime is usually sufficient.

Each timed-release Triaminic Juvelet® provides:

½ the formulation of the Triaminic Tablet.

Dosage: 1 Juvelet in the morning, midafternoon and at bedtime.

Each tsp. (5 ml.) of Triaminic Syrup provides:

¼ the formulation of the Triaminic Tablet.

Dosage (to be administered every 3 or 4 hours):

Adults—1 or 2 tsp.; *Children 6 to 12*—1 tsp.; *Children 1 to 6*—½ tsp.; *Children under 1*—¼ tsp.

TRIAMINIC®

timed-release tablets, juvelets, and syrup

STOP *running noses* *and open stuffed noses orally*

SMITH-DORSEY • a division of The Wander Company • Lincoln, Nebraska

This goes to the heart of a moral obligation as old as the human race.

Also, a tax deduction for physicians who provide medical aid without compensation? This has been a moral obligation for the medical profession since Hippocrates.

A more liberal tax break for employers who set up programs for their employes and ex-employes?

A tax deduction is always to be preferred to direct outlays by the federal government. For it emphasizes self-help and also less enlargement of the federal bureaucracy.

Facts, Not Oratory

Moreover, the estimated costs of all plans now before Congress are completely without reliability. The British National Health Service has cost vastly more than the estimates. No one can ever calculate what a free service will cost, because so many will take advantage of it who are not in need. It is reliably calculated by experts who are independent that the proposed $1.2 billion cost of one plan should be at least $2.5 billion the first year, and that the cost would rapidly mount after that. For when the service is free, uncounted thousands will immediately drop the insurance they are now carrying.

What are needed are more facts, rather than the oratory of a campaign year.

(Reprinted by permission of *The Plain Dealer* and Associated Newspapers Inc.)

Cleveland Plain Dealer
May 17, 1960

Drug Markup Needed

Fulton Lewis Jr.

WASHINGTON: The Senate's loudest investigator, Estes Kefauver, has adjourned his headline-gathering probe into the prescription drug industry, but he'll be back before the klieg lights and the TV cameras early next month.

Kefauver's drug hearings have created quite a stir among the political pros in the capital. The consensus is that the Senator has himself another winner, an investigation that may match in headlines his rackets investigation of almost a decade ago.

This doesn't mean that Kefauver has nabbed a villain; he hasn't. But the economics of the drug industry are so complex, so easily misunderstood, that the Tennessee Senator will probably be able to get away with his broadsides against the "drug profiteers" and his pious pleas for the "welfare of the nation's aged and sick."

Kefauver's newspaper publicity a fortnight ago followed his sensational charges that American drug manufacturers are reaping exorbitant profits at the expense of the consumer.

On the surface, drug markups appear high; in comparison to most other industries, they undoubtedly are. But this markup is a necessity if drug makers are to continue with the research and development programs that have supplied the solutions for countless diseases over the past decades.

The drug industry is spending some $200 million in basic research this year—10 cents out of every sales dollar as against one percent by the rest of American manufacturers. It amounts to a five-fold increase in the last 10 years, and within another decade American drug manufacturers will be spending a third of a billion dollars a year on such research.

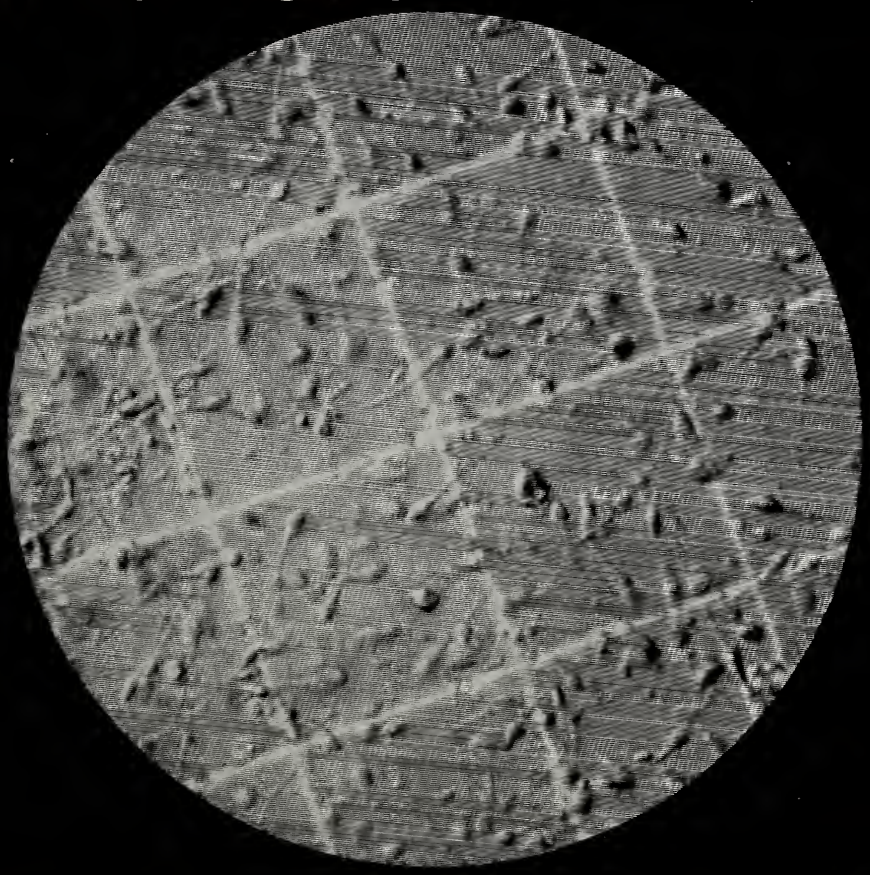
Yet only a small part of that research bears fruit. Last year the nation's laboratories worked with 114,000 different chemical substances. Nineteen hundred of those "ideas"—about two percent—showed enough promise for clinical testing. But of those 1900, fewer than 40 will ever become prescription drugs. This boils down to a laboratory success rate of some .0003.

Yet that fraction of one percent has meant the saving of millions of American lives. Nine-tenths of all drugs prescribed by doctors today have been introduced within the last 20 years. Fully 40% couldn't have been filled even five years ago.

Paradoxically, the high cost of research has served to bring down the price of many drugs. One of the original innovators of the arthritis-easing drug cortisone, Merck and Co., spent millions on further development and perfection of the drug. Within three years it had reduced the price of cortisone from $200 to $20 a gram.

When Kefauver's investigation resumes in January, the Senator is expected to hit hard at what he terms "price-fixing" by the 20 largest drug firms. Unable to come up with any evidence of collusion or other anti-trust violations by the drug manufacturers, Kefauver will level his fire at the so-called "recommended" retail

IN CONTRACEPTION...



PHOTOGRAPH: HUMAN SPERMATOZOA 400X. HEMOCYTOMETER DIFFUSION TEST.

WHY IS DIFFUSION IMPORTANT?

Because the active ingredients of a spermicidal preparation must diffuse rapidly into the seminal clot and throughout the vaginal canal to be clinically effective. Lanesta Gel offers this *dual* protection. Its four spermicidal agents quickly invade the clot to stop the main body of sperm. It spreads evenly and quickly throughout the vaginal canal—seeks out every wrinkle and fold that may offer concealment to sperm. With this rapid diffusion, your patient receives full benefit of the swift spermicidal action of Lanesta Gel — in minutes — a decisive measure in conception control.

In Lanesta Gel 7-*chloro-4-indanol,* a new, effective, nonirritating, nonallergenic spermicide, produces immediate immobilization of spermatozoa in dilution of up to 1:4,000. The addition of 10 per cent NaCl in ionic form greatly accelerates spermicidal action. Ricinoleic acid facilitates rapid inactivation and immobilization of spermatozoa and sodium lauryl sulfate acts as a dispersing agent and spermicidal detergent.

Lanesta Gel with a diaphragm provides one of the most effective means of conception control. However, whether used with or without a diaphragm, the patient and you, doctor, can be certain that Lanesta Gel provides faster spermicidal action — plus essential diffusion and retention of the spermicidal agents in a position where they can act upon the spermatozoa.



new Lanesta® Gel

Supplied: Lanesta Exquiset® . . . with diaphragm of prescribed size and type; universal introducer; Lanesta Gel, 3 oz. tube, with easy clean applicator, in an attractive purse. Lanesta Gel, 3 oz. tube with applicator; 3 oz. refill tube — available at all pharmacies.

A product of Lanteen® research.

Manufactured by Esta Medical Laboratories, Inc., Alliance, Ohio. Distributed by GEORGE A. BREON & Co., New York 18, N. Y.

Continued

prices that the companies suggest druggists follow.

Because the nation's 56,000 pharmacists must do its selling, a typical large firm, Parke, Davis, designs its "recommended prices" to give the pharmacist a 33% profit. Yet even with this seemingly high markup, almost a third of those 56,000 druggists ran in the red last year because of high operating costs.

Senator Kefauver to the contrary, prescription prices have not been skyrocketing. The cost of prescriptions in the consumer price (cost of living) index over the last decade has risen 19.5 points. The index for all other items rose 20.7 points in that same period.

Americans are actually paying about one percent more for prescription drugs than they did 20 years ago. It amounts to something like $12 a year for the average person. Putting that in some perspective, every man, woman and child in this country spends $34 a year for tobacco, and $55 a year for alcohol.

Cincinnati Enquirer
Dec. 29, 1959

(Copyright King Features Syndicate)

The Kokomo Shelter Plan

On Page One of *The Tribune* today is a story about the efforts of local civilian defense and the Kokomo Foremen's Club to complete a basement registration and assignment program in Kokomo. The program is designed to provide protection for families of this city if a nuclear blast should ever hit near the community.

Radiation from such a blast could be tragically destructive, as everyone knows. Families that have concrete fallout shelters would be protected the best, but those with ordinary home basements would, in the opinion of civil defense officials, have around 90% protection.

No one knows whether such a disaster will strike this or any other American community. The possibility exists, however, and the Foremen's Club has taken the initiative in promoting a basement registration plan to afford as much shelter as possible.

Under this plan, the foremen, with the aid of PTA groups in the 18 school districts of Kokomo, have been listing available basements and assigning families to their neighbors' basements. If the plan is completed 100%, every family in the city would have a shelter where it could go if a radiation threat should develop.

The only program the federal government has offered thus far is one which encourages families to construct concrete shelters. The response to this plan has not been widespread, and the next best idea, in the opinion of civil defense officials, is the Kokomo plan of basement assignment.

Beginning this week, the civil defense office here, together with the Foremen's Club, is making a special appeal to volunteers in the school districts to help organize the basement plan in their districts if they have not already done so, and is urging those in the districts where the program is partially completed to push its completion.

It is a worthwhile movement, deserving the cooperation of residents in all parts of Kokomo. There are varying opinions as to whether shelters will ever be needed, and there is apathy and indifference by some persons. But there is also enthusiasm and deep interest on the part of many citizens who have participated in the registration program so far.

If the city is completely organized for basement protection and no emergency ever comes, the time and effort will not have been wasted. Details of how to cooperate in the program are carried in the news story on Page One of this newspaper today.

Kokomo Tribune
June 13, 1960

Sen. Case's Proposal for Traffic Clearinghouse

Since it is estimated that one million drivers whose driver licenses have been revoked in their own states may obtain licenses in others, U. S. Sen. Clifford Case of New Jersey proposes a national clearinghouse for major traffic offenses. It would be comparable to the FBI's criminal files which supply identification data to law enforcement officials in all states. With such a central file, habitual traffic violators would be known not only in their own state, as at present, but throughout the nation.

Here are some things Sen. Case says his clearinghouse would record:

Continued

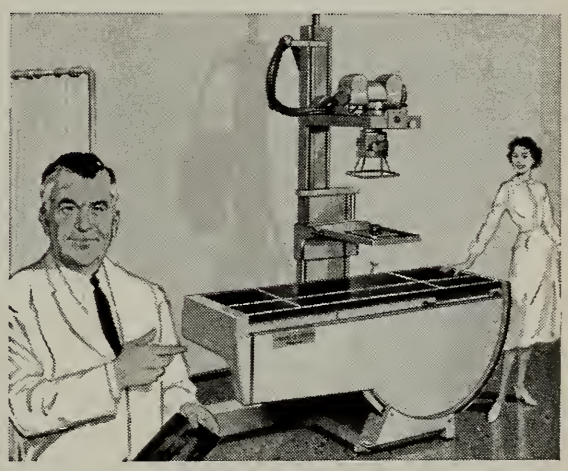
Don't settle for "slow-power" x-ray



get a full 200-ma with your Patrician combination

When anatomical motion threatens to blur radiographs, the 200-ma Patrician can answer with extreme exposure speed, *twice* that of any 100-ma installation. Film images show improved diagnostic readability . . . retakes are fewer. And you'll find the G-E Patrician is like this in everything for radiography and fluoroscopy: built right, priced sensibly, *uncompromising* in assuring you all basic professional advantages. Full-size 81″ table . . . independent tubestand . . . shutter limiting device . . . automatic tube protection . . . counterbalanced fluoroscope, x-ray tube and Bucky . . . full-wave x-ray output.

You also can rent the Patrician— through G-E Maxiservice® x-ray rental plan. Gives you the complete x-ray unit, *plus* maintenance, parts, tubes, insurance, local taxes — *everything*—for one, uniform monthly fee. Get details from your local G-E x-ray representative listed below.



Progress Is Our Most Important Product

GENERAL ELECTRIC

DIRECT FACTORY BRANCHES

CHICAGO
1061 W. Jackson Blvd. • SEeley 3-0700
CINCINNATI
3056 W. McMicken Ave. • MUlberry 1-7230—31
INDIANAPOLIS
1845 W. 18th St. • MElrose 5-4576
LOUISVILLE
501 W. Oak St. • JUniper 3-9562

RESIDENT REPRESENTATIVES

FORT WAYNE
H. J. WALLACE, 918 Oakdale • KEnmore 9749

Fourth Estate

Continued

1. Drivers of commercial vehicles whose licenses had been revoked or whose reciprocal driving privileges had been canceled by any state. This would be extended as soon as possible to the drivers of private cars.

2. Drivers of private cars or commercial vehicles convicted of contributing to accidents through drunken driving.

3. Drivers of commercial vehicles convicted of two or more "major" offenses in any state, such as reckless driving, disobeying traffic officers and greatly exceeding speed limits. Again, this would be extended to the drivers of private cars as soon as possible.

Case figures that a driver with two major offenses against him would have a record available to all states, and this record would grow if he committed further violations. Even if his own state failed to take action against him, other states could protect themselves, the Senator argues. They could withdraw reciprocal driving privileges and enforce their edict by periodic checks at their borders. Case thinks the drivers, knowing they were on record, would be more cautious, and as two-time losers they would risk never being able to drive anywhere again.

The Senator cites some good arguments for keeping dangerous drivers from moving into other states. He recalls the truck-bus crash last Oct. 9 in New Jersey which cost the lives of 11 college coeds and a professor. The driver of the truck which hit the bus had been convicted of eight moving (as against parking) offenses scattered through New Jersey, New York and Pennsylvania, yet he was still on the road. He also cites the deaths of nine persons in a crash between a bus and a truck near Tucson, Ariz., four days before Christmas. The truck driver in this case had at least half a dozen previous violations in another state, yet was still on the road.

Sen. Case's proposal for a national clearinghouse means, of course, that another federal bureau would have to be created to operate it. With the federal government so overrun with bureaus, and with more being proposed day after day, there is a question about the wisdom of establishing more of them. While the bureau advocated by Case has merit, it would be better, it seems to us, to try first to get all the states to adopt a compact—as has been done by some eastern states—among themselves under which they agree to send the record of all moving violations by a visiting driver to the authorities in his home state. If the worthy objectives outlined by the New Jersey Senator could be attained through a general compact between all the states, the taxpayers could be saved the expense of supporting still another federal bureau.

Kokomo Tribune
June 9, 1960

OVER 80 YEARS' SPECIALIZED EXPERIENCE IN THE RESTORATIVE TREATMENT OF

"THE PROBLEM DRINKER"

At The Keeley Institute your patients are assured of receiving:

- the most modern, coordinated, comprehensive, rehabilitative regimen
- in addition to medical, nutritional and physiotherapeutic treatment, we also offer psychiatric diagnosis and psychotherapy
- full cooperation throughout with the referring physician
- in addition to the care of the alcoholic we also treat narcotic and drug addiction
- surprisingly low cost—to cover all medical care, medicines, laboratory work, room and excellent cuisine

You can obtain more detailed information by writing us direct.

WE WELCOME YOUR REFERRALS...

THE KEELEY INSTITUTE
DWIGHT, ILLINOIS

Member American Hospital Association, Member Illinois Hospital Association. Licensed by the Department of Public Health, State of Illinois.

RADIUM
(including Radium Applicators)

For All Medical Purposes
Est. 1919

Quincy X-Ray & Radium Laboratories
(Owned and Directed by a Physician-Radiologist)

Harold Swanberg, B.S., M.D., Director
W.C.U. Bldg., Quincy, Illinois

Deportment

As we write this bulletin the Indiana Department of the American Legion is meeting in annual convention at the Claypool. The decorum of delegates is excellent compared to meetings of yore. Yes, they brought their 40 hommes and 8 chevaux for the parade, their informal clothes, and the traditional French overseas cap with decorations attesting personal achievements during the years in the Legion. The "makings" for some lively parties are in evidence. But rowdiness that characterized so many past gatherings of the Legion seems to be gone. For this we are thankful.

Hoopla, we guess, has been appropriated by the political party convention goers. A recent political state convention group that we had to live with for a couple of days, made the Legion look like a Sunday School party. And out there in Los Angeles, such shenanigans that went on, plus the make-your-own-rules-as-you-go-along, make one wonder how wise it is to entrust the choosing of leaders to mob hysteria. After all, a great country and 180,000,000 people are concerned in its government and who runs it. A Harvard "Old Grad" day to crown the most popular alumnus belongs on the campus, not in the arena of great political decision.

Possibly the time has come for a saner and better way to nominate candidates for public office. We don't want Democracy to change into "Mobocracy."

Bulletin
Rotary Club of Indianapolis
July, 1960

'Me, Too?'

Some "Me, too" Republican senators have hatched a plan for spending government funds on a so-called medical care program for elderly citizens.

This must be pleasant to Walter Reuther and the other "liberals" of organized labor who have managed to drum up an election-year issue. One of the mysteries not yet explained is how the nation managed to get along from 1776 until today without a program of government-controlled medicine.

The explanation is that the "liberals" are always ready to make an issue from any idea which involves greater taxation, greater deficit spending and greater Federal control over the life of the people.

Indianapolis Star
April 17, 1960

◄

...MALNUTRITION OR
LEG CRAMPS DURING PREGNANCY?
OUTMODED AS GODEY'S FASHIONS!

℞ NEW
PRENALIN-O®
PRENATAL SUPPLEMENT

1. Oyster Shell Calcium - Phosphorus Free!
2. New Form of Iron!
3. Dry Filled Capsule - Sure, Quick Absorption!
4. Economical Once-A-Day Dosage!
5. Wider Range Nutritional Support!
6. Relieves Troublesome Leg Cramps!

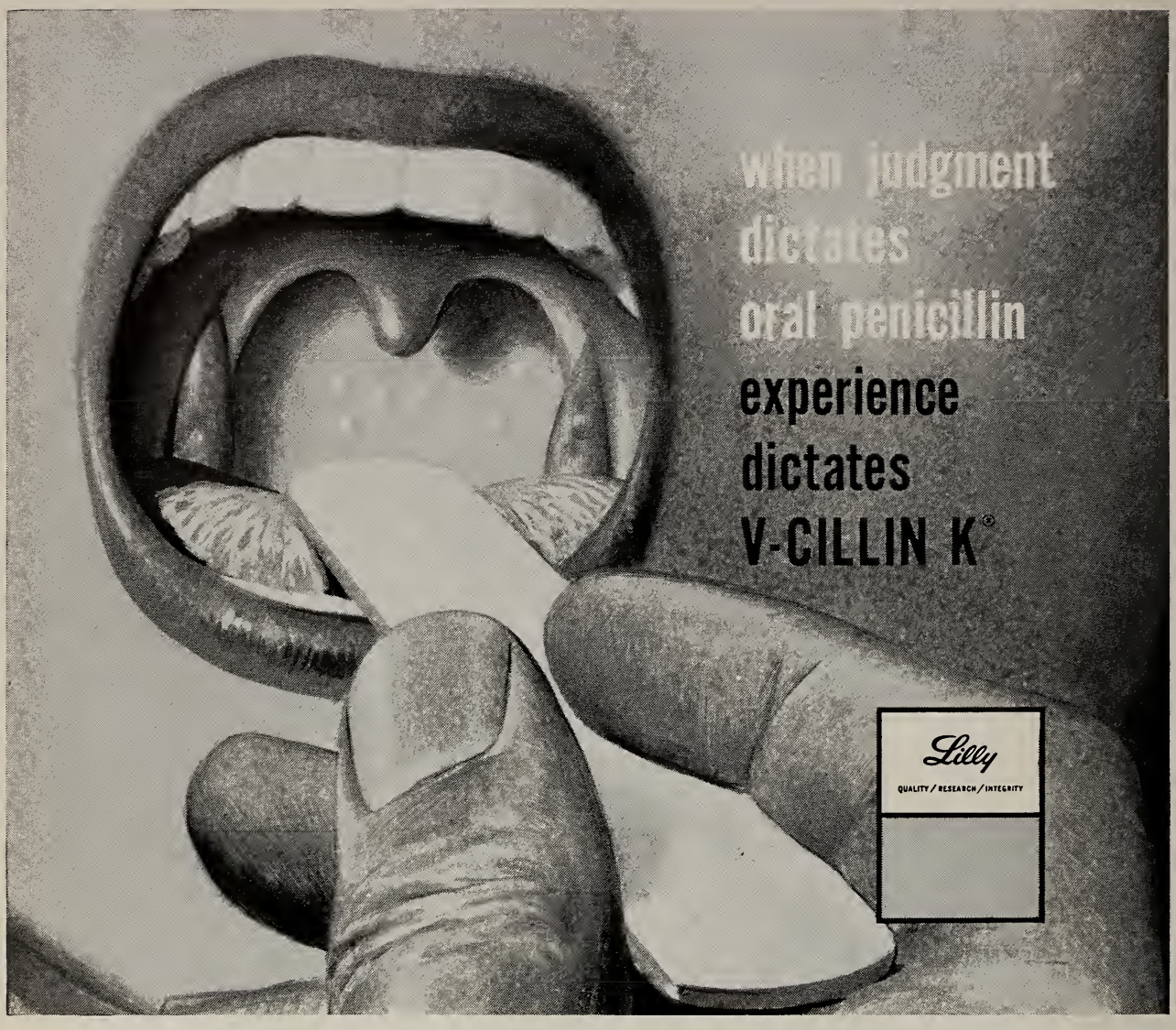


EACH dry filled capsule (lavender and white) provides:

Ferrous Fumarate (Iron)	150 mg.	Vitamin B-12 (Cobalamin conc. NF)	2 mcg.
Deep sea oyster shell (Calcium)	600 mg.	Folic Acid	0.25 mg.
Vitamin C	50 mg.	Niacinamide	10 mg.
Vitamin A	4000 USP Units	Vitamin K (Menadione)	0.25 mg.
Vitamin D	400 USP Units	Rutin	10 mg.
Vitamin B-1	2 mg.	Sodium Molybdate	3 mg.
Vitamin B-2	2 mg.	Fluorine (Calcium Fluoride)	0.25 mg.
Vitamin B-6	0.8 mg.	Iodine (Potassium Iodide)	0.15 mg.

SAMPLES ON REQUEST

TUTAG
S. J. TUTAG & CO.
DETROIT 34, MICHIGAN



for maximum effectiveness Recently, Griffith[1] reported that V-Cillin K produces antibacterial activity in the serum against penicillin-sensitive pathogens which is unsurpassed by any other form of oral penicillin. This helps explain why physicians have consistently found that V-Cillin K gives a dependable clinical response.

for unmatched speed Peak levels of antibacterial activity are attained within fifteen to thirty minutes—faster than with any other oral penicillin.[1]

for unsurpassed safety The excellent safety record of V-Cillin K is well established. There is no evidence available to show that any form of penicillin is less allergenic or less toxic than V-Cillin K.

Prescribe V-Cillin K in scored tablets of 125 and 250 mg., or V-Cillin K, Pediatric, in 40 and 80-cc. bottles.

1. Griffith, R. S.: Comparison of Antibiotic Activity in Sera Following the Administration of Three Different Penicillins, Antibiotic Med. & Clin. Therapy, 7:No. 2 (February), 1960.

V-CILLIN K® (penicillin V potassium, Lilly)

ELI LILLY AND COMPANY • INDIANAPOLIS 6, INDIANA, U.S.A.

033001

The Journal of the INDIANA STATE MEDICAL ASSOCIATION

Supervised by THE COUNCIL

Volume 53 — September 1960 — Number 9

Case report and review of literature with attention to etiology, diagnosis and treatment.

Reiter's Syndrome

JACK W. HICKMAN, M.D.
RICHARD H. CHILDRESS, M.D.
*Indianapolis**

SINCE 1946 the diagnosis of Reiter's Syndrome has been made only two times at Marion County General Hospital, with enough certainty for the attending physicians to code the cases as such. The triad of urethritis, arthritis and conjunctivitis which compose the syndrome is probably not this rare. Certainly papers such as those of Harkness[1] and Paronen,[2] in which they report 126 and 344 cases, respectively, attest to this fact. Periodic reports of Reiter's Syndrome are therefore worthwhile to draw the attention of physicians to this condition.

Generally known as Reiter's Syndrome, the triad was also described by Feissinger and Leroy[3] in 1916, the same year as Reiter's paper.[4] Later authors have criticized Reiter because he attributed the disease to a spirochete, which was isolated in pure culture and survived nine to 10 days, but did not survive sub-culture. He attempted guinea pig inoculation, but was unable to find these organisms in the animals, which died after eight days. He was unable to see them on direct examination of the patient's blood and suggested that flies and/or mosquitoes might transmit the disease.

Reiter's patient was apparently quite ill as contrasted with many subsequently reported cases. There were frequent temperature spikes to 103° F. The arthritis progressed so that the patient was unable to feed himself, and he, as our patient, developed iritis, so that vision was threatened.

Case Report

The patient, a 33-year-old Negro male, noted urethral discharge and dysuria on July 20, 1958. A urethral smear done in the hospital receiving

* From the Departments of Internal Medicine, Indiana University School of Medicine and Marion County General Hospital.

ward two days later was reported as showing gram negative intracellular diplococci. He was given Procaine Penicillin G, 600,000 units, intramuscularly, without relief of the symptoms. Urethral smears on 8-7-58 and 8-20-58 failed to show any diplococci.

He was followed from 9-19-58 until 10-6-58 in the medicine clinic. The urethral discharge and dysuria continued. Multiple arthritic complaints arose, involving soreness of the ball of the left foot, a numb feeling on the second, third and fourth toes of both feet, backache, bilateral shoulder pain, pain in the third finger of the left hand and muscle aching in the legs. All symptoms were worse in the mornings.

Past history revealed a positive serology in 1945, which was said to have been treated with some injections; a psychiatric illness requiring hospitalization in California in September, 1956; fractured skull in 1949 and a peptic ulcer, diagnosed by upper gastrointestinal series in 1949. The latter had been manifested by hematemesis and melena. He specifically denied any previous hot, swollen, tender or painful joints.

Physical examination on 9-19-58 was not remarkable. His blood pressure was 125/80, and pulse was 60. Head, eyes, ears, nose, throat and neck examination were normal. The lungs were clear. Heart tones were normal and no murmurs were heard. Abdominal examination was normal. There were no penile lesions, but a slight yellowish urethral discharge was present. The left third finger was swollen and tender but no increased warmth was noted.

No Response to Therapy

Initial laboratory studies showed a serum uric acid of 6.6 mgm%, a sedimentation rate of 21, and C-reactive protein of 2 plus. The symptoms became more marked, the patient being unable to work. Salicylates, heat, Penicillin, 600,000 units and Streptomycin 0.5 gm a day for five days, buccal Varidase and Darvon gave no relief.

Because of the lack of response to therapy, he was admitted from 10-6-58 through 10-22-58. On admission erythema, increased warmth and tenderness of the third finger of the left hand were noted. Hemoglobin was 14.5 gm%; white blood cell count 6,800 with a normal differential; urinalysis normal, except for 6-8 WBC/HPF; sedimentation rate 26; blood urea nitrogen 9 mgm%; creatinine 1.5 mgm%; uric acid 5.3 mgm%. There were negative sheep cell agglutination tests, two negative lupus erythematosis preparations, three negative blood cultures and a negative V.D.R.L.

Penile lesions which were now present on the glans and corona, were diagnosed as herpes progenitalis by the dermatology consultant. Treatment consisted of heat to the affected joints, salicylates, Erythromycin 250 mgm every six hours for 10 days and bed rest. He became afebrile and was discharged with partial relief of the joint and genitourinary symptoms.

Four days after discharge pain started above both eyes, being more severe on the right. Conjunctival injection on the right also appeared. He returned to the hospital, where the authors saw him for the first time and advised re-admission. This hospitalization was from 10-30-58 through 12-17-58. Physical examination showed the same joint involvement, except that the left knee was also swollen, red and tender. There was marked conjunctival injection on the right. Moderate periorbital edema was present and he complained of photophobia. Funduscopic examination was negative. A yellowish green, raised coronal lesion approximately two cm in diameter was present.

Ophthalmologic consultation was obtained and local treatment with Neo-Hydeltrasol drops was started. However, uveitis developed on 11-3-58 and vision was threatened. Meticorten 10 mgm every eight hours orally was started, the dosage being varied as the vision gradually improved. The uveitis was the most serious aspect of the patient's course, but by 12-1-58 he had improved to 20/25 and 20/20 vision in the right and left eye, respectively.

ASA 0.6 gm every four hours, local heat and physiotherapy were instituted with only moderate relief of the joint symptoms. A trial of Colchicine on 11-14-58 gave no relief to the patient. The urethral symptoms gradually became less troublesome.

While on Meticorten, he developed numerous furuncles. Penicillin 600,000 units a day for seven days produced clearing of the lesions, but had no effect on the joint symptoms. Routine blood counts and urinalyses were normal. Other studies included a fasting blood sugar of 84 mgm%, total proteins of 9.4 gms% with 5.0 gms% albumin and 4.4 gms% globulin, and

serum calciums of 11.6 and 11.9 mgm%. The gonococcal complement fixation test was four plus on 11-12-58, and one plus on 12-30-58. The following studies were normal: two sickle cell preparations, two L. E. cell preparations, P-A chest roentgenogram, Frei test and lymphogranuloma venereum complement fixation test. Joint aspiration was strongly and repeatedly advised, but the patient refused steadfastly.

After clearing of the uveitis and urethritis, the patient was discharged and advised to continue the salicylates, heat and was to return for physiotherapy. He did this, with slight improvement in joint discomfort, but he still needed a cane for ambulation.

His last admission was on 1-12-59 because of a history of recent black stools, and intermittent epigastric pains which were relieved by milk, and vomiting. He denied hematemesis. It was thought that he had a recurrence of his peptic ulcer, and he was re-admitted to the hospital. Hemoglobin was 13 gms, WBC 6,400, urinalysis negative, and stool examination showed a four plus reaction for blood. The enteric coated sodium salicylate was continued because the joint symptoms were still quite troublesome to the patient. He was placed on a full ulcer management program. Symptomatically, he cleared quite rapidly, and his stools no longer contained blood, but before full radiographic investigation of his G. I. tract could be completed, he signed his own release against medical advice on 1-17-59. The last contact with the patient was on 3-16-59, at which time he stated that virtually all his symptoms had cleared, and that he was once again able to maintain his full daily activities.

Case Discussion

This patient presented the full triad of Reiter's Syndrome and his symptoms occurred in the most frequent sequence. The main differential diagnosis was gonococcal arthritis. Despite the one reportedly positive urethral smear and positive complement fixation test, which might favor gonococcal arthritis, the appearance of the joints of this patient was not clinically like that of gonococcal arthritis. (Foxworthy *et al.*[5] report three of 10 patients having Reiter's Syndrome as well as a questionable associated gonococcal arthritis.) The absence of response to penicillin on three occasions and to Erythromycin also mitigates against the gonococcus as the causative agent.

The penile lesions described by various authors fit the one shown by our patient. Generally the other laboratory findings are non-specific. We are unable to account for the slightly elevated serum calcium and uric acid determinations from our review of the literature.

Etiology

Reiter and Macfie[18] independently described finding a spirochete and postulated this organism as the etiologic agent in this condition. Others have failed to find such an association. Paronen concluded that the syndrome occurred only subsequent to bacillary dysentery, finding this to be the case in 96.4% of 344 cases; however, even though many authors[19, 21, 31] have felt that there is a correlation, the evidence is not conclusive. It has been postulated that Reiter's Syndrome is in part a non-specific arthropathy fired off by a variety of infections,[25] or is a type of psoriasis,[28] or may be related to the gonococcus as rheumatic fever is to the streptococcus.[33]

Steinberg[35] states, "If one examines not only Reiter's original case but also subsequent accounts of Reiter's Syndrome it becomes evident that Reiter's Syndrome is a variant of rheumatoid arthritis." Csonka[7] and Morton[9] have presented some evidence for this; however, other writers[37] do not appear to substantiate it. Murray *et al.*[15] failed to find radiographic changes typical of rheumatoid arthritis in 19 cases of the triad. Buchan[21] and Ford[33] felt that Reiter's Syndrome was probably not a variant of rheumatoid arthritis since the long term joint changes were not the same.

The American literature concerning Reiter's Syndrome, which was initiated by Bauer and Engleman in 1942, has dealt largely with cases not associated with a post-dysenteric state but rather implies a venereal syndrome.[20] Harkness[1] has discussed a classification including a venereal form of the triad as first published by Sir Benjamin Brodie in 1818 and a post-dysenteric form which he credits to Launois in 1899, both prior to Reiter's description in 1916. Buchan[21] belives that the urethral form is seen in males only, but that the intestinal form may occur in either sex. He states that the former may follow either gonorrheal or abacterial urethritis. McCracken[30] reports an industrial legal case in which previous trauma was ruled to precipitate the triad.

In recent years there has been much interest

in the pleuropneumonia-like "L" organisms as the possible etiologic agent. Authors[1, 42] point out that these organisms were found by Dienes and Smith in 1942, in the genitourinary tract in a fairly high percentage of patients having the syndrome, but they are also found in a number of normal people in the 20-30 year age group.[18, 33, 39] These have been isolated from urethral washings, synovial fluid and large intestines of patients having Reiter's Syndrome.[10, 23] Cairo[24] postulates that the evidence for a causative role of these "L" organisms is circumstantial in that they are found normally in both sexes. Skin testing with phenolized suspensions of "L" organisms was abandoned because of the large number of false positives.

Wilcox and Findlay[17] reported the disappearance of "L" organisms from the urethral scrapings of two patients with the syndrome after treatment with Terramycin, yet they were unable to consistently pass the "virus" in their series.[32] Interesting discussion is found concerning the effect of Penicillin on the gonococcus with possibility of a resultant non-coccal phase of antigen-antibody reactions contributing to the syndrome, and of joints, skin and eye tissues having a high level of hyaluronic acid making these sites particularly susceptible to several bacteria with hyaluronidase activity.[22]

Although pleuropneumonia-like "L" organisms are most often postulated as etiologic agents, conclusive evidence as to pathogenesis appears to us to be lacking.

Diagnosis and Course

Buchan reports that Musger in 1934 was the first to give the name "Reiter's Syndrome" to the triad of nonspecific urethritis, conjunctivitis and polyarthritis, and the symptoms usually appear in that order. Montgomery *et al.* suggest a tetrad—to include mucocutaneous lesions. Others with large series of patients state that the incomplete syndrome is important to recognize as such and that the complete triad may not be evident for months or possibly years.[6, 9, 41] In a series of 185 patients, Hollander reported 87 exhibiting arthritis only, and all of these followed genital infections. Weinberger and Bauer[19] reported that no cases of the full triad in a female had been described. Paronen, in his large series of 344 cases reported 10% female patients, and 70% of all his patients exhibited the complete triad.

All writers agree that thorough studies should eliminate the gonococcus as the etiologic agent before the diagnosis of Reiter's Syndrome is made, but there is some variance of opinion regarding other necessary criteria, e.g. the incomplete triad. Harkness,[1] in a paper reporting 126 cases lists primary abacterial urethritis of venereal origin, bilateral conjunctivitis and polyarthritis as the fundamental criteria with balanitis, keratodermia blenorrhagica and cardiac abnormalities as supportive evidence.

There are a number of generalizations about Reiter's Syndrome. Csonka reports 82% of 185 patients being between the ages of 25 and 40 years (Paronen reported one case in a two-year-old male). Durel *et al.*[34] report Reiter's Syndrome to be 18 times more frequent in the male.

Csonka, in his series of 185 cases, reported 97.8% with genital infections, 87% with polyarthritis, and 45.8% with eye lesions. Hall and Finegold[14] report 61% of 23 cases having urethritis. Paronen reported genitourinary involvement in 79.3%, polyarticular involvement in 92%, and eye lesions in 89% of his 344 cases.

Many findings in addition to the triad are reported in varying incidence. Among these are sacroiliitis, plantar fasciitis, keratodermia blenorrhagica, balanitis circinata, iritis, keratitis, osteoporosis, painless mucocutaneous lesions, inguinal and femoral adenopathy, nephropathy, splenomegaly, pleuritis, prostatitis and cystitis, ankylosis, bone atrophy, myocarditis with heart block and pericarditis, iridocyclitis and corneal ulcerations. The most commonly reported are mucocutaneous lesions (e.g. 80% in 38 cases reported by Montgomery *et al.*[26]), and eye lesions other than conjunctivitis. Uveitis, as seen in the present case, is apparently not seen frequently, and if seen, is late in appearance.[5, 38]

The urethral discharge is described as mucopurulent to purulent, and of less volume than that seen in gonorrhea. Harkness reports either a mild or acute onset of the urethritis and the occasional finding of hematuria. It is interesting to note that he also reports that neither urethritis nor skin eruptions are often seen in postdysenteric arthritis.

Radiologic Evidence

Although monoarthritis has been reported, polyarthritis is the rule. Lowman and Boucek[13] report that osteoporosis is the most common

x-ray change with periosteal proliferation occasionally seen, but rarely bone atrophy. Murray *et al.*[15] reported normal x-ray findings in 158 of Paronen's 344 cases, and in their series of 53 patients.

A common x-ray abnormality is fusiform thickening of periosteal tissues particularly in the interphalangeal joints of the fingers. "Questionable" osteoporosis which was not so definite as in rheumatoid arthritis, destruction of the articular surfaces of the small joints of the extremities, narrowing of joint spaces (particularly of the feet), periostitis and deformities of the ankles are other radiologic evidence. Hall and Finegold[14] report the following joints involved, clinically, in order of incidence: knees, ankles, wrists, shoulders, spine and hips. Sacroiliac involvement, sometimes seen, may be a variant of ankylosing spondylitis[25] and may be progressive.[31] Joint effusion is common, but almost never suppurative[23] in contrast to gonorrheal involvement, and there is usually little residual joint damage[5] except possibly in the feet. Harrison[41] states that arthralgia without clinically objective findings is rare.

The white blood count and ESR usually are elevated, the latter often remaining elevated even after clinical improvement. Serology, BUN, serum proteins, uric acid and other laboratory determinations are normal usually. A temperature range of 99-103° F. orally with a duration of one to five weeks is reported in the majority of cases.[2, 43]

Other less common symptoms and findings are reported. Foxworthy *et al.*[5] mention reversal of the A/G ratio but this is not common. Csonka and Oates[8] reported two patients with clinical pericarditis and six patients with transient chest pain in a series of 128 cases. Several authors have mentioned findings of increased P-R interval on EKG,[11] audible friction rub, systolic murmurs or rarely acute myocarditis with heart block, voracious appetite, night sweats,[12] fatigue, weight loss[19] and insomnia,[16] but not with a significant frequency to contribute to the diagnosis of the condition.

Mucocutaneous lesions have been reported in a significant number of cases. Sites of occurrence are genitalia, mouth and nails, in that order of frequency.[14] Csonka reports keratodermia blenorrhagica in 14% and subcutaneous nodules in 1.6% of his 185 cases. Rinkoff[18] reports keratodermia blenorrhagica as rare and late. Perhaps one-third of patients exhibit oral mucous membrane erosions or plaques. Montgomery *et al.*[26] mention that some lesions on the mouth or glans support the diagnosis. Buchan[21] reports balanitis circinata in 87%. Smyth *et al.*[31] report temporary loss of the nails similar to psoriatic arthritis and the tendency toward balanitis in the uncircumcised.

All authors agree that Reiter's Syndrome is self-limited, the initial attack lasts two to six months, is non-fatal, and frequently recurs in less severe episodes. Harkness reports three months to 18 years between attacks, and states that in subsequent attacks the arthritis is not necessarily preceded by urethritis.

Some of the more suspect entities in the differential diagnosis of Reiter's Syndrome are gonorrhea, arthritis with bacillary dysentery, Stevens-Johnson syndrome, rheumatoid arthritis and psoriatic arthritis. Most authors agree that the finding of the major triad in the absence of bacterial etiology and with findings as mentioned above warrant the diagnosis.

Treatment

To date no specific curative therapy is available despite the wide range of measures used. Despite reports of good results[8, 13, 23] with fever therapy, most authors do not feel that it is beneficial.[40] There is no evidence that antibiotics actually alter the disease process.

Some of the many other measures that have been used are phenylbutazone, high caloric diet, salicylates,[29] sulfonamides, physiotherapy, bed rest, adrenal steroids, arsenicals, gold, splints, disinfectants for eye and urethral irrigation and radiation therapy.

The conclusion of most authors at this time is that steroids are beneficial since they give temporary relief of symptoms and permit more active supportive measures and physiotherapy.[27] Since the condition is self-limited, long-term steroid therapy will rarely be necessary, and the patient can be kept comfortable while the disease runs its course.[36] We are still of this opinion despite the complications that arose in our own reported case, which points up the inherent complications of steroids, even on a short-term basis.

Summary

A case of Reiter's Syndrome is presented. Our review of the English literature is given with attention to etiology, diagnosis, and treatment. Physicians should be aware of this condition because of its relatively benign course, as contrasted with the progressive and disabling effects of other rheumatic diseases. Correct diagnosis should be reassuring to both patient and physician, since with its self-limited course, Reiter's Syndrome is suited quite well to treatment with adrenal steroids.

Acknowledgment

The authors wish to thank Erwin Permer, M.D., for his translation of Reiter's original paper.

BIBLIOGRAPHY

1. Harkness, A. H.: Reiter's Disease. *Brit. J. Ven. Dis.* 4:185, 1949.
2. Paronen, I.: Reiter's Disease: A study of 344 Cases Observed in Finland. *Acta Med. Scand.* Supp. 212, 1948.
3. Feissinger, N., Leroy, E.: *Bull. Soc. Med. Hop.* Paris, 2030, 1916.
4. Reiter, H.: Uber Eine Bisher Unerkannte Spirochäten Infektion (Spirochetosis Arthritica). *Deutsch Med. Woch.* 42:1535-36, 1916.
5. Foxworthy, D. T., *et al.:* Adrenocorticotropin and Cortisone in the Treatment of Severe Reiter's Syndrome. *Ann. Int. Med.* 44:55-62, Jan., 1956.
6. Hollander, J. L. *et al.:* Arthritis Resembling Reiter's Syndrome. *J.A.M.A.* 129:593, 1945.
7. Csonka, G. W.: The Course of Reiter's Syndrome. *Brit. Med. J.* 1088, May 10, 1958.
8. Csonka, G. W., Oates, J. K.: Pericarditis and Electrocardiographic Changes in Reiter's Syndrome. *Brit. Med. J.,* April 13, 1957.
9. Morton, R. S.: Reiter's Syndrome in First Cousins. *Brit. J. Ven. Dis.* 34:50, 1958.
10. Ford, D. K.: Further Tissue Culture Studies of Non-Gonococcal Urethritis and Reiter's Syndrome. *Brit. J. Ven. Dis.* 34:53, 1958.
11. Feiring, W.: Reiter's Disease with Prolonged Atrioventricular Conduction. *Ann. Int. Med.* 25: 498, 1946.
12. Miller, C. D., McIntyre, D. W.: A Syndrome Termed Reiter's Disease (Urethritis, Conjunctivitis, and Arthritis) *Ann. Int. Med.* 23:673, 1945.
13. Lowman, E. W., Boucek, R. J.: Reiter's Disease; Treated with Hyperthermia. *Ann. Int. Med.* 28: 1075-85, 1948.
14. Hall, W. H., Finegold, S.: A Study of Twenty-three cases of Reiter's Syndrome. *Ann. Int. Med.* 38:533, 1953.
15. Murray, R. S. *et al.:* Radiological Changes in Reiter's Syndrome and Arthritis Associated with Urethritis, *J. Fac. Rad.* 9:37-43, 1958.
16. Golderos, A. F.: Abacterial Urethritis, Abacterial Pyuria and Reiter's Syndrome. *J. Urol.* 73:536-539, 1955.
17. Willcox, R. R., Findlay, G. M.: Terramycin for Non-gonococcic Urethritis and Reiter's Disease. (Preliminary Report) *Pub. Health Report* 67:196, 1952.
18. Rinkoff, S.: Reiter's Disease. Report of a Case in a Woman. *J.A.M.A.* 148: March 1, 1952.
19. Weinberger, H. J., Bauer, W.: Diagnosis and Treatment of Reiter's Syndrome. *Med. Clin. N. Amer.* :587, 1955.
20. Montgomery, M. M. *et al.:* Problems in Early Diagnosis of Arthritis, Gout, Reiter's Syndrome and Systemic Lupus Erythematosis. *Med. Clin. N. Amer.*: 119, Jan., 1950.
21. Buchan, J. F.: Reiter's Disease—A Review of the Present Position. *Proc. Roy. Soc. Med.* 48:432, 1955.
22. Lydon, F. L.: Letters to the Editor, *Lancet* 1:918, 1955.
23. Harkness, A. H.: Arthritis Associated with Non-gonococcal Urethritis. *Rheumatism* 10:91, 1954.
24. Cairo, A. A.: Reiter's Syndrome. *Bull. Georgetown Univ. Med. Cent.* 8:86, 1953.
25. Hart, F. D.: The Rarer Arthropathies. *Postgrad. Med. J.* 31:628, 1955.
26. Montgomery, M.M. *et al.:* The Mucocutaneous Lesions of Reiter's Syndrome. *Am. Int. Med.* 51: 99, 1959.
27. Larson, E. and Zoeckler, S. J.: ACTH in Reiter's Syndrome: Four Cases with Review of the Literature. (Abstracted from *Amer. J. Med.* 14:307) *Ann. Rheum. Dis.* 13:180, 1954.
28. Sidell, C. M.: Reiter's Syndrome (Psoriasis with Arthropathy ?). *A.M.A. Arch. Derm. and Syph.* 71:774, 1955.
29. Reid, H. A.: Reiter's Syndrome and Cortisone. *Ann. Rheum. Dis.* 13:161, 1954.
30. McCracken, W. J.: The Role of Trauma in Arthritis. *Indust. Med. and Surg.* 24:327, 1955.
31. Smyth, C. J. *et al.:* Rheumatism and Arthritis: Review of American and English Literature of Recent Years. *Ann. Int. Med.* 50:633, 1959.
32. Willcox, R. R. *et al.:* Attempts to Passage the "Virus" of Nonspecific Arthritis. *Brit. J. Ven. Dis.* 1:31, 1954.
33. Ford, D. K.: Natural History of Arthritis Following Venereal Urethritis. *Ann. Rheum. Dis.* 3: 177, 1953.
34. Durel, P. *et al.:* Nongonococcal Urethritis. *Brit. J. Ven. Dis.* 2:69, 1954.
35. Steinberg, C. L.: *Arthritis and Rheumatism.* Springer Publishing Co., Inc., New York, N. Y., 1954.

36. Cecil, R. L.; Loeb, R. F.: *A Textbook of Medicine*. W. B. Saunders Pub. Co., Philadelphia, Pa. p. 1378, 1959.
37. Ford, D. K.: Arthritis and Venereal Urethritis. *Brit. J. Ven. Dis.* 29:123, 1953.
38. Harkness, A. H.: Therapeutics of Nongonococcal Urethritis. *Brit. J. Ven. Dis.* 29:134, 1953.
39 Nicol, C. S., Edward, D. G.: Role of Organisms of the Pleuro-pneumonia Group in Human Genital Infections. *Brit. J. Ven. Dis.* 29:141, 1953.
40 Fowler, W., Knight, G. H.: Value of Treatment in Reiter's Disease. *Brit. J. Ven. Dis.* 32:2, 1956.
41. Harrison, T. R. *et al.: Principles of Internal Medicine*. The Blakiston Division, McGraw Hill Book Co., Inc., New York, N. Y., pp. 1257-1259, 1954.
42. Conn, H. F. *et al.: Current Therapy*. W. B. Saunders Pub. Co., Philadelphia, Pa., p. 143, 1958.
43 Kestel, J. L. *et al.:* Reiter's Syndrome, *Neb. State Med. J.* 44:3, p. 111, March, 1959. ◄

Nice Physicians

There are plenty of capable physicians—the need is for physicians who are nice to people. To some, this art seems to be inherent; to others it has to be a conscious and planned part of their behavior. We frequently look askance at those members of our profession who have developed the art of being nice to people to such a high degree while allowing their scientific knowledge to deteriorate. These individuals invariably have highly successful practices much to the dismay and chagrin of their more scientifically orientated colleagues. The patients of these physicians are unusually loyal. Because of our disdain for the professional qualifications of this type of physician, many of us swing rather far in the opposite direction. We sometimes erroneously associate the quality of being "too nice" to our patients with professional mediocrity. Nothing could be farther from the truth.—*Armed Forces Medical Journal,* Vol. 11, No. 7.

A general discussion on breast cancer, examining values of irradiation therapy and advantages of Cobalt-60 over conventional x-ray.

Cobalt-60 Teletherapy in Mammary Cancer

*JAMES C. KATTERJOHN, M.D.**
Indianapolis

COBALT-60 THERAPY offers a real advantage over conventional x-ray therapy in the treatment of carcinoma of the breast. There is virtually no skin effect following the administration of significantly larger tissue or tumor doses of cobalt-60 than is usually attained with conventional x-ray. This advantage is more striking in the case of cobalt-60 than in the case of other supervoltage modalities. This paper will discuss briefly breast cancer in general, the value of irradiation therapy in this disease and the advantage of cobalt-60 over conventional x-ray.

General Considerations

Treatment policy—irradiation or surgery—is based upon the original concept of Sampson Handley,[5] namely that most breast cancers extend first and primarily via the lymphatic pathways and that they extend about equally in all directions from the primary focus. Hematogenous spread can occur almost any time in the course of the disease, but the majority of these tumors spread first to the regional nodes. It follows, therefore, that effective surgical treatment must consist of extirpation of all areas involved in disease (primary and nodal) without cutting through disease and without producing cellular spill or contamination in the wound. there are numerous nodal metastases, the chan of adequate surgical removal is reduced a surgical treatment in these individuals may act ally be harmful. Cushman Haagensen,[2] a su geon with vast experience in this field, apt summarized this view at the International Ca cer Congress in London in 1958 as follows:

> "Breast cancer surgery is being discredited because of indiscriminate radical mastectomy in all stages of the disease and poor technics. Careful selection excludes 50% of the patients who have no hope of cure by radical mastectomy and actually may be harmed by surgical spreading of the disease. Inoperable patients are best treated by irradiation: higher voltage is better than conventional."

Effective irradiation therapy consists of trea ing all areas of potential lymphatic draina from the site of the tumor bed, attempting destroy minute metastatic foci and helping stimulate the formation of barriers of scar ti sue in all the drainage pathways.

There is no doubt that there is a great var ability in the behavior of mammary cancer different patients. Since 1947 we have treate patients radiologically following a great variet of surgical procedures. Patients having loc excisions, simple mastectomies, modified radic mastectomies, poor radical mastectomies, fa radical mastectomies and good radical maste

* From the Department of Radiology, St. Francis Hospital, Beech Grove, Ind.

Presented at the 110th Annual Meeting of the Indiana State Medical Association, Indianapolis, Ind.; Oct. 6-8, 1959.

ies with thin skin flaps have been referred treatment. Following this 12-year experie, one conclusion is inescapable, namely the e rate in mammary cancer is not necessarily endent upon the extent of surgery.

I have seen a young patient with a lesion 1 cm diameter succumb to her disease nine months er a very good radical mastectomy followed irradiation therapy. I have treated another ient 70 years of age for a solitary metastatic posit in her clavicle, the only manifestation of mmary cancer in 27 years following a simple stectomy, obviously not very extensive sur- y. This great variability in behavior of mam- ry cancer allows conflicting reports of end sults and has contributed to a general mis- derstanding regarding this disease. Whether e variability is due to differences in the en- crine system, the parous state of the individ- l, the antibody constitution of the patient or some still unknown factor or factors is pure eculation. We must be aware of this area of edical ignorance and exercise our best clinical dgment in individualizing each patient when eatment is selected.

Internal Mammary Chain

In the past 10 years, the importance of the ternal mammary chain of lymph nodes as a rainage pathway for mammary cancer has been cognized. Robert Handley's[4] report in 1950 rst brought this matter to our attention. Prior that time and before the advent of cobalt-60 letherapy, some radiologists omitted the para- ernal area from their treatment fields. The nportance of this group of nodes as a primary rainage pathway from inner, upper quadrant sions, and its prognostic significance in the se of other quadrant tumors, is now well un- erstood. In inner, upper quadrant tumors the ternal mammary nodes are apt to be invaded ery early in the course of the disease and may e invaded before the axillary nodes. In lesions f the outer quadrant, where the axillary nodes re apt to be first involved, the presence of etastatic deposits in the internal mammary ain is of grave significance. In Dr. Haagen- en's clinic, the internal mammary chain of odes is biopsied early in the operative pro- edure, and if this group of nodes is involved, o further surgery is done and the patient is eferred for irradiation therapy.

Dr. Jerome Urban[10, 11, 12] has done much to enlighten us regarding the importance of the internal mammary chain. He first excised this group of nodes in patients with recurrent disease in the chest wall and improved the cure rate. In his report to the James Ewing Society in 1958, Dr. Urban reported a small but significant net gain in the five-year survival rate in patients with tumors of the inner, upper quadrants when the internal mammary chain was excised *en bloc* with the breast lesion and the axillary contents as a primary treatment. It is important for us to realize the significance of this group of lymph nodes, and the area cannot be neglected when irradiation therapy is used.

In addition to the above-mentioned developments in the field of mammary cancer, super-radical surgical procedures have been advocated by some surgeons, for example, Dr. Wangensteen[14] of Minnesota. Dr. Wangensteen has proposed radical mastectomy, neck dissection (including the clavicle) and anterior mediastinal node excision in continuity in advanced lesions of the breast. It appears doubtful that the good that might be accomplished by such radical procedures could outweigh the ill-effects and the disability produced. The place of the super-radical operation has not been established. Beyond the contributions of Robert Handley, Urban and Haagensen there is very little new in the primary surgical treatment of carcinoma of the breast since the operation of Halsted[3] many years ago.

The report of Park[9] and Lees[7] at the Second National Cancer Conference in Cincinnati in 1952 is noteworthy. Briefly summarized, their report was to the effect that "it has not been proved that the five-year survival in patients treated for cancer of the breast is affected by treatment at all." Further, "that treatment is quite ineffectual in reducing the number of deaths due to metastatic spread." Statistical difficulties apparently arise from the fact that there have been no large series of untreated cases available for reporting and comparison. Certainly all of us have seen breast cancer cured frequently, and the earlier the patient has definitive treatment, the better her chances appear to be. Park and Lees report has at least caused therapists in the field of mammary cancer to ponder their results.

At the Cincinnati conference, Robert McWhirter[8] of Edinburgh reported unusually good

Breast Cancer Therapy[1]

Author and years in which patients first seen	Location	Number of Patients
R Haagensen (1935-42)	Presbyterian, N. Y. C.	668
R McWhirter (1941-7)	Royal Infirmary, Edinburgh	1882
R Paterson (1940-4)	Christie, Manchester	1675
R Smithers (1937-44)	Royal Cancer, London	1093
Taylor (1936-42)	M. G. H., Boston	430
Prudente (1939-45)	Sao Paulo, Brazil	64
R Richards (1933-43)	Toronto General	1056
R Robbins (1924-49)	Temple, Philadelphia	317
R Watson (1944-9)	Saskatoon, Canada	629
R Bryant (1936-47)	Ann Arbor, Michigan	742
Harrington (1910-42)	Mayo Clinic	9649
R Nohrman (1936-41)	Radiumhemmet, Stockholm	1042
R Kaae (1931-44)	Radium Centre, Copenhagen	1412
R Adair (1935-42)	Memorial, N. Y.	3836
R Engelstad (1932-42)	Norwegian Radium, Oslo	1384

R indicates irradiation therapy used extensively

Of the reporting institutions, only Drs. Taylor, Prudente and Harrington do not make widespread use of irradiation therapy.

TABLE I

results in patients treated by simple mastectomy followed by intensive irradiation therapy. His results were as good as those following radical mastectomy alone, and better than those following radical mastectomy plus irradiation therapy. His report could not be discredited by the participants at this conference, many of whom were strong advocates of routine radical mastectomy. We shall refer to McWhirter's report later in the discussion of irradiation therapy.

Irradiation Therapy

It is not within the province of this paper to attempt to prove the value of irradiation therapy in the treatment of mammary cancer. Its value as a palliative agent is unquestioned. Following adequate irradiation therapy, malignant ulcers will heal and massive tumors will regress. Pain will diminish or disappear entirely and recalcification of bone will occur after bony metastases are treated. Prolonged palliative results can be achieved in patients with these problems.

Dr. McWhirter has proved the efficacy of irradiation therapy as a form of primary treatment of this disease. Haagensen has emphasized the importance of irradiation therapy. We feel that the report of McWhirter and the opinion of Haagensen substantiate the concept that mammary cancer frequently can be controlled by irradiation therapy.

The widespread use of irradiation therapy in mammary cancer is illustrated in the above table, constructed from data from a recent survey of treatment policy in many major clinics in various parts of the world. You will note that of 15 institutions studied and surveyed, 12 rely heavily upon irradiation therapy as a form of treatment of this disease.

Radiotherapists have long advocated postoperative irradiation therapy in this disease, despite occasional troublesome skin reactions when irradiation in the orthovoltage range (200 to 250 kv) is used. Some surgeons have utilized conventional routine postoperative treatment, but others have been reluctant to do so because of the moist desquamation of the skin following its use in the effective dosage range. Cobalt-60 with significantly larger tissue doses can be



FIGURE 1A

SKIN REACTION (left) following 2200 r (air dose) conventional 220 kv x-ray contrasted with peak reaction following 6000 r (air dose) of cobalt teletherapy (right).



FIGURE 1B

LATE EFFECTS contrasted: patient's left chest wall received 2100 r of 250 kv x-ray two years before picture; her right chest wall received 3300 r cobalt-60 one year before picture.

administered absolutely without skin effect (Figures 1A and 1B) and without lymphedema, in our experience. If postoperative irradiation therapy is useful in mammary cancer, cobalt-60 teletherapy is useful and it is better because of the lack of skin reaction. No longer should we weigh the value of postoperative therapy against possible damage to the patient; we must weigh its use in the light of possible increased survival rate alone.

Present treatment policy as regards postoperative irradiation therapy is based upon the concept that when it does not appear likely that all of the patient's tumor can be removed without spill or contamination, limited surgery should be performed and a good irradiation bed preserved. If the patient has a small, upper, outer quadrant lesion with a relatively short history, and if nodes are not clinically palpable, conventional radical mastectomy alone is the

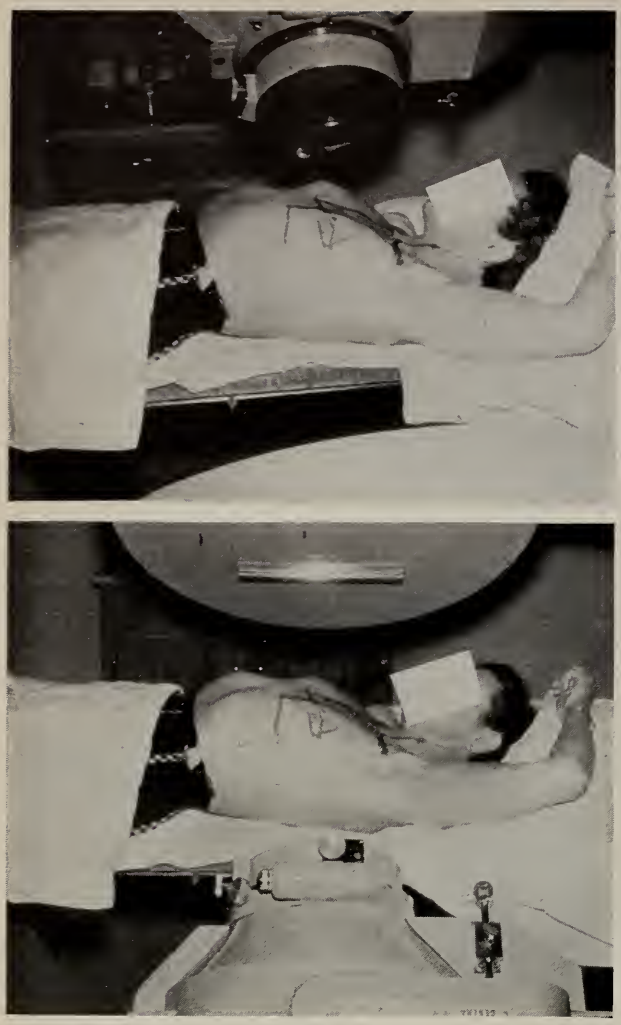


FIGURE 2

POSITION OF patient and cobalt machine during tangential chest wall treatment (portals 4 and 5).

treatment of choice. An unusually virulent tumor histologically, or adverse endocrine factors may influence the decision to employ irradiation therapy, even in the case of the patient with a very small upper, outer quadrant tumor. If the cancer is extensive, and if there are clinically involved lymph nodes, only gross disease should be extirpated and irradiation therapy should be started early in the postoperative period. A complete series of treatments can be given to the parasternal area and to the supraclavicular area with the axilla while the surgical wound is healing.

Cobalt-60 Teletherapy

After treating about 80 patients routinely with postoperative cobalt therapy for carcinoma of the breast, a treatment policy has evolved. The tissue dose has not been definitely established and will probably be revised upward from the present 3,000 to 3,500 roentgens. The initial aim has been to deliver a significantly larger dose than possible with conventional x-ray, but at the same time preserve the skin and inflict no permanent injury upon the patient.

Most patients can be treated by the utilization of four portals. The parasternal area is treated through a narrow portal extending downward from the sternoclavicular joint and covering at least the first, second and third interspaces. Dr. Urban[13] has stressed that nodal involvement in this area rarely occurs below the second interspace. To insure a good chest wall dose, we frequently treat a longer parasternal portal than would seem to be necessary. At a depth of 5 cm, 3,000 to 3,500 roentgens or more are administered.

The supraclavicular space and axilla are then treated conjointly by a transverse portal transecting the clavicle approximately at its mid point and missing the larynx. The axilla at mid depth receives 3,000 to 3,500 roentgens. We are not concerned about injury to the pulmonary apices since fibrosis in this area is not disabling. The third and fourth opposing portals (Figure 2) are aimed at the chest wall, missing the lung parenchyma; 3,500 roentgens or more are given to the entire mass of tissue at the base of the breast. Portal films with the cobalt-60 apparatus can be obtained in order that we may be certain that lung parenchyma has been spared.

Complications of treatment are rare in the conventional dosage range referred to above, but one out of five patients treated will develop a very small area of pulmonary fibrosis (Figure 3) where the tangential and axillary portals inadvertently overlap. The patient is not aware that any change has occurred in her lung in these instances; 80% of the patients so treated have no change whatsoever, clinically or radiologically. The skin fields must be carefully marked because cobalt-60 has no *signature,* and even when extremely large doses are administered, there will be no skin reaction. Lymphedema has not occurred in patients given routine postoperative therapy in our series in the dosage range referred to above.

Dosage Tolerance

A few patients having recurrent tumors or having other adverse factors in operation have received considerably larger doses. From this group of patients we have learned to define the

upper limits of dosage tolerance. If 5,000 to 6,000 roentgens are given to the mid mediastinum through the parasternal portal, central pulmonary fibrosis will be produced (Figure 4). Clinically, the manifestations of such pulmonary fibrosis are a brief period of mild central pneumonitis lasting five to six weeks, accompanied by coughing and some respiratory irritation. Such symptoms are self-limited and require no special medication.

When 5,500 to 6,000 roentgens are received in the costal cartilages, the patient may experience pain nine to 12 months after treatment. There appears to be no danger of severe chondritis or necrosis in the patients we have treated, and the pain is readily managed by conservative

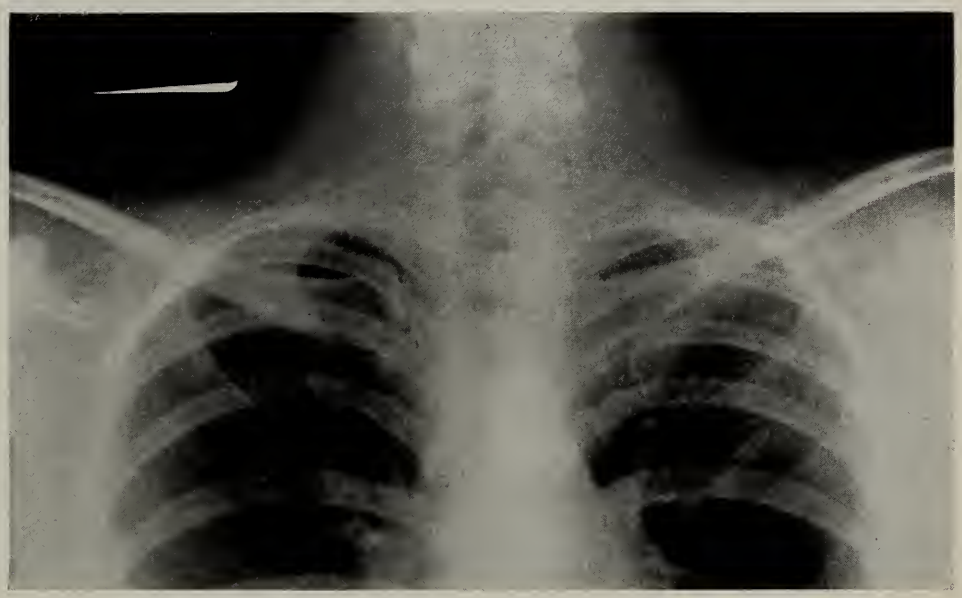


FIGURE 3

ABOUT 20% of patients treated in usual dosage range will develop minimal asymptomatic scar illustrated here in left second interspace anteriorly.

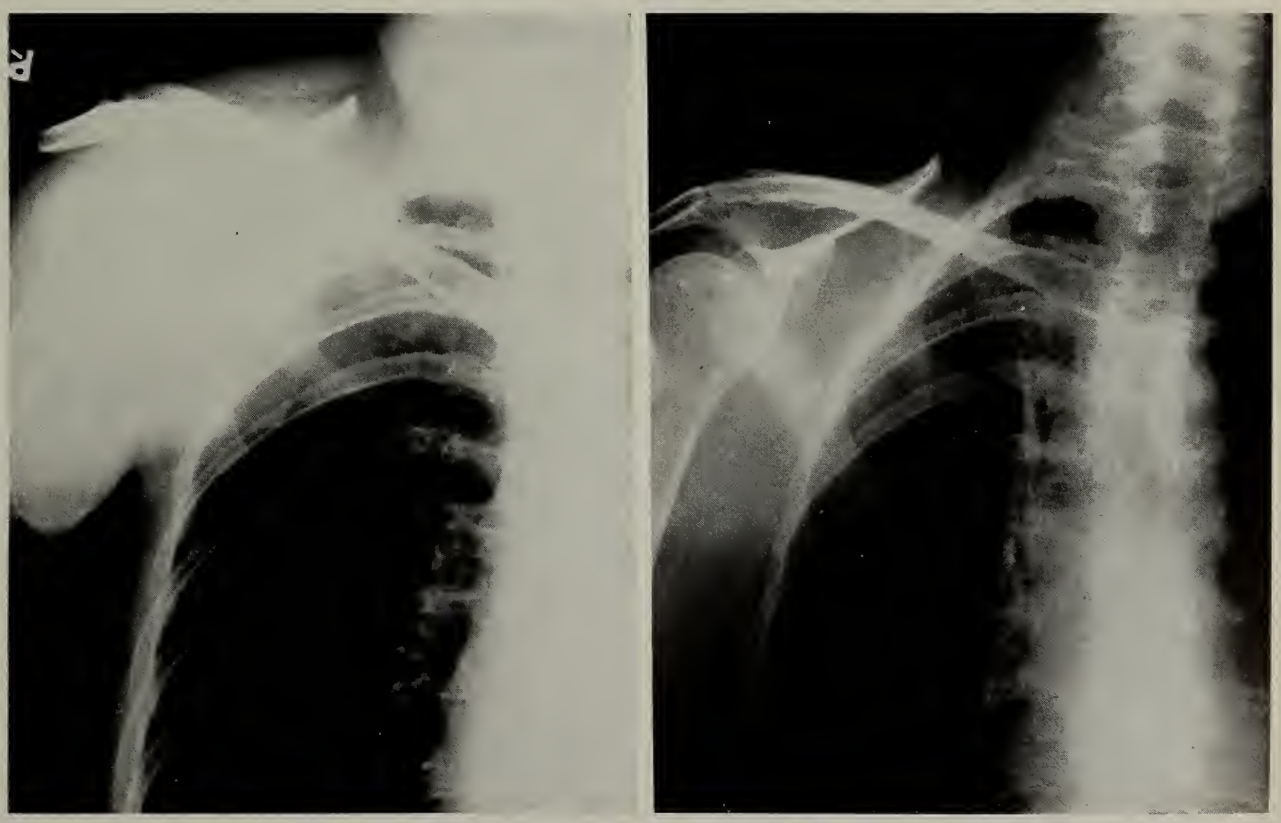


FIGURE 4

CHEST RADIOGRAPHS made before and after 5700 r to mid-mediastinum. Non-disabling parahilar fibrosis developed in the two patients receiving large doses.

means. Here again, the complication is self-limited.

A word regarding the McWhirter technic appears to be in order. Dr. McWhirter utilizes the presence of bolus in the form of rice bags surrounding the breast to insure a homogeneous distribution of tissue dose. We have not used bolus because its use with cobalt-60 would negate the skin-sparing effect of the beam—the most important advantage of cobalt-60 over conventional forms of irradiation in the treatment of this disease.

Sterilization of premenopausal patients with mammary carcinoma is advocated. Oophorectomy can be utilized, or the patient can be sterilized by irradiation of the ovaries with cobalt-60 teletherapy.

No attempts to assess end-results will be made at this time. Of the 80 patients treated proplylactically following surgery, five obvious failures have been found. Three patients are in trouble with recurrent or residual disease and two patient have died of disease. Both of the patients who have died following treatment were under 34 years of age. One of these developed brain metastasis six months after surgery, while the other developed generalized osseous metastasis followed by a very rapid deterioration. Both of these patients had been castrated radiologically, and there was no palpable residual disease following surgical treatment.

Of the three living patients who are in trouble, one patient remained well for two years and just recently developed hepatic metastasis; a second patient has developed en cuirasse disease during treatment, apparently due to contamination or spill at the time of surgery. A third patient has developed recurrent nodular disease in the chest wall.

I do not wish to imply or suggest that 75 of the 80 patients are out of danger. End-results following this form of therapy cannot be evaluated until several more years have elapsed.

Treating Advanced Cancer

Treatment of advanced mammary carcinoma in the chest wall or metastatic disease in the axilla or bone can be accomplished very well with cobalt teletherapy. Massive disease in the breast or in the chest wall is treated in the tangential fashion, usually from the medial aspect of the chest wall laterally through long, narrow portals in an attempt to miss the lung parenchyma. At the completion of 5,000 to 5,500 roentgens to chest wall disease, one usually sees a good regression of the tumor mass. If superficial skin nodules are present, it may be necessary to administer additional treatment using low or intermediate voltage x-ray. If the nodules are few, they are best treated, of course, by superficial irradiation only to each separate nodule. Nodes in the supraclavicular space and axillary nodes are treated by a direct beam aimed at the lesion. In these instances dosages in the vicinity of 6,000 roentgens are given. Hilar lymph nodes have been treated, but the response is generally not good.

In treating bone metastasis the dosage required to achieve a satisfactory clinical result is 25 to 40% higher than that required with conventional x-ray. This can be attributed to the fact that there is less absorption of the cobalt beam in bone than in the case of x-ray. There is no problem in giving larger doses. Certainly if repeated series of treatments are to be given, cobalt offers a great advantage over conventional irradiation in that re-treatment is possible for longer periods of time.

In summary, therefore, we can conclude that cobalt teletherapy is a very satisfactory modality for treating carcinoma of the breast, either supplementing surgery or as a primary form of treatment in advanced disease or recurrences. Cobalt teletherapy has a definite and important advantage over conventional x-ray in that no untoward skin reactions are produced, despite the fact that much larger tissue dosages are administered. There is no proof that cobalt-60 will produce an increase in survival rate. If an increased cure rate in this disease is to be experienced as a result of utilizing cobalt-60, it will come as a result of our ability to increase tumor dose. No longer should one weigh the value of postoperative irradiation therapy against possible injury or damage to the skin of the patient. One must weigh the advantages of cobalt teletherapy in the light of possible increased survival alone.

BIBLIOGRAPHY

1. Benninghof, D., Tsien, K. C.: Treatment and Survival in Breast Cancer: A Review of Results. *Brit. J. Rad.* 32:450-454, July, 1959.
2. Haagensen, C.: *CA, Bulletin of Cancer Progress.* 8:xxii, Nov.-Dec., 1958, American Cancer Society.
3. Halsted, W. S.: Clinical and Histological Study of Certain Adenocarcinomata of the Breast. *Ann. Surg.* 28:557-576, 1898.

4. Handley, R. S. and Thackary, A. C.: The Internal Mammary Lymph Chain in Carcinoma of the Breast. *Lancet* 2:276-282, 1949.
5. Handley, W. S.: *Cancer of the Breast and Its Treatment.* 2nd Ed. 1922, N. Y. C. Hoeber.
6. Katterjohn, J. C.: Cobalt-60 Teletherapy, *J. Ind. State Med. Ass'n.* 51:185-188, February, 1958.
7. Lees, J. C.: Significance of Statistical Analysis of End-Results in the Treatment of Breast Cancer. *Proceedings of the Second National Cancer Congress* 1952 1:107-122, American Cancer Society.
8. McWhirter, R.: Simple Mastectomy with X-Ray Therapy. *Proceedings of the Second National Cancer Congress* 1952 1:214-224, American Cancer Society.
9. Park, W. W., Lees, J. C.: The Absolute Curability of Cancer of the Breast. *S.G.O.* 93:129-152, 1951.
10. Urban, J. A.: Discussion on Radical Mastectomy in Breast Cancer with Supraclavicular and/or Internal Mammary Node Dissection. *Proceedings of the Second National Cancer Congress* 1952 1:243-246.
11. Urban, J. A.: Radical Excision of the Chest Wall for Mammary Cancer. *Cancer* 4:1263-1285, 1951.
12. Urban, J. A.: Radical Mastectomy in Continuity with En Bloc Resection of the Internal Mammary Lymph Node Chain. *Cancer* 5:992-1008, 1952 and *Third National Cancer Conference Proceedings* 59-68, 1957, Lippincott.
13. Urban, J. A.: Personal communication.
14. Wagensteen, O. H.: Super-Radical Operation for Breast Cancer in the Patient with Axillary Node Involvement. *Proceedings of the Second National Cancer Congress* 1952 1:230-241. ◄

Roads to Immortality

Neither Milton's imagery nor Harvey's profound biological insight would have reached heights which astonished the world if their early years had been occupied by a rigid curriculum and required hours of "elective" courses rather than in the freedom of study granted even to youths 17 years of age at Cambridge.—William Dock: Curiosity, Culture and Curricula. *J.A.M.A.,* Feb. 13, 1960.

Postoperative Radiation for Carcinoma of the Breast

JOHN W. BEELER, M.D.*

Indianapolis

RADIATION THERAPY for carcinoma of the breast has been a problem for many years but in the last five or 10 years its role has become even more complex. Although radical mastectomy has not changed essentially since the days of Halsted, the x-ray dosage, length of treatment, position of treatment portals and voltage used have all changed tremendously. Today most of the large medical centers have very different attitudes and technics, and breast cancer is treated according to whether the predominant philosophy of the center is surgical, radiotherapeutic or a combination of the two as seen in some tumor clinics.

Just three years ago, Dr. W. D. Gatch[1] in a paper, "The Effect of Treatment on the Natural Course of Breast Cancer" said ". . . the death rate of breast cancer . . . has been about stationary for the last 30 years. We can no longer ignore this fact, for it proves that the theory which has controlled our treatment is wrong."

Today, three years later, I think I can safely say that the treatment for breast cancer is unchanged, at least in Indiana, and the survival rate remains unaltered. Early discovery of the tumor and immediate radical mastectomy are *not* obtaining the desired result. X-ray therapy following the radical operation apparently increases the five-year survivals by only five or 10 percent. Is there any apparent reason for this disturbing situation?

* Assistant Professor of Radiology, Indiana University Medical Center, Indianapolis.

Presented at the annual meeting of the Indiana State Medical Association meeting, Oct. 6-8, 1959, Indianapolis.

Biologic Variability

The survival patterns of treated and untreated patients with cancer of the breast show a definite biologic variability which makes cancer of the breast different from other neoplasia. This has long been recognized by Gatch,[1] Crile,[2] Macdonald[7] and others and seems to form three general groups: those of rapid growth and poor prognosis in spite of early detection, those of slow growth with good prognosis and that group of patients in whom the cancer grows moderately fast and who require prompt diagnosis and treatment. Statistical study[2, 5, 8] seems to indicate that the unfavorable group (those having metastases before the cancer is detectable clinically) is over 50%. These patients apparently have lethal cancer without coherence of tumor cells and little or no resistance on the part of the host.

Radiosensitivity

Primary carcinoma in the breast is considered to be only moderately radiosensitive, while the metastatic nodes are usually more radiosensitive than the primary tumor. This belief has led to the use of simple mastectomy, to remove the primary lesion, followed by radiation therapy to control the axillary, supraclavicular and internal mammary nodes, as advocated by McWhirter.[8]

An increasing number of surgeons are accepting Haagensen's[5] criteria for operability and those patients with extensive axillary or supraclavicular metastases are being treated with irradiation alone or in combination with simple mastectomy. In general, there are factors other than radiosensitivity and biologic variability which should enter into the type of treatment

chosen. These are: (a) the size of the primary lesion (50% of tumors over 1.0 cm in diameter have metastases); (b) the duration (the longer the lesion has been present, the later the stage and greater chance of metastasis) and (c) location of the tumor within the breast (inner quadrant lesions metastasize more frequently to the internal mammary nodes).

Treatment

Today there are four major methods of treatment in carcinoma of the breast: (a) the radical mastectomy with or without postoperative x-ray therapy; (b) the simple mastectomy followed by irradiation (the McWhirter technic[8]); (c) the extended radical mastectomy or "super-radical" operation and (d) irradiation alone. In Indiana, I believe that the first method, that of classical Halsted mastectomy is used in 90% of patients. The second method is practically never used; the superradical is infrequently used and recent evidence[4, 9] suggests it fails to improve the surgical cure rate.

Radiation therapy alone is usually reserved for patients who are poor surgical risks, the very elderly and those with extensive disease and distant metastases. Some surgeons decide to use radiotherapy if metastatic axillary nodes are discovered at surgery while others avoid any irradiation in these patients because they feel that no increase in survival results from its use. The fact that only a five to 10% increase in five year survival results from radiotherapy in this group should not be discouraging. I say this, knowing full well that, if the biological factors of breast cancer are predetermined, this type of therapy probably has little effect on prognosis; but any salvage which may result is certainly worthy of extra effort.

What then is the course or what should it be? Most radiologists agree that, in those patients in whom the axilla does not appear to be clinically involved and the tumor appears localized in the breast (Stage I), the treatment of choice is radical mastectomy. If, however, there are axillary nodes which are not fixed, in addition to the above (Stage II), radical mastectomy may well be useless and even harmful.

Personally, I feel that if the axilla is negative following a thorough dissection and the cancer is in the outer quadrant, then postoperative radiation therapy need not be given. When axillary nodes are discovered, a modified McWhirter technic is applicable,[8] giving 2,000 to 2,300 roentgens in 14 days or 3,500 to 4,000 roentgens in 21 to 28 days.

Therapy should usually be started about seven to 12 days following surgery with the axillary and supraclavicular areas being treated. With inner quadrant lesions and in all Stage III patients, the internal mammary nodal area should also be treated extensively. Treatment of the "breast area" or chest wall is omitted in patients whose surgeon is known for excellence of surgical technic and who has reduced the possibility of local recurrences to the absolute minimum. Even in skilled hands, this may run five to 10% of cases and tangential x-ray beams directed to the chest wall will occasionally be used in an attempt to control possible skin recurrences at the operative site.

Should postoperative radiation be given by conventional therapy (250 kv) or by supervoltage (1 mev to 30 mev—including cobalt 60 units, linear accelerators, and betatrons)? In the light of present knowledge, it is my opinion that the use of supervoltage is probably limited. The cancer in the treated areas is usually not deep-seated and the superficial nature of these nodes gives no particular advantage to the use of these new sources of high-energy radiation, the internal mammary chain possibly being an exception. Many radiation centers still prefer the 250-400 kv units for all or part of their therapy and have found the skin reactions to be less annoying than the pulmonary fibrosis and pneumonitis which may develop with supervoltage (Figures 1 and 2).

Preoperative Irradiation

A brief mention of the use of preoperative x-ray therapy is indicated for several reasons. Most radiologists rarely have the opportunity to use this form of treatment and the assessment of statistics is, therefore, difficult. In many large clinics,[3, 7] some patients who have had biopsy of a breast cancer before coming to the clinic are given x-ray therapy before any surgery is attempted. The feeling is that the handling of the cancer and the incidental trauma at the time of biopsy release neoplastic cells which may float freely in the blood. Radiation before further surgery devitalizes the cells and tends to localize the cancer, thus helping to prevent dissemination.

The two or three-week period following ces-



FIGURE 1

PA CHEST ROENTGENOGRAM made April 7, 1959 on an 84-year-old female following right radical mastectomy in December 1958 for carcinoma of the breast.



FIGURE 2

CHEST ROENTGENOGRAM on the same patient following cobalt therapy over the right axilla and chest. Note the extensive pulmonary fibrosis, retraction of the mediastinum to the right, and elevation of the diaphragm. These changes were slowly progressive during the 6-month period between Figure 1 and Figure 2.

sation of radiation and prior to operation is longer than most surgeons care to wait. In addition, the radiation reaction sometimes adds to the problem of postoperative healing. Macdonald[7] believes that those patients of doubtful operability should have such treatment. This procedure serves as a therapeutic test enabling him to determine radiosensitivity and operability.

Conclusions

Selection of an optimal treatment plan for the patient with cancer of the breast should be done *before surgery* when the stage of advancement is determined. If certain conditions exist, such as metastatic supraclavicular nodes, large fixed axillary nodes, satellite skin nodules or fixation of a large primary tumor (Stage III), then heavy radiation with or without simple mastectomy should be given. If movable axillary nodes are present with a movable primary breast tumor (Stage II), consider using a simple mastectomy with heavy postoperative radiation therapy.

I doubt, however, that the next three years will find much acceptance of this consideration, if the experience of the past three to six years is any criterion. The third group, those with no axillary nodes and a small movable tumor confined to the breast (Stage I), will probably need the greatest thought. Today, either the radical or simple operation could be defended. The real job is to determine which patients have the type of cancer which requires radical surgery and who will not have their cancer disseminated by the operation.

Finally, it is admitted that neither surgery alone nor in combination with roentgen therapy is the answer to the problem. McWhirter,[8] using the simple mastectomy and heavy postoperative x-ray therapy, has given us all needed stimulation, for his statistics are remarkable and, even though some surgeons are dubious of the role radiation plays, a few are impressed and willing to try a new approach to this disease. Until the biochemist discovers that "magic injection" for cancer which will alter cellular metabolism, kill a virus, or neutralize a hormone, all of us should be willing to try any new technic which might improve survival. With this impetus, the feeling of renewed cooperation and mutual respect between the radiotherapist and the surgeon should grow.

REFERENCES

1. Gatch, W. D.: The effect of treatment on the natural course of breast cancer. *J. Ind. S. M. A.* 49: 1562-1563, Dec. 1956.
2. Crile, G., Jr.: Factors influencing the spread of cancer. *Surg. Gyn. & Ob.* 103:342-352, Sept. 1956.

3. Fletcher, G. H.: Radiotherapeutic management of advanced breast cancer. *Breast Cancer, The Second Biennial Louisiana Cancer Conference.* Pp. 109-113. The C. V. Mosby Company, St. Louis, Mo. 1958.
4. Haagensen, C. D.: Criteria of operability in breast cancer. *Breast Cancer, The Second Biennial Louisiana Cancer Conference.* Pp. 98-100. The C. V. Mosby Company, St. Louis, Mo. 1958.
5. Haagensen, C. D.: *Diseases of the Breast,* Chapter 26. W. B. Saunders Co., Philadelphia, Pa. 1956.
6. Macdonald, I.: The role of extirpative procedures in cancer of the breast. *Cancer* 10:805-807, July-Aug. 1957.
7. Macdonald, I.: Clinical evidence of biologic variability in mammary carcinoma. *Breast Cancer, The Second Biennial Louisiana Cancer Conference.* Pp. 37-45. The C. V. Mosby Company, St. Louis, Mo. 1958.
8. McWhirter, R.: Treatment of cancer of the breast. *Irish Journal Med. Sci.* 371:475-483, Nov. 1956.
9. Thal, A. P.: The extended radical operation for carcinoma of the breast. *Breast Cancer, The Second Biennial Louisiana Cancer Conference.* Pp. 93-97. The C. V. Mosby Company, St. Louis, Mo. 1958. ◄

Undercover Agents

The striking and perhaps sobering implication to be drawn from current virology is that a large proportion, perhaps the bulk, of the agents responsible for human virus disease still remains to be discovered. . . . possibly viruses exist which do not cause obvious acute diseases but which may well be reponsible for chronic or long-term results which at present are not suspected of being of viral etiology. A significant pointer in this direction is the circumstantial evidence that a strain of mumps virus had been responsible for a large number of cases of subacute thyroiditis. It appears likely that the mumps virus could, in a few days, so damage the thyroid as to lead to autoantibody production which in extreme cases could result in virtual extirpation of the functioning thyroid by autoantibody.—John F. Hotchin: Virology Advances. *Health News,* Feb., 1960.

Combined use of two procedures—the tuberculin test, and, when necessary, the x-ray, should be a part of every complete individual examination.

The Tuberculin Test

EDWARD W. CUSTER, M.D.

South Bend

DECLINE IN MORTALITY from tuberculosis has been spectacular during the twentieth century. Decrease in morbidity is also encouraging, but it is smaller than the death rate. Tubercle bacillus is still widespread, but it is no longer ubiquitous. Things are not the same as they were a few years ago. Less than 10% of the present population is infected by the time they reach maturity. The number increases in older age groups but it still remains a minority even late in life. This situation is contrary to the notion, once widely held, that tuberculous infection was almost universal in adults.

Despite these gains, we cannot afford to become complacent with a communicable disease which still disables hundreds of thousands, and of which some 8,000 die in a year. New cases still develop at a high rate. Too many are discovered in advanced stages, after they have been spreading tuberculosis for months, sometimes for years. We have been seeking ways to break up this chain of infection more quickly. Diagnosis of active disease must be made early to check its progress in the infected individual and to prevent its spread to others.

Case-Finding Methods

For a while the case-finding campaign was chiefly educational, like the cancer program of today. People were taught the symptoms so that they would seek medical attention as soon as they were noticed. The method proved relatively ineffectual because tuberculosis does not produce symptoms in its earlier stages. Even when advanced, its effect on the host may be slight and unnoticed.

With the development of photo-fluororoentgenography, it became possible to screen large numbers of people easily and cheaply. The cost of x-ray examination was reduced to less than the price of a motion picture show. During the past few years a great multitude of people have been screened by this technic and many cases have been found. Frequently the disease had not been suspected previously, and sometimes it was discovered early. Originally, surveys of the general population were productive, but the yield decreased with subsequent examinations as the backlog of unrecognized cases was gradually depleted. Now mass surveys are considered uneconomical and unproductive unless they are used on a selective basis in groups which have a high incidence of tuberculosis. Some of these special areas are admissions to general hospitals, inmates of jails and mental institutions and people over the age of 40, especially men.

Recently a harmful genetic effect from radiation has been proposed as a reason for limiting the use of x-ray. The danger from this source is rather slight but it is still significant, and it imposes a definite responsibility upon medical and health workers. X-rays should be used carefully and with discrimination. Unnecessary radiation should be avoided.

Long ago our colleagues in veterinary medicine demonstrated the use of an effective tool for tuberculosis case-finding—the tuberculin test.

In 1909 all 1,700 cattle in the District of Columbia were tested. Over 18% reacted and were eliminated. No animals with positive reactions were permitted to enter the District after this, and the entire cattle population was tested periodically. By 1916 only one percent reacted. By 1925 there were none, and there have been none ever since.

The tuberculin test is based upon specific skin sensitivity which develops three to eight weeks after invasion of the tissues. Once this allergic state is established, it tends to remain indefinitely, or at least as long as the organisms remain alive within the body. This may be as long as the life of their host! Viable tubercule bacilli have often been demonstrated in lesions long after infection occurred.

Effectual in Pre-Symptom Stage

We have, therefore, with the tuberculin test an objective method which detects the presence of tuberculous infection even when it is not apparent by x-ray, long before it has progressed to the stage where it produces symptoms. Once they are identified, individuals with these infections may be kept under observation to watch for the development of clinical disease. Fortunately the microbes in most of these lesions remain dormant or even die. However, they are not all so benign; some will become active again. Perhaps five percent of these small infections may be expected to develop the more serious form of the disease. When they do, progress is usually slow. It can usually be detected early if those who have them are examined periodically. These tests need not be expensive. Miniature x-ray is satisfactory for the purpose.

Tuberculin is available in two forms. "Old Tuberculin" (O.T.) was first prepared by Robert Koch and is made by concentration of glycerin beef broth upon which tubercle bacilli have grown. It is slightly cheaper and keeps better after it has been prepared. Solutions may be kept as long as six weeks. However, it is not well standardized and varies in strength from one laboratory to another, and from time to time in the same laboratory. Dosage is controlled by dilution.

Purified Protein Derivative (PPD), is prepared by chemical precipitation of heated culture filtrate after growth of tubercle bacilli on a synthetic, non-protein medium. PPD is well standardized, but it should not be kept longer than two weeks after dilution, even when refrigerated. The National Tuberculosis Association recommends PPD as the tuberculin of choice because its uniform strength allows more accurate interpretation and comparison of reactions.

Amount of diluent remains constant and dosage is controlled by variation of the size of the pellet which is dissolved: 0.1 ml of first strength solution contains 0.00002 mg of PPD (one tuberculin unit), 0.1 ml of intermediate strength provides 0.001-0.002 mg of PPD (5-10 tuberculin units), 0.1 ml of second strength solution has 0.005 mg of PPD (250 tuberculin units). It should be noted that the intermediate dose is only a little stronger than the first, but the third is very much greater.

Testing Procedures

Various methods have been used to give tuberculin. Robert Koch injected it subcutaneously. For a while it was applied to the scarified skin (Pirquet Test). More recently it has been placed in direct contact with normal skin according to a technic evolved by Vollmer (Patch Test). The last method became quite popular for a while because of ease of application and convenience. However, it is not recommended now because of inaccuracies. Most recently, a multipuncture procedure known as the Heaf Test has been developed in England but it has not been generally accepted yet in this country.

The method of choice for administering tuberculin is the intracutaneous test (Mantoux), in which a measured amount of tuberculin (0.1 ml) is introduced into the skin. Injection is made with a short sharply-beveled steel or platinum needle (No. 26) and a tuberculin syringe. The syringe should not be used for other diagnostic materials because of the possibility of cross-sensitivity from the introduction of other allergens. Injection should be made into the skin just beneath the surface with the bevel up. When done properly, a pale elevation of the outer layers of the skin appears at the tip of the needle. Subcutaneous injection will not produce a local reaction capable of interpretation, and it may cause a general febrile response.

In our experience, first strength tuberculin (one tuberculin unit) is too weak. Even patients with positive sputum may fail to react to it. However, it can be used if there is reason to fear a violent reaction in an allergic individ-

ual, or for one who is strongly suspected of having active tuberculosis. If a negative reaction is obtained, it should always be followed by an injection of intermediate and/or second strength tuberculin.

It is generally agreed that the intermediate strength (five to 10 tuberculin units) is best for case-finding. A positive reaction can be expected in 95% of cases with active disease. Second strength tuberculin (250 tuberculin units) is not recommended for routine use because of the possibility of false positive reactions. However, it is helpful in the differential diagnosis of demonstrable lesions to discover the five percent of active cases which do not produce positive reactions to smaller concentrations. The test should be read after 48 to 72 hours. Redness is less significant than swelling.

Interpretation of Reactors

A characteristic, positive reaction consists of edema and/or induration of the skin at least five millimeters in diameter. This may, or may not, be surrounded by an area of hyperemia. Induration should be noted by gentle palpation and not by inspection alone. The indurated area should be measured. Reactions are usually reported as follows:

Negative—no induration (may have redness without swelling or a trace of induration less than 5 mm in diameter.)

Positive, plus one—induration 5 to 10 mm in diameter

Positive, plus two—induration 10 to 20 mm in diameter

Positive, plus three—induration over 20 mm in diameter

Positive, plus four—severe induration with necrosis (rare).

If there is no reaction whatever to the injection of tuberculin of intermediate strength, there is little chance that a tuberculous infection is present. A low degree of sensitivity with induration less than five millimeters in diameter could be the result of infection from other acid-fast organisms, or of an insignificant tuberculous infection. The chance of active tuberculosis being present is extremely small. Once acquired, strong sensitivity usually persists throughout life, although it may decline in old age. This sensitivity may vary in intensity, and may decrease temporarily or disappear during a high fever, exanthematous disease, miliary tuberculosis, terminal tuberculosis of other types and during steroid therapy. Conversely, there appears to be a relationship between the degree of sensitivity and the probability of having or developing active tuberculosis. Recent studies indicate that more intense reactions are found in those who have, or who are most apt to develop, active tuberculosis.

Today there is much talk about crash programs, such as the one which developed the atomic bomb. These are all-out efforts to obtain maximum results in the shortest space of time. Such a plan is possible for the control of tuberculosis. Everyone would have a tuberculin test and all positive reactors would be x-rayed. The number of unknown active cases would thereby be reduced immediately from about 33% to five percent, or less. Those with positive reactions from less serious tuberculous infections could be examined annually (by photofluororoentgen technic, to save expense). Clinical lesions would be detected early and treated before they advanced to the communicable stage, or at least the contagious period would be held to a minimum.

All negative reactors could be re-tested annually to pick up new infections which develop later. Each new resident would be screened. Conversion of the reaction from negative to positive would indicate the need for x-ray surveillance. Indeed, some believe that this is an opportune moment to institute antibiotic therapy, and evidence is accumulating to support this thesis. The diagnostic use of radiation for tuberculosis control would thus be confined to those with a definite indication for its use.

A program like the one described would, of course, require much effort and a lot of money, but it would also yield a big return. Prevention of spread of the disease by better case-finding would reduce the need for isolation and treatment, which is now costing us hundreds of millions of dollars per year. The goal of elimination of tuberculosis may be brought closer. The time might come when this disease would join other great pestilences, which have been reduced to the point that they are no longer serious problems.

There does not appear to be sufficient interest or knowledge to support a crash program for the control of tuberculosis at this time. In what group of people then, has the test its greatest value?

The tuberculin test should be used on everyone who has been recently exposed to a newly discovered case of tuberculosis. Negative reactors should be redone in four to six weeks to make sure they were not tested before sensitivity had time to develop. Positive reactors should be watched closely for the next few years. An x-ray every three or four months for the first two years would be considered good practice. The interval between examinations might then be increased to six months for another year or two. After this an annual checkup should suffice, and the use of miniature x-rays would be economical and adequate for the purpose.

Productive in Pre-School Age

Tuberculin testing is especially productive in pre-school children. The yield of positive reactions should be small, but each one that is found would have special significance. It means that infection must be recent, and therefore, possibly unstable. Many authorities now believe a positive reaction at this age is sufficient to indicate treatment with isoniazide, even though there may be no other evidence of tuberculosis present. The social contacts of very young children are limited. A positive reaction in an infant, for example, frequently means that the source of infection is close at hand in the household or family circle. Thus the tuberculin test may have an unique value. It can lead to the discovery of active disease in someone else beside the person tested.

The school population is relatively easy to reach with the tuberculin test. Our state board of health recommends the following program: Each student should be tested in the first grade, or before he enters school. He should be retested, if he is a negative reactor, before he completes the elementary grades. While in high school two tests should be done, one of which ought to be in the senior year since this may be the last opportunity. A good health program for institutions of higher education would also include two tests. Incidently, it is good practice to reduce radiation of these young people by the use of standard equipment which produces less exposure than survey machines.

Testing Indiana School Personnel

In Indiana we now have a special opportunity to use the tuberculin test effectively and economically. The last legislature made it permissible to use this test in the physical examination of school personnel. Formerly teachers were required to have an x-ray of the chest every three years as a precaution against any of them spreading tuberculosis among their students. Now those with a negative reaction to tuberculin, need not have an x-ray. Teachers as a group do not have a high incidence of tuberculous infection. Thus, the majority will avoid unnecessary exposure to radiation, and the school boards will be spared expense. On the other hand, positive reactors will be watched more closely to prevent them from developing communicable disease. The new law requires these individuals to have an x-ray annually.

The patients in a physician's practice are another special group in which the tuberculin test is a valuable procedure. The doctor should know whether his patient harbors a threat to health in the form of a latent tuberculous infection. Often x-ray alone will not give him the answer, but the tuberculin test will. Most of his patients will react negatively and they can be assured that they are in no danger from this source without further examination and cost. The positive reactors can be warned so that they will be protected by periodic x-ray examinations. The combined use of these two procedures, the tuberculin test, and when necessary, the x-ray, should be a part of every complete individual examination. The physician will have the satisfaction of knowing that his diagnosis is thorough and that he is practicing good preventive medicine, both of which reflect to the benefit of the patient. ◄

Healthwin Hospital
20531 Darden Road
South Bend, Ind.

The Journal of the Indiana State Medical Association

MEDICAL ESSAY CONTEST

for

Interns and Residents of Indiana Hospitals

During the intern and resident year of 1960-61 The Journal is sponsoring a medical essay contest open to interns and residents of hospitals in Indiana. The subject matter will be limited to clinical experience observed primarily in the teaching hospital of the author. Presentations may contain up to 4,000 words and preferably should be illustrated with clinical pictures, graphs or tables.

A first prize of $100.00, a second price of $75.00 and a third prize of $50.00 will be awarded. All entries are eligible for consideration for publication in The Journal.

Manuscripts will be judged by a prize award committee selected by the Editorial Board of The Journal and by the Dean, Indiana University School of Medicine.

Manuscripts should be prepared in accordance with the specifications outlined on the masthead page of The Journal.

Entries must be submitted prior to May 1, 1961.

The manuscript itself is to be identified only by the title. The author's name must not appear in the manuscript. Instead, a special title page bearing the title and the author's name and address should accompany the paper. Mail entries to Mr. James A. Waggener, 1021 Hume Mansur Bldg., Indianapolis 4.

The Case of the Changing Personality



*ARNOLD LIEBERMAN, M.D.**
New York, N. Y.

EVERY FAMILY has tales of fabulous relatives and ours was no exception. As a very small child, I had been brought to this country by my parents who had decided to leave Czarist Russia after the abortive 1905 revolution. As an infant, I had been left with my grandparents while my mother and her brother Vitia had gone out on the barricades against the detested Cossacks.

It was her brother, Vitia, who had saved her life by a bit of derring-do; it was Vitia who had stayed on in Russia and had become a hero of the underground; it was Vitia who had married his childhood sweetheart and had become a most successful lawyer in St. Petersburg, the nation's capital. It was Vitia this and Vitia that—my earliest memories are tales about this extraordinary relative.

Particularly fascinating (among many) was the tale of a terrifying experience Uncle Vitia had undergone back in his student days. He, along with many other wealthy youngsters, had dabbled in bold talk about a brave new world, social justice and other such things. However, in actual life he seems to have been a social butterfly more interested in amour than Marx. One fine spring day Uncle Vitia had been scheduled to leave for his summer vacation at the family's country estate. He had remained in the big city just because of an extra special date with THE girl, Nina.

By the time he had squired her around, escorted her home and said the last lingering good night, it was early morning. Rather than take a drozhka, the horse-drawn cab of those days, he decided to take a stroll in the cool dawn. Early risers on their way to work were already on the streets. He was passing a corner just as a policeman was corralling an argumentative drunk; it was strictly none of his business but he stayed to see the outcome. The police whistle blew; a passing squad of Cossacks appeared as if by magic—a tumult whirled up. Uncle Vitia was ridden down by the horses and picked up as an instigator of the riot; what other reason was there for this elegantly attired student being out so early in the morning?

He was taken before a sleepy police functionary who resented thoroughly the high-falutin, upper class students with their fancy uniforms and dandyish airs. Uncle Vitia was tossed into the maximum security ward of the prison for politicals! There had been many student riots that spring and the Minister of the Interior was put into an especially bad mood by the report of the latest disturbance afflicting

* One of a series of case reports. Dr. Lieberman formerly practiced in Lake County, Ind.



. . . Nina had chatted . . . about former times.

the capital; the minister ordered the warden "to make an example" of several ring-leaders.

Cat of Nine Tails

The jailer happened to be an unregenerate sadist at heart: a forerunner of the Ilse Kochs and Heydrichs of a later generation. On the strength of the vague order, he chose several men to be flogged in succession. Each prisoner was to be led into the courtyard, spread-eagled and given a HUNDRED lashes with the cat of nine tails! As the youngest of those "chosen," Uncle Vitia was last on the list of the doomed.

Fortunately for him, a bribed guard had gone post haste to Uncle Vitia's father (my grandfather), a wealthy merchant prince who knew all the right people. On learning about Uncle Vitia's predicament, my grandfather had dashed immediately to a prince in the Czar's immediate entourage. My grandfather and this prince got a peremptory order from the Czar himself; with the document in their possession, their coach galloped to the jail in time to release Uncle Vitia and to save the others from death by flogging.

Many other tales were told about Uncle Vitia; still, this was the one that made him a sort of combined Count of Monte Cristo and d'Artagnan in my eyes. During the early part of World War I, we used to get mail rather frequently from Uncle Vitia and his wife, Nina. Then came the 1917 Revolution and chaos. We did get a letter from another relative telling us, among other things, about Uncle Vitia's heroic intervention saving the officers of the Baltic squadron to which he was attached. It seems that the revolting sailors had wanted to toss their officers overboard; Uncle Vitia had been made the ranking revolutionary commissar for that unit; he had made a point of "revolutionary justice" being meted out by a shore tribunal; the officers were held until port was made and then turned over unharmed. Uncle Vitia had run no small personal risk when he had interposed himself between the mob of armed sailors and their chosen prey! Be it as it may, we did get a brief note from uncle himself saying that he was doing important work in the foreign commissariat as the personal secretary of Foreign Minister Chicherin. As the latter was not a party member, it was Uncle Vitia's task to keep an eye on the minister himself! That, of course, he did not spell out; it was obvious in the context.

After that, the mail all but ceased filtering out from behind the heavy fog blanketing the horrors of the rending Civil War and ultimate Bolshevik triumph. Then, rather suddenly, a childhood friend of my mother arrived in our fair Hoosier city; he was a refugee from Russia and he had news. For one thing, Nina, Vitia's wife, had died. For another thing, Uncle Vitia himself had become an important official under Dzerdzinsky, the dread fanatic first head of the CHEKA, the secret, special committees administering "Revolutionary Justice"—in short, the secret police. Only the toughest, least squeamish, most dedicated fanatical Bolsheviks worked there!! My mother was absolutely dumbfounded.

"My gentle, lovable Vitia? Why, he would never hurt a fly."

"But, Sophie, I saw him in his office and furthermore . . ." He dropped his voice with a meaningful look in my direction, but then, I did hear him saying that Uncle Vitia had been with Marshall Tukhachevsky when the Kronstadt sailors were ordered massacred for insubordination (Lenin had ordered the holocaust personally). That was a gory and shameful chapter in Russian Revolutionary history—apparently, Uncle Vitia had been up to his ears in that, too.

Then the guest went on further about something else; seeing that I had been trying to listen, he leaned over and whispered something into my mother's ear. She recoiled with horror and then flushed with indignant wrath, "I don't believe it; that must be all malicious gossip. You men are all alike; Ninochka never could have had an affair with him. And as for Vitia—I would not believe it if I saw it with my own eyes!"

Our guest sighed solemnly and regretfully; the subject was changed. However, Uncle Vitia was no longer mentioned in my presence by either of my parents.

Gallantry is Thin Veneer

That is—not until Uncle Vitia arrived—unheralded and unannounced but very much in the flesh! The tingling twenties were just beginning, I was just starting my college career and was coming home from Chicago only over the week-ends. The door bell rang one Friday night—and there he was. Superficially, he had the air of debonair loquacity and gaiety always ascribed to him. After the first startled gush of greetings, we sat and had supper together. It was obvious that this gallant overlay was a very thin veneer.

He was a smallish man with prematurely thinning hair; lean, not over 130 pounds and barely five feet-four in height. He had extraordinary hazel eyes which could twinkle as he narrated an anecdote and then could, in the very next instance, become menacingly hooded and bleak. The nose was beaked with flaring piratical nostrils; the chin jutted pugnaciously suggesting one accustomed to command and impatient of restraints. The tiny mustache, later made famous by Charlie Chaplin (and Hitler) added to the slightly dandyish note of camouflaging social grace. But he strode with a gliding, lithe, all-muscle and sinew flow suggestive of a hungry leopard on the prowl. His skin was deeply weathered by long exposure to the harsh outdoors. The hands were small and almost effeminately manicured and polished; the fingers could run caressingly over the strings of a violin. He was very good with water colors—also, he was a first class judo expert, superb horseman and absolutely deadly with saber and sword.

Uncle Vitia was attired most expensively in the latest London mode. When my mother twitted him rather jokingly about how capitalistic he seemed to have become, he replied, rather nonchalantly, that he had stopped in London en route and that representatives of the Great Soviet Union (mouthed as one word in the best grandstand manner) had to maintain appearances. "I've come as a lawyer attached to Amtorg to help negotiate some deals," was all he would say about himself.

He was to share the other bed in my room; he came up with his small valise. On the book shelf was a volume of Pushkin's poems that he and his wife had sent to me as a birthday present—many, many years ago. Uncle Vitia picked up the book and started leafing through it; he saw Nina's casual handwriting of the inscription on the fly leaf. He grew rigid; the fists clenched so that the knuckles turned white; recessed fires glowed in his eyes as color mantled his cheeks. I could all but hear the inarticulate, throaty growl; his hair bristled and I could almost see his hackles rising. All I could think of was an inane, "I'm sorry but I forgot that Nina is dead; it has been so long ago and I never knew her."

Glad We Were in Chicago

"What did you hear?" There was such cold menace in that simple question that I was absolutely taken aback. I was rather glad (uncle or no uncle) that we were in our prosaic Chicago suburb and not in the cellar of the Liubianka prison, the Moscow lair of the Chekists.

"Why, we learned just last year that she had died during the Civil War; I was told that you had loved her deeply; I'm sorry that the sight of her handwriting should have upset you so."

My evident surprise and ingenuousness satisfied him; slowly, he wrenched his feelings back under control. Soon, he was telling a gay anecdote. I admired the exquisite craftsmanship of his new boots.

Next week our émigré friend was over for a visit. He was alarmed to hear of my uncle's presence in this country. "If he is here, something BIG is brewing, believe me." Then he leaned over to me and said, "You are a grown man now and you should know that your uncle was a ranking commissar during a crucial battle of the Civil War. It was his home city and Nina was with him. Well, Nina had been seen chatting with a former good friend of theirs. That very evening, this friend was pinpointed as a Czarist spy; a babbling confession was

wrung from this poor wretch. I don't know the details but your precious uncle was right there; one report had it that this man confessed to being Nina's lover; another man who should have been in a position to know stated categorically that Nina had chatted merely on a chance street corner about former times. All accounts agree, however, on one thing: Nina died that same evening . . . Whether she just had a merciful bullet behind her ear or whether Uncle Vitia had had her tortured—she *died*. Along with many thousands of others, she was buried in a mass grave—one of many that were dug for the victims of the ferocious fighting that devastated the unfortunate city. Of course, there was no one to dare ask Vitia as to what did transpire between husband and wife in the last hour of her life."

Uncle Vitia dropped us a brief note from New York; we heard that he had sailed back to Russia. We heard—indirectly, of course—that there had been a real purge in Amtorg. Our émigré friend had been so right. . . . We heard also other tales: about the deadly struggle between Stalin and Trotsky that broke out after Lenin's death. About Uncle Vitia's fanatical devotion to Trotsky—other things . . . just as one example, many years later we were told how this same Marshal Tukhachevsky (Stalin purged him in 1937) and—my uncle, of course, had come to Trotsky for permission to liquidate Stalin and his entire entourage while they still had the physical capacity. Trotsky had said, "The Revolution does not eat its children (quoting Danton)." My uncle was quoted as saying, "Oh, yes, it will. The difference is that you, my dear leader, and your followers will be eaten; it really is too bad that you still have some of that *Jewish compassion* in you! The Georgian won't hesitate."

Somber Specter of His Youth

Anyways, more years passed; my folks seldom spoke of my uncle. My mother still snorted, "You men are all alike"; however, her heart was not in it. Her brother in the flesh was nothing as she had remembered; he was actually terrifying—almost a somber specter of the radiant youth she had always evoked.

Still more years passed by; I graduated from medical school and opened an office in my home town; Uncle Vitia himself had become a hunted refugee from Stalin, the vengeful Nemesis of all his opponents, great and small. Uncle Vitia came to this country but he avoided our family even if he did not know that we were aware of the circumstances of Ninochka's death, his bloody revolutionary career—other things. . . .

And then one day, he stalked into my office, "I'm a patient this trip! My headaches are getting worse; my memory is failing me; and I just do not seem to be able to think—or even give a damn about it. I've been to several expensive men in New York and they tell me it is all nerves; that I've worked too hard and that I am having belated pangs of remorse for all my misdeeds! Getting a sort of pre-senile fear of HELL! Still, I tell you! I used to have agonizing nightmares about Nina—other things; but lately that has all changed. I just don't care one way or another. The headaches are constant, gnawing and getting worse; I think I am going mad."

As a little boy, I had had a vision of Uncle Vitia as exemplifying all things romantic and glamorous; as a teenager I had seen Uncle Vitia as something tough and terrifying but still as a tremendous personality; now—a decade later—I was looking professionally at Uncle Vitia and I was astonished at what I saw! There was an obvious subtle but definite personality alteration. The sharp and ruthless zealot seemed to have lost his fire; the keen intelligence seemed blurred—somehow, out of focus. The features, the body—all was the same—yet completely different! He looked like a shell drained of content.

In the hospital, Uncle Vitia was gone over with a fine tooth comb. Physical examination was totally unrevealing. The eye grounds might reflect a slight nicking of the arteries and the edges of the discs were, maybe, a trifle less than sharp. He gagged normally and the careful sensory and motor testing was entirely within normal limits. Every reflex in the book failed to give a clue; there was no weight loss; the usual (and bizarre) laboratory tests gave no leads. Neurological consultations led nowheres; pneumoencephalograms, arteriograms, repeated E.E.G.'s, spinal taps, myelograms and all such probing was maddeningly unrewarding!

Personality Flatness Incongruous

The psychological tests, however, were startling! The I.Q. was in the moronic range; the Rorschach and Bellevue Wechsler-type tests

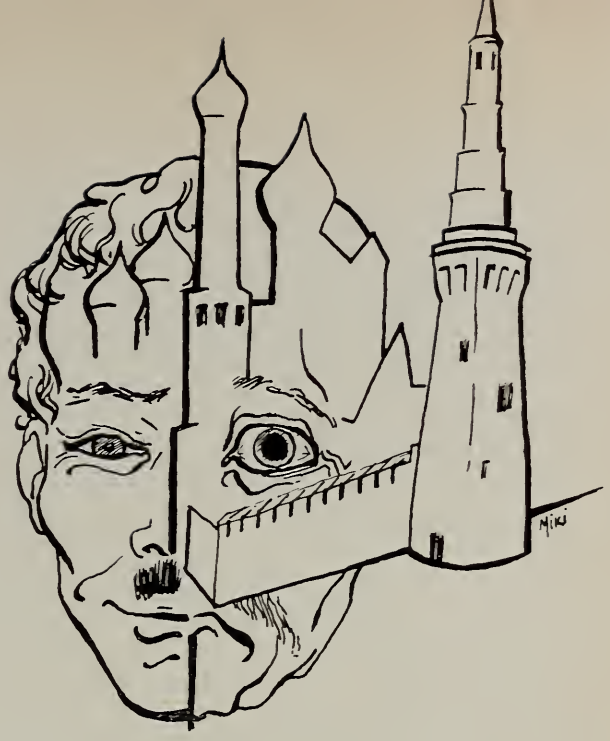
showed a personality flatness which was incongruous: almost ridiculous. Further consultations with renowned specialists elevated eyebrows but only compounded the confusion. There did not seem to be any degenerative disease such as syringomyelia or a sclerosis, multiple, amyotrophic or lateral. No periodic type of lesion seemed present; air studies had failed to suggest a space displacing lesion. Spinal fluid dynamics were normal. The diagnosis of schizophrenia had much to favor it and yet it was just palpably wrong. The same held for either Pick's Disease or Alzheimer's; so—where were we?

After two fruitless weeks in our hospital, Uncle Vitia was reassured, given some powerful pain killers and referred to the Mayos. A long letter and a telephone call went through to the neurological division there. Several weeks later, I heard from them. They suggested—very tentatively—total cerebral atrophy with resultant amentia; cause? Unknown!

Uncle Vitia stopped in Chicago while on his way back to New York. He called us from a hotel and we went over to see him. His gait now was definitely shambling; the voice had the dreadful flat monotone of one in a trance. As I sat there attempting to probe into the wreckage of the person in front of me, I remember thinking distinctly, that Uncle Vitia was behaving just exactly as Pavlov dogs do as they go through their conditioned reflexes routine; at a much later date, the term, "brainwashing" was applied to this phenomenon—that does not change the thing being discussed one bit.

Uncle Vitia rambled along for some five minutes or so; then, loudly and petulantly, he said in Russian, "This headache is unbearable." With lackluster eyes, he gazed around vacantly—and pitched on his face; within seconds he was snoring stertorously even as he lay there, prone, completely unconscious.

Within the half hour, he was at the hospital where we (yet once again) went over him painstakingly. One pupil was now fixed and did not react to light; it was widely dilated; the eyeground seemed unexceptional. The superficial reflexes were gone; the Babinski and Hoffman were positive on the side opposite to the dilated pupil. The spinal fluid was under increased pressure; it had only a little albumin in it and no blood. The neurosurgeon agreed with the



diagnosis of a massive sub-arachnoid hemorrhage.

It did seem a bit unusual in so young a man who had been studied so exhaustively and who had no history of any trauma whatever. The surgeon did not think that there was anything to be accomplished by him but he yielded to my earnest pleas and did a cranial flap under a little local. An enormous astrocytoma was revealed. . . . The tumor seemed to have destroyed most of the visible cortex. The massive, acute hemorrhage could be glimpsed at the very edge of the exposed area extending far beyond the visible field.

Three to 30 Years Progressing

The patient breathed for another day but the coma deepened as all treatment did absolutely nothing to check the terminal signs. The autopsy was startling: almost the entire cerebral cortex *on both sides* was replaced by this most slowly growing, ill-defined neoplasm.* Microscopic

* Recent References to Massive Brain Tumors:

1) Cordero, Ricardo, Lichtenberg, Francisco: "Hemisferectomia cerebral izquierda, por glioma, en uno de cinco meses de edad." *Boletin de la Asociacion Medica de Puerto Rico Enero,* 50:1, 18-20, 1958 (23 references and 7 illustrations).

2) Koranyi, George, Rutkai, Paul: "A Case of a Ventricular Cyst," *Brit. M. J.*, Mar. 8, 1958, p. 564.

3) Austin, George, Grant, Francis: "Physiologic Observations Following Total Hemispherectomy in Man." *Surg.* 38:1, pp. 239-258, July 1955.

These authors present four successful cases of ablation performed by them and give 22 references to some 40-odd cases treated by other surgeons.

In essence, surgery seriously affected perception only: Otherwise, psychological testing showed but little post-operative alteration . . .

sections showed destruction of most of the underlying reticulum system! Yet the pathologists were even reluctant to call the growth malignant; there were no metastases anywhere; the ventricles of the brain seemed to have remained uncompressed until the first (and final) massive hemorrhage! Eminent histologists reviewed the slides; they all agreed on the minimal malignancy; they estimated the tumor as having taken from three to THIRTY years in progressing from inception to the final mammoth dimensions! They declined to be more specific as to time.

In the many years that have elapsed since the events just outlined, I have had ample time in which to try and puzzle out some answers; I cannot say I have obtained them. How did Uncle Vitia manage to get around—especially toward the end? What was he THINKING *with?* "Quién sabe?" There could be no scientific affirmation of any sort. More specifically, was there already a personality change when the gay, lovable young Uncle Vitia started to become a revolutionary? Was the nightmarish experience in a Czarist prison merely an incident and not the cause?

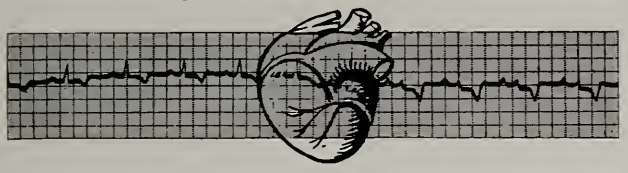
It is certain that personality changes occur as the reticular system and the cerebral cortex become damaged progressively. Was my good mother correct in her memories? And in her shocked surprise at seeing what her brother had become? Most tantalizing, was he already on the way to becoming an automaton when he executed his beloved wife, Ninochka? Did she ever come to whisper to his remaining mind? The grave is silent and science does not have the answer. . . . ◄

1026 Sixth Ave.
New York, N. Y.

SFPOGGWTR

Inglewoods (Calif.) *News Advertiser* published the following letter in its April 26, 1959 issue: "The initials are: SFPOGGWTR, or the Society for the Prevention of Giving Gold Watches to Retirees. Of all the cruel and misguided gestures, this is about the worst. Of all times when a man least needs a reminder of time it is when he leaves a busy normal workaday world and has nothing but time on his hands. It is sad enough when a man, who may still have health, ability and experience to carry on, must leave his job because he reaches a certain age. As he deteriorates in his idleness, the gold watch only serves to make him feel how useless he has become. Besides, any many who has had to arrive on the job on time year after year, already has one or more watches.—*Journal of the Michigan State Medical Society,* May, 1960.

Electrocardiogram of the month



Presented as a regular feature of The JOURNAL, Electrocardiogram of the Month is a series of short talks on cardio-vascular diagnosis and treatment, edited by the staff of the Robert M. Moore Heart Clinic of the Marion County General Hospital, Indianapolis.

Diagnosis of Ventricular Tachycardia

*CHARLES FISCH, M.D.**

Indianapolis

THE RECOGNITION of ventricular tachycardia is extremely important in the management of patients with heart disease. This importance is paralleled only by the difficulties besetting this diagnosis. Ventricular tachycardia can be mimicked by every form of supraventricular tachycardia, be it paroxysmal atrial tachycardia, atrial fibrillation, atrial flutter or on occasions sinus tachycardia when these arrhythmias are associated with pre-existing bundle branch block, aberrant intraventricular conduction due to rapid rate or depression of myocardium such as may result from quinidine administration. We would like to present examples of ventricular (QRS) complexes which, if present, make the diagnosis of ventricular tachycardia a certainty.

Tracings

Figure 1—Lead I shows an extremely regular and rapid rate (220 beats per min.) with aberrant conduction strongly suggestive of ventricular tachycardia. However, the extreme regularity, as well as the rate over 200, raises the possibility of a different diagnosis. This suspicion is confirmed in V2, a tracing obtained after administration of .8 gms of quinidine. This strip shows an atrial tachycardia with a 3:1 response and obvious right bundle branch block. It is the latter which imitated ventricular tachycardia in Lead II when the response was 1:1.

Figure 2—Inspection of this cardiogram reveals runs of distinct P waves in all leads with a P-P interval of 0.60 seconds (rate 100). Inspection of the QRS reveals two distinctly differently appearing ventricular complexes. One is of normal duration preceded by a P wave and the other is broad, measuring .14 seconds. The aberrant complexes represent idioventricular (parasystolic) rhythm with a rate slightly less than 100 beats per minute. The diagnosis is confirmed by appearance of complexes intermediate in appearance between the aberrant and the sinus beats marked F (fusion beats). The fusion beats represent a combination of an impulse originating in the atrium, as shown by a preceding P wave, and one originating in the ventricle. Such a beat rules out either aberrant conduction or preexisting bundle branch block. It in itself is pathognomonic of a ventricular focus.

Figure 3—Strips A, B, C are taken on the same patient after increasing doses of quinidine. Strip A shows a rate of approximately 150 beats per minute with aberrant conduction in questionable independent P waves. The possible diagnoses are: (1) ventricular tachycardia, (2) supra-

* From the Robert M. Moore Heart Clinic, Marion County General Hospital and the Department of Medicine, Indiana University School of Medicine.

Supported by the Herman C. Krannert Fund of the Indiana Heart Association and the Indiana State Board of Health, Indianapolis.

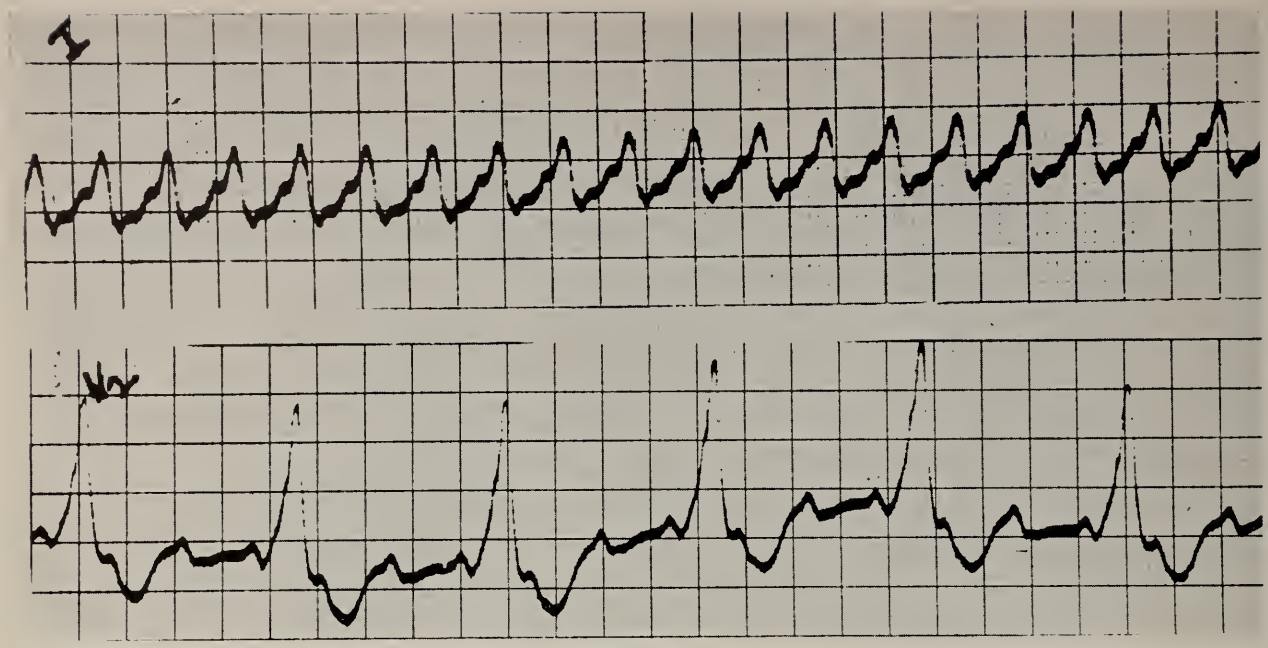


FIGURE 1

LEAD 1 SHOWS a rapid, regular run of aberrant ventricular complexes strongly suggestive of ventricular tachycardia. However, failure to identify independent P waves, the rate over 200 and absolute regularity suggests caution in accepting this diagnosis. Lead V2, obtained after treatment with quinidine, discloses an atrial tachyardia with a 3:1 ventricular response and right bundle branch block. The possibility of W-P-W cannot be ruled out (short P-R with slurring of the upstroke of QRS).

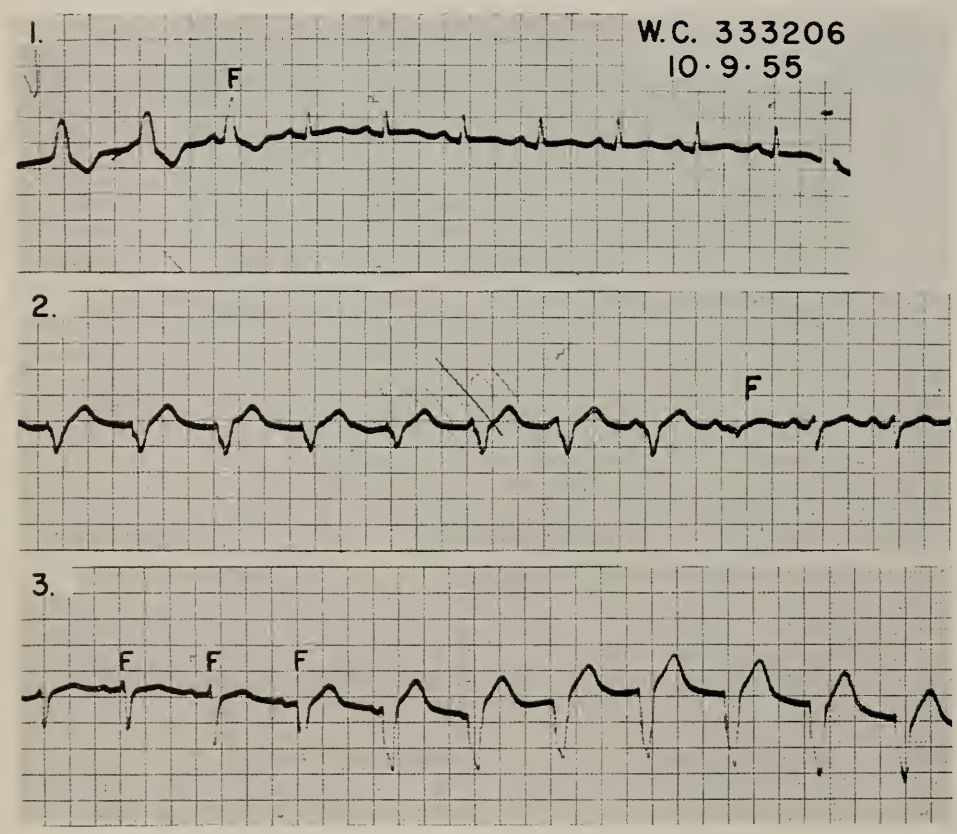


FIGURE 2

THIS TRACING SHOWS sinus rhythm interrupted by a slow ventricular rhythm and fusion (F) beats. For details see text.

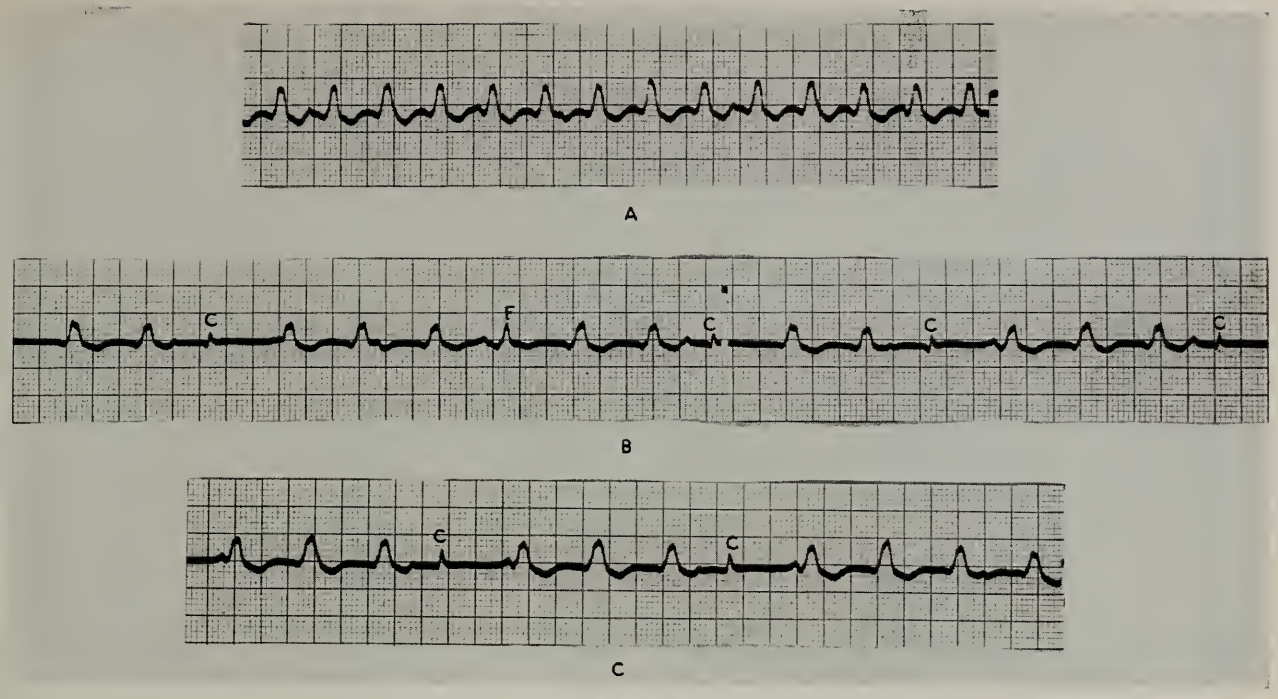


FIGURE 3

STRIPS A, B AND C were recorded on the same patient as the dose of quinidine was being increased. In strip A ventricular tachycardia is suggested by rapid (150 beats per minute), aberrant ventricular rhythm. This diagnosis is supported strongly by the independent sinus rhythm with P waves identifiable after 1, 4, 6, 10 and 14 ventricular complex. However, the possibility of A-V nodal tachycardia with retrograde block and aberrant forward conduction cannot be ruled out. In strips B and C, as the rate shows, definite fusion (F) and capture (C) beats are present ruling out either aberrant conduction or pre-existing bundle branch block. With these two possibilities ruled out the aberrant QRS can be explained only by their originating in an ectopic ventricular focus.

ventricular tachycardia with pre-existing bundle branch block, and (3) supraventricular tachycardia with aberrant conduction. However in strip B, with slowing of the ventricular rate, one sees not only the aberrant complexes but also occasional normally appearing QRS preceded by P waves and marked C. These complexes originate in the atria and have a normal intraventricular conduction. Such beats rule both bundle branch block and aberrant conduction. In strip B a fusion (F) beat and normally conducted (C) beats are present. Normally conducted beats are also seen in strip C. Such beats are commonly called captures and indicate that the ventricle is activated by an impulse originating in sino-atrial node.

Although fusion and capture beats as a rule are pathognomonic of ventricular tachycardia, unfortunately these are discernable in a small proportion of cases of ventricular tachycardia. The clinician must therefore depend on additional features of ventricular tachycardia namely: (1) aberrant conduction with an independent atrial rhythm, (2) presence of premature ventricular beats prior to onset of tachycardia with the appearance similar to that of the ventricular tachycardia and (3) the presence, upon termination of the tachycardia, of a compensatory pause. From the practical standpoint if a patient has received unknown amounts of digitalis, or has sustained a recent and severe myocardial infarction and a definite differential diagnosis between ventricular tachycardia and the other arrhythmia cannot be made, quinidine is the treatment of choice. ◄

wherever there is inflammation, swelling, pain

VARIDASE®

Streptokinase-Streptodornase Lederle

BUCCAL Tablets

conditions for a fast & comfortable comeback

Host reaction to injury or local infection has a catabolic and an anabolic phase. The body responds with inflammation, swelling and pain. In time, the process is reversed. VARIDASE speeds up this normal process of recovery.

By activating fibrinolytic factors VARIDASE shortens the *undesirable phase,* limits necrotic changes due to inflammatory infiltration, and initiates the constructive phase to speed total remission. Medication and body defenses can readily penetrate to the affected site; local tissue is prepared for faster regrowth of cells. In infection, the fibrin wall is breached while the infection-limiting effect is retained. In acute cases, response is often dramatic. In chronic cases, VARIDASE Buccal Tablets can stimulate a successful response to primary therapy previously considered inadequate or failing.

for routine use in injury and infection
...new simple buccal route

VARIDASE Buccal Tablets should be retained in the buccal pouch until dissolved. For maximum absorption, patient should delay swallowing saliva.

Dosage: One tablet four times daily usually for five days. When infection is present, VARIDASE Buccal Tablets should be given in conjunction with ACHROMYCIN® V Tetracycline with Citric Acid.

Each VARIDASE Buccal Tablet contains: 10,000 Units Streptokinase and 2,500 Units Streptodornase.

Supplied: boxes of 24 and 100 tablets.

1. Innerfield, I.: Clinical report cited with permission
2. Clinical report cited with permission

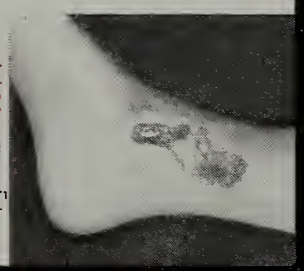
Lederle LEDERLE LABORATORIES, a Division of AMERICAN CYANAMID COMPANY
Pearl River, New York





FORCE INJURY
severe bruises ... swelling ... cleared by fifth day[2]





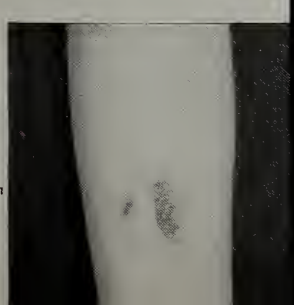
VARICOSE ULCER
15 years duration ... resolved with VARIDASE[1]





INFLAMMATORY DERMATOSIS
rapidly spreading rhus dermatitis healed within a week[1]





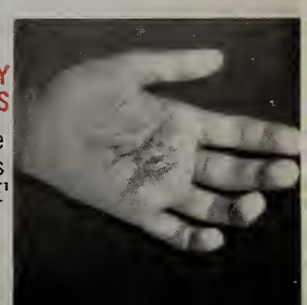
INFECTED LACERATION
marked reversal in 3 days... returned to school... closure advanced[1]





THROMBOPHLEBITIS
back on his feet in a week after recurrent episode[1]





REFRACTORY CELLULITIS
normal routine resumed after 4 days of VARIDASE[1]

The Journal

of the INDIANA STATE MEDICAL ASSOCIATION

Devoted to the interests of the medical profession of Indiana

Editor: Frank B. Ramsey, M.D., 1802 North Illinois Street, Indianapolis 2, Indiana

Associate Editors: A. W. Cavins, M.D., 221 South Sixth Street, Terre Haute, Indiana; Lall G. Montgomery, M.D., Ball Memorial Hospital, Muncie, Indiana; David A. Bickel, M.D., 515 Odd Fellows Building, South Bend, Indiana; Stephen L. Johnson, M.D., 521 Sycamore Street, Evansville, Indiana.

Editorial Board: Term Expires

George M. Johnson, M.D., Richmond . . Dec. 31, 1960
Irvin W. Wilkens, M.D., Indianapolis . Dec. 31, 1960
Harold D. Lynch, M.D., Evansville . . Dec. 31, 1961
Jene R. Bennett, South Bend . . . . Dec. 31, 1961
Samuel R. Mercer M.D., Fort Wayne . Dec. 31, 1962
Franklin F. Premuda, M.D., Hammond . Dec. 31, 1962

Necrologist: James B. Maple, M.D., 117 West Washington Street, Sullivan, Indiana.

Assistant Editor: Sara M. Snyder

Business Manager: James A. Waggener

1019 Hume Mansur Building, Indianapolis 4, Indiana

Voluntary Plans Grow in Coverage, Benefits

VOLUNTARY HEALTH insurance paid out 3.1 billion dollars in benefits in a 12-month period in 1957-58. This was more than twice the benefits during a similar period five years previously.

During the five-year interval the number of families covered by voluntary insurance increased by 16%.

The most important trend was the increasing ability of voluntary plans to cover more of the medical and health costs.

The average insured family in 1957-58 received $80 in benefits. This was an increase of 78% over the $45 reported during 1952-53. On an average, 24% of the total bill for all health services was covered by insurance, whereas, in 1952-53, the figure was 19%.

A recent survey, the third such study, demonstrated that, in addition to the increase in payments, the families with unusually high costs were helped the most by the increased benefits.

Families with total health expenses of $1,000 or more received an average of $362 in 1952-53, as compared with $572 five years later. Families with health costs below $100 per year received relatively small benefits.

This is in line with the intended function of health insurance—to protect against the high and infrequent expenses and to leave the lower expenses which almost every family incurs each year to be paid from the family budget direct without the added cost due to administrative expenses.

The Health Information Foundation reported the results and statistics of the survey in their bulletin of April, 1960, and pointed out that the unusually high medical bills could be more adequately covered under the present voluntary setup if the public was willing to pay for the cost of the added protection.

Insurance is at its best and operates most economically for its customers when it covers the high-cost events which do not happen very often, and is not concerned with frequently recurring relatively low-cost health items.

Today approximately 70% of American families are the beneficiaries of voluntary insurance.

In some states this figure is as high as 90%. A 100% coverage will never be obtained but there are some groups that should have more coverage. Some of the deficiency is by areas, some of it by occupation: as for example, the farmers. Age groups are also pointed out for improvement. Persons over 65 in 1958 were noted as being under-insured, a situation which since then has been considerably improved.

Health insurance is one of the fastest developing phenomena in modern life. Periodic surveys are required to gauge its growth and to plot its evolution. More changes are to expected in the future. It is now demonstrating that it is an economical method for protection against unusual expenses, and a costly method for providing anything which approaches pre-payment of all health expenses.

Complex – Controversial – Costly

CANADIAN NATIONAL hospital insurance is now well along in its second year. To judge from a special story appearing in *The Financial Post* of Toronto, the hospital system which is run on government money (half federal and half provincial) has generated a lot of things beside hospital care. It is described by the *Post* as complex, controversial and expensive.

In the first fiscal year (1958-59) the total cost was around $110 million. This did not cover a full year, nor did it cover all provinces. Quebec province is not included in the scheme even today.

The first nine months of fiscal 1959-60 have seen costs of $220 million.

The estimate for 1960-61 is said to be roughly $335 million. This is real rough—and it doesn't include Quebec. The estimate if Quebec comes in is $435 million.

By 1965 some prophets think the total bill will be $550 million; others set the figure at $650 million. This is an increase of 60% and assumes no inflation of prices.

Another big problem, probably bigger than the huge cost, is overcrowding of hospitals. New general hospital beds, if provided by new construction, will soak up $200 million a year for the next decade. This is labeled as a guess: no one knows for sure how many they will need or how much they will cost.

"Almost no one will want to junk government-sponsored hospital insurance. In fact, it will be certainly expanded."

With the large hospitals crowded, some to over-capacity, most of the provinces are seeking means of lightening the load. There are drives for greater hospital efficiency and shorter hospital stays, while hospital waiting lists deal with the situation directly. Moves toward the building of more nursing homes, homes for the aged and hospitals for chronically ill are under consideration to take the pressure off the hospitals for the acutely ill.

Meanwhile patients tend to stay longer, rather than less. Labor unions are complaining that the government officials are difficult or impossible to deal with, and that the pay scale is too low. Officials complain that unions are difficult to deal with.

The hospital situation has apparently been brought to focus by the proposal to graft a giant government medical care scheme on to it. The doctors are against that. Some officials think that the coast-to-coast medical "insurance" should be adopted as soon as they are able to assure complete freedom of medical practice and free choice of doctors. Others think the government medical insurance should wait until they get the bugs out of the hospital set up. When, if ever?

Foreign Medics Must Meet Standards

TWO CIRCUMSTANCES in the past decade or more have combined to increase greatgreatly the number of foreign medical graduates who seek postgraduate medical training facilities in the United States: (1) the popularity of the American intern and resident training system together with a large number of foreign graduates who seek it, and (2) tremendous disparity (several thousand positions) between the number of U. S. medical graduates and the number of approved internships. The disparity is so large that even with foreign graduates filling many internships there are still many that are unfilled.

These two circumstances have dovetailed nicely to the mutual advantage of the foreign graduates in search of training and the U. S. hospitals in search of interns and residents.

One of the problems, and probably the largest one in selecting foreign graduates for hospital training, is the difficulty of evaluating the candidates' medical qualifications. Medical education throughout the world, outside of the United States and Canada, lacks the standardization to which we are accustomed. The caliber of foreign medical training courses varies from very good down to almost valueless.

In 1950 the AMA and the Association of American Medical Colleges evaluated foreign medical schools and published a list of those schools of sufficient excellence to warrant consideration of their graduates for internships and residencies.

After a few years the number of graduates entering the United States for training had increased so much, and the difficulties of maintaining accurate information about foreign schools had become so difficult, that a new system was needed.

Accordingly, in 1957, the Educational Council for Foreign Medical Graduates (ECFMG) was founded under the sponsorship of the AMA, the A. A. M. C., the American Hospital Association and the Federation of State Medical Boards of the United States.

Since 1957 the Educational Council has examined foreign medical graduates to determine their medical knowledge and also to determine what is almost as important in the case of a candidate applying for a position involving patient care—his ability to communicate in the English language.

The English test is oral. The medical test is a written multiple-choice examination which utilizes questions from the National Board of Medical Examiners. Questions are selected as being least likely to confuse one whose command of English is limited. Educational credentials are verified prior to the examination.

Citizens of foreign countries and U. S. citizens who have received their medical training abroad, exclusive of Canada and Puerto Rico, must take the examination if they are seeking hospital appointments which involve patient care. About 4,000 individuals have taken and passed the examination.

The last examination was held on March 16, 1960. There were 7,500 persons registered for the exam, held in 55 centers in the United States and in 64 foreign countries.

The AMA has stated that beyond July 1, 1960, no hospital should expect to maintain an approved internship or residency program unless its appointees who are graduates of foreign medical schools either:

a. have a full and unrestricted state license to practice,

b. are in their final six months of training,

c. have secured a standard or temporary certificate from ECFMG, or

d. have been given a contingent appointment for not more than six months based on their having been accepted for the September 1960 ECFMG examination.

The American Hospital Association has announced that it will not list any hospitals, with or without residency training programs, as eligible for accreditation, if they have not relieved uncertified medical graduates from patient care situations by Dec. 31, 1960.

Examination and certification of those who pass the test, together with the actions of the AMA and the A. H. A., will insure high standards of patient care in hospitals which are training foreign medical graduates. Under this system thousands of otherwise vacant internships and residencies may be filled and the advantages of American residency training may be made available to properly trained foreign graduates, with adequate safeguards to insure high quality patient care.

Youngsters are the Safest

AUTOMOTIVE CRASH Injury Research of Cornell University, which originated following the pioneer research activity of the Indiana State Police, and with which the Indiana State Medical Association has been associated for many years, recently published a special report on "Child Injuries in Automobile Accidents."

The report is based on the analysis of 14,250 non-pedestrian automobile accidents on rural or open highways in which 31,925 occupants were exposed to the possibility of injury. Of the total number of occupants 75.7% were injured. Except as noted, all the findings set out below have been determined to be statistically significant.

Children were spared injury to a much greater degree than were adolescents and adults. Only 52.2% of the children passengers were injured, while 71.3% of the adolescents and 79.5% of the adults were injured.

When examined in regard to severity of injury the record showed that children sustained more minor injuries and fewer serious injuries. The children received more head injuries proportionately than did their elders, but fewer injuries to other body areas.

Multiple injuries were also more frequently observed in the older groups. Injured children had an average of 1.4 body areas involved, adolescents 2.0 areas and adults 2.2 areas involved.

In a classification of severity of body area injuries, children were found to have less severe injuries in all areas except the lower extremities. Injuries of the head, thorax, abdomen and neck were less severe and injuries of the upper extremities were the same.

It is well known that the injury rate in an automobile varies with the different seat positions. Analysis showed that the more favorable experience of children in regard to injury was not due to their more frequent location in the safer seats. Children's injuries varied with seat location almost exactly as do adult injuries. Rear seats are the safest, front seats the most dangerous. Unusual seating (lap-carried, standing, reclining, fourth occupants of three-passenger seats, occupants of center bank of seats in station wagons, etc.) in this report showed for children a slightly higher injury rate than the front seat, but the number was too small to be statistically valid.

The study definitely identifies two factors which account for the favorable injury record for children. One—age probably contributes to safety because of less weight and height, and greater resiliency. Further study may indicate how these factors may be taken into account to further reduce the injury pattern. The other factor—seating area occupied is a reliable lead to greater safety. Children occupy rear seats more often than adults; rear seats are safer. A secondary factor, that of less ejection from the car from rear seats and the avoidance of severe injury due to ejection, is very probably an important consideration.

Future studies of this problem will examine other possible factors—speed, area of impact, type of accident, and type of automobile involved. In the meantime, the favorable injury pattern for children may be reduced even more by taking advantage of the rear seat positions.

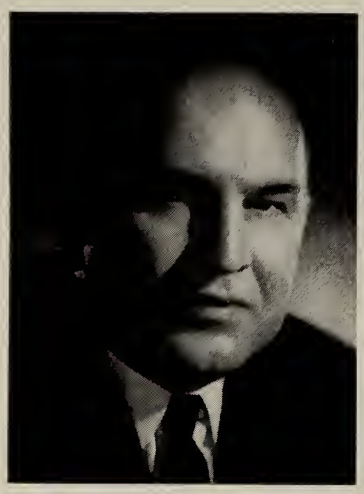
Journal Offers $5 Each for Anecdotes

A new department of *The Journal* is being organized for the publication of accounts of personal experiences of Indiana physicians. The practice of medicine is interwoven and frequently involved with the drama of life. In a lifetime of practice doctors are in contact with many episodes of amusing, thrilling, ridiculous or dramatic import. Members of the association are invited to submit manuscripts for this purpose. Author's names need not be published, initials may be used. The narrations may be short, but should be limited to 1200 words. *The Journal* will pay $5.00 for each one published.

President's Page

The national political conventions have come and gone and, again, the platforms are not too dissimilar. Both platforms have planks which, if implemented, will lead our nation farther down the pathway toward the "welfare state."

Medicine again finds itself girding for the fight that is certain to come—welfare state versus private enterprise. In the years since World War II, medicine has had to devote much of its strength to this continuing struggle. We were inexperienced and poorly prepared for the encounters of the past, some of which were won, and others lost. In the main, however, our efforts did stem the steamroller dedicated to making our society a welfare state.



Our fight now is, perhaps, the most critical we have ever faced. Our enemies are entrenched and well-organized. There is much to be desired in our own ranks. Our strength is not being marshaled to its greatest possibility because communication within our ranks is not effective. We have two physicians running for public office and support from our own Association is poorly organized in their behalf. This is typical of many of our actions. We must develop communication in order that unity can be achieved so that strength is available where needed and not left unused or used unwisely.

Medicine has a colossal power to promote the best interests in our society and these interests are to private enterprise and not toward a welfare state. Our patients will listen to us and consider our advice in these matters but we must offer it before it can be considered.

At one time the state of Florida was threatened by a political disaster and this was prevented by organized medicine's effort to defeat it. This is proof that it can be done. In that state communications were effective and singleness of purpose with unity was achieved.

Continued

In Acute Illness...

NILEVAR®

Can Speed Recovery

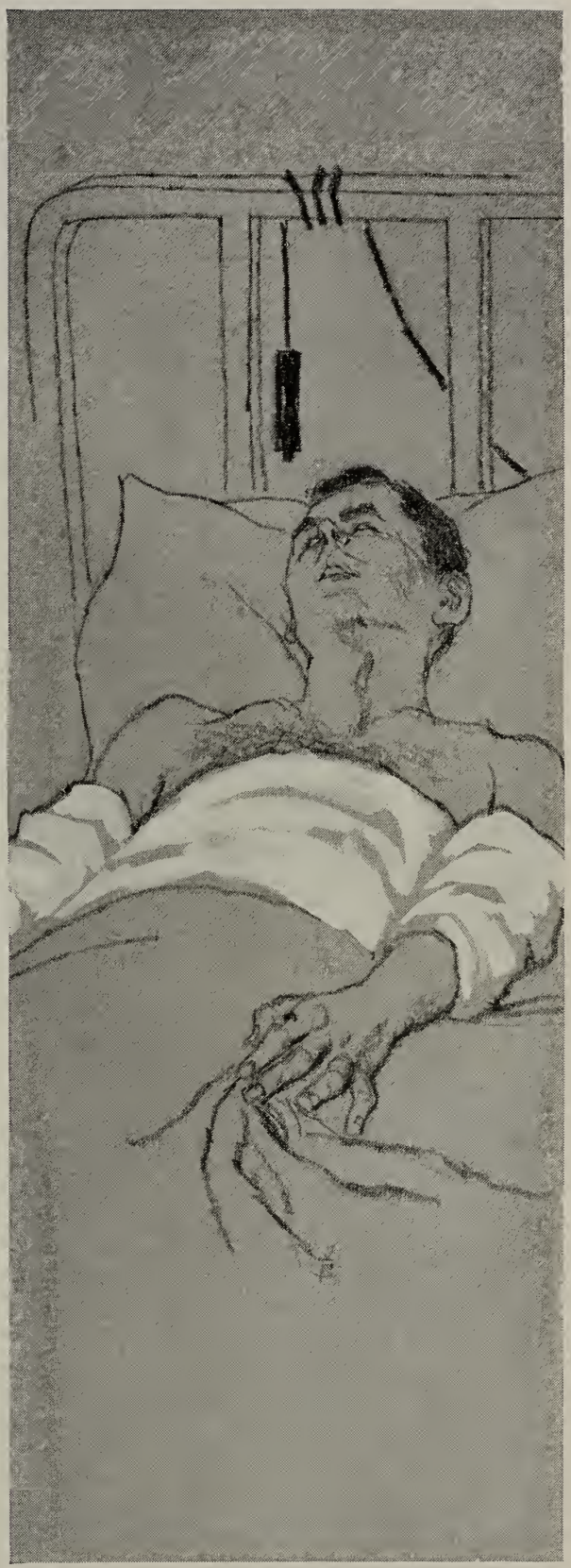
"Commonly, negative nitrogen balance[1] occurs during acute febrile illnesses and following traumatic events and surgical procedures." As much as 300 to 400 Gm. of nitrogen[2] may be destroyed daily in severe infections. Convalescence[1] is delayed when negative nitrogen balance is large and persistent.

NILEVAR Builds Protein, Speeds Convalescence to Complete Recovery[3-6] ". . . we were impressed[3] with the efficacy of Nilevar as an anabolic agent. All of the patients reported feeling much more vigorous and experiencing an increase in appetite. . . ."

The actions of Nilevar[4] in reversing a negative nitrogen balance—and therefore a negative protein balance—improving the appetite and increasing the sense of well-being can be expected to shorten the illness and the convalescence of these patients.

An initial daily dosage of 30 mg. of Nilevar (brand of norethandrolone) is suggested. After one to two weeks, this dosage may be reduced to 10 or 20 mg. daily in accordance with the response of the patient. Continuous courses of therapy should not exceed three months, but may be repeated after rest periods of one month. Nilevar is supplied as tablets of 10 mg., drops of 0.25 mg. per drop and ampuls of 25 mg. in 1 cc. of sesame oil with benzyl alcohol.

1. Eisen, H. N., ond Tobochnick, M.: Protein Metobalism, M. Clin. Narth Americo 39:863 (May) 1955. 2. Jomison, R. M.: Generol Nutritive Deficiency, Virginio M. Month. 83:67 (Feb.) 1956. 3. Goldforb, A. F.; Nopp, E. E.; Stone, M. L.; Zuckermon, M. B., and Simon, J.: The Anobolic Effects af Norethondrolone, a 19-Nortestasterone Derivotive, Obst. & Gynec. 11:454 (April) 1958. 4. Botson, R.: Investigotor's Report, Feb. 11, 1956. 5. Weston, R. E.; Isoacs, M. C.; Rosenblum, R.; Gibbons, D. M., ond Grossmon, J.: Metobolic Effects of on Anobolic Steroid, 17-Alpho-Ethyl-17-Hydroxy-Norondrostenone, in Humon Subjects, J. Clin. Invest. 35:744 (June) 1956. 6. Brown, C. H.: The Treotment of Acute ond Chronic Ulcerative Colitis, Am. Proct. & Digest Treot. 9:405 (Morch) 1958.



G. D. SEARLE & CO.
CHICAGO 80, ILLINOIS

Research in the Service of Medicine

Presidents Page

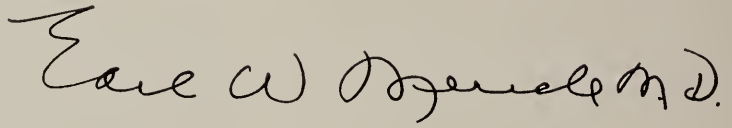
Continued

Our state Association publishes a magazine; news flashes are sent to members; actions of commissions are sent to members of commissions and local societies have bulletins that are published and sent out to their members. In spite of all these efforts one finds many members uninformed about matters of civic interest. This may be due to apathy on the part of our people; however, after an experience of seeing some of our members in small groups one does not find apathy or disinterest.

Our state has 82 county societies. In some of them civic concern is high. Where this concern is high the members are informed and unity is accomplished. The efforts of such a society are effective. In other societies, where the concern is not great, the efforts of the society to help in molding public opinion is poor. The difference between the two is a lack of communication.

One can be certain that if all physicians of the state were sufficiently aroused to the present dangers we face, our efforts would be tremendously enhanced. Certainly now all county society officers, all state officers, and, in fact, all doctors must become very active in alerting all possible physicians to action. Our members can accomplish much in the public interest, but before much can be accomplished, all must be informed as to the situation and the need.

One pertinent fact stands out and that is—if every physician will make an effort to inform himself, our communications will be all that can be desired.



Clinical results with Trancopal®[2]

	Excellent	Good	Fair	Poor	Total
LOW BACK SYNDROMES					
Acute low back strain	25	19	8	6	58
Chronic low back strain	11	5	1	1	18
"Porters' syndrome"*	21	5	1	1	28
Pelvic fractures	2	1	—	—	3
NECK SYNDROMES					
Whiplash injuries	12	6	2	1	21
Torticollis, chronic	6	2	3	2	13
OTHER MUSCLE SPASM					
Spasm related to trauma	15	6	1	—	22
Rheumatoid arthritis	—	18	2	1	21
Bursitis	2	6	1	—	9
TENSION STATES	18	2	4	3	27
TOTALS	112 (51%)	70 (32%)	23 (10%)	15 (7%)	220 (100%)

*Over-reaching in lifting heavy bags resulting in sprain of upper, middle, and lower back muscles.

Dosage: **Adults, 200 or 100 mg. orally three or four times daily.**
Relief of symptoms occurs in from fifteen to thirty minutes and lasts from four to six hours.

How Supplied: Trancopal Caplets®
200 mg. (green colored, scored), bottles of 100.
100 mg. (peach colored, scored), bottles of 100.

Winthrop LABORATORIES, New York 18, N. Y.

The Women's Auxiliary

REPORTS TO ISMA

HAVE YOU MADE YOUR RESERVATIONS FOR THE ISMA CONVENTION, OCTOBER 2-5?



The 1960 Annual Indiana State Medical Convention at French Lick, Indiana may well prove to be one of our most outstanding conventions to date. Do come and bring your wife. The convention is open to all members of the Auxiliary, and a most cordial invitation is extended to the Doctor's wife who is not an Auxiliary member. The convention program has been planned to allow as much free time as possible so that you and your wife may enjoy the beauties and recreational facilities available.

French Lick is a nationally known community nestling in the Cumberland foothills. The French Lick-Sheraton Hotel is now completing a three million dollar renovation program which will completely modernize all facilities. Everything will be ready by the first of October. A few of the recreational facilities that will be available:

2 champion golf courses (Tournament)
skeet and trap shooting

2 outdoor swimming pools—2 indoor swimming pools
horseback riding

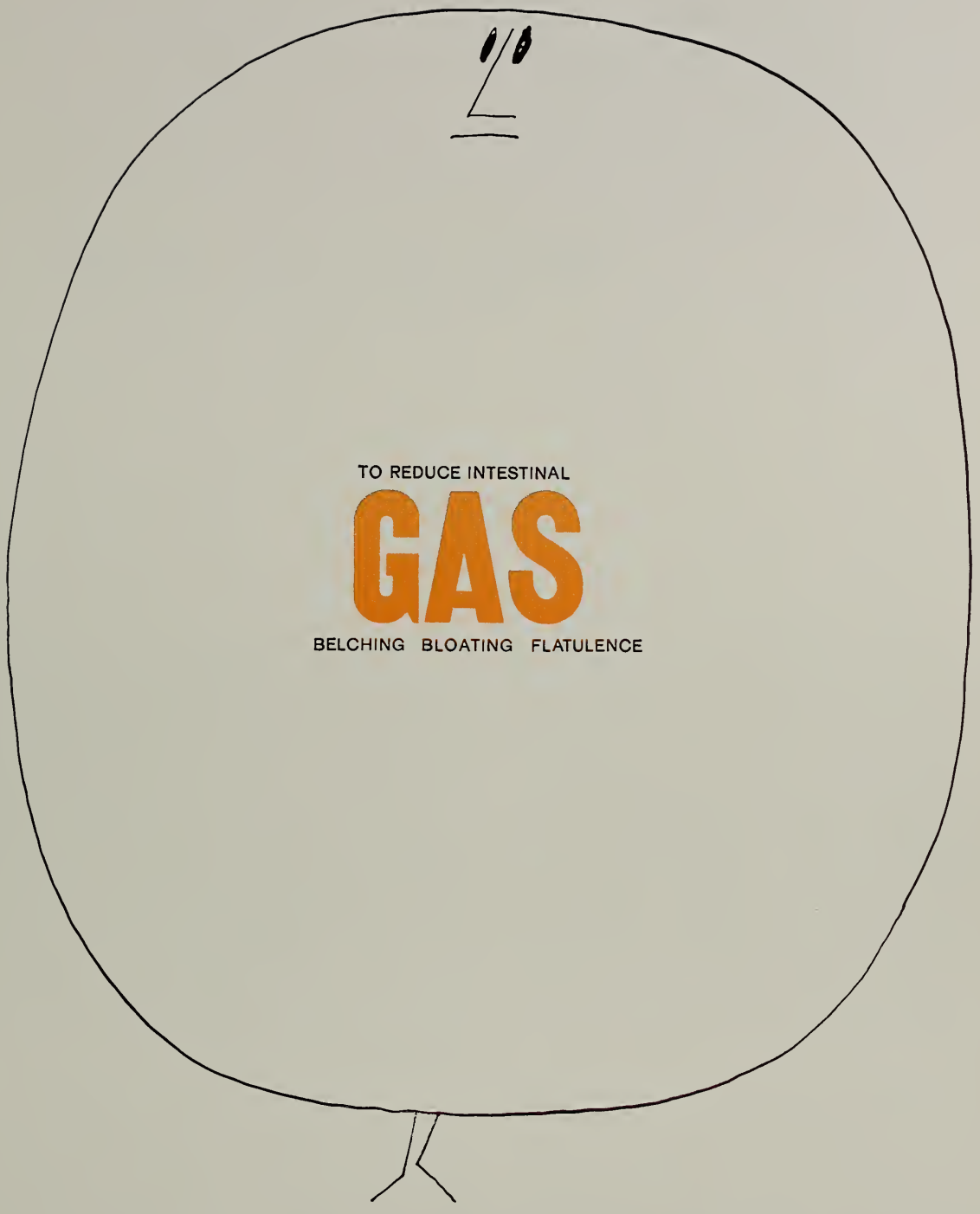
plus—

tennis, croquet, archery, badminton, table tennis, an orchestra for nightly dancing and ENTERTAINMENT provided by your convention committee.

Of course it won't be all play. *Member participation* in the affairs of the medical profession is imperative. The program will be geared to educate and assist all members in their work for the forthcoming year.

Once again the date is October 2-5, which is not far away. Make your reservations now.

Ira. Rigley



A biochemical compound used to diminish intestinal gas in healthy persons and those patients having digestive disorders ■

KANULASE

Each Kanulase tablet contains Dorase,* 320 units, combined with pepsin, N.F., 150 mg.; glutamic acid HCl, 200 mg.; pancreatin, N.F., 500 mg.; oxbile extract, 100 mg. Dosage: 1 or 2 tablets at mealtime. Supplied: Bottles of 50 tablets.

*DORSEY BRAND OF CELLULASE, EXPRESSED AS DIGESTIVE ACTIVITY UNITS.

SMITH-DORSEY • a division of The Wander Company • Lincoln, Nebraska

The world is now in its biggest thrust forward since man has been on earth. There is no such boom behind the Iron Curtain—Russia has kept the spotlight on Sputnik and rockets so long that they have us fooled about how pitifully backward they are on the ground.

Wings Over the World

*JOHN H. FURBAY, Ph.D.**

New York, N. Y.

Excerpts of an address given before the annual meeting of the Conference of Presidents and Officers of State Medical Associations, June 12, 1960, Bal Harbour, Fla.

AFTER SPENDING 22 years around over the world I was very glad to hear someone say that above all the other issues in this country on which the American people will pass their opinion in this next election the greatest and the highest of them all is what are we going to do about our relations with the rest of the world?

Now medical doctors are a pretty intelligent group, but I have found in contacts with my own personal friends many of whom are medical doctors, that the grind of the office and the job and the operating room keeps you from knowing many of the things going on in the world besides what you read in the newspapers. And yet we are the ones who are going to have to find a way through this modern world. We are still going to be here at the end of this century, we hope.

I am going to take you on a quick trip, a very quick trip, and show you a few things that have impressed me most in the last few years, that have struck me as being enormously important in our world.

I am not a pessimist; I don't think the world is falling to pieces. I think the world is going through a gigantic transformation. It is sort of like living in a house when you are trying to remodel the blamed thing and half of it is torn down, it is a horrible mess. Some people only see the mess and some see in their minds the plan that is emerging.

Rapidly Changing World

This world is going to emerge by the end of this century a vastly different world from what it was when it started this century, or when you and I started in it, and you and I are living through the transition. It is a bit uncomfortable, but there is something emerging.

The biggest thing that I notice traveling around the world is that the rate of change has speeded up enormously. Everything is changing so much faster than it ever changed before. You doctors know that. At a state medical convention where I spoke recently, I was sitting by the president and I asked him, "How long have you been practicing medicine?"

* Syndicated newspaper columnist, recipient of the Brewer Aviation Trophy, guest lecturer at the World Seminar in Geneva, Switzerland, Director of the Casa Pan-Americana at Mills College and Senior Specialist for the United States Office of Education.

"Thirty-five years," he answered.

And I said, "Tell me something. How many of the drugs and medicines that your prescribe today have been discovered since you left medical school 35 years ago?"

And he replied, "Well, I would say at a rough guess at least 95% of them."

That is nothing new to you. You know about this. But it impressed me, because I thought about the other areas in which the same kind of thing has been going on.

I was in Connecticut, where they recently made a vocational survey and discovered that 58% of the people industrially employed in the State of Connecticut are making their living at jobs which did not exist anywhere in the world 50 years ago.

The two largest employments in the United States, the automobile and aviation industries, are just barely 50 years old.

What will happen in the next 50 years God only knows.

I gave a commencement address in Ohio the night before last. They had about 18,000 people in a big stadium and I said to the graduating class, "If we would call you back for a class reunion 50 years from tonight, I will bet my last dollar"—the one I had left over from Las Vegas—"I will bet my last dollar that more than 58% of this class will at that time be making their livings at jobs nobody on earth has heard of today." And I said, "I will bet you one more thing, too: that more of you than have any idea will come back for that class reunion from countries all over the world, on every continent, because America has suddenly become a world power with men and women all over the earth."

Two million Americans are living outside the United States, right now while I am speaking to you, because their jobs are outside the United States, and a quarter of a million American children are going to school outside the United States this year because their parents live and work outside of the United States.

Five thousand American corporations have set up their branches all around the world like we used to set our branches up out across the 48—now 50—states.

But we are not the only ones getting changed. Even in the new industries change is coming pretty fast. Just take aviation, born in our lifetime, the propeller—the fellow who invented the propeller, I suppose he said, "Well, I have got it made. I can relax now. My sons can carry on the business and then my grandsons." The poor fellow who invented the propeller! Before his first bank account really got cooled off, the propeller passed out and became obsolete and now —I flew down here today on nothing but a stream of hot air.

Even the new things we think are here to stay become obsolete.

Others Change Faster

There are many people in the world whose rate of change is faster than ours. I have just come back very recently from a long, extensive trip down through Africa—my twelfth consecutive year out there—and I was this time down through the new country of Ghana, the brand new country of the Cameroons, Nigeria, which gets her independence this year, then in the Congo, which gets her independence the 30th of June, along with Somaliland. Then I went 2,000 miles up the Congo River, down in South Africa, up through East Africa. I was amazed at the fantastic change just since I was out there last.

They took me outside of Leopoldville in the Belgian Congo and they showed me housing projects! Twenty-five thousand new homes in one project, every one of them completely modern houses with electricity and running water. Twenty-five thousand will be finished in three months and inhabited.

Before I was finished marveling at this they said, "Let us show you some more." They took me out on the other side of town and they showed me 30,000 houses in another project, just finished and all of them occupied, all modern.

You go down in the heart of the city and here you find a city that reminds you of the most modern cities in this country—Miami Beach, for instance. I brought back photographs of some of these cities that amazed my friends. They said, "My goodness, this looks like you are down in Phoenix, Arizona, or out in Hollywood, or something." This is the new Africa.

When I left Africa at the beginning of the war there was, in Liberia, not a single railroad, not a single harbor and only one highway 65

Continued on page 1652

Each of the babies pictured on this page was borne by a mother with a *documented* previous history of true habitual abortion, who was treated with DELALUTIN during the pregnancy leading to this birth

LIVING PROOF OF FETAL SALVAGE WITH DELALUTIN

SQUIBB HYDROXYPROGESTERONE CAPROATE

Improved Progestational Therapy



Garden City, N. Y.



Lincolnwood, Ill.



Skokie, Ill.



Denver, Colo.



Denver, Colo.



No. Massapequa, L. I., N. Y.



Roselle, Ill.



Seaford, N. Y.



Hartford, Conn.



East Williston, N. Y.



Norwich, Vt.

DELALUTIN offers these advantages over other progestational agents

• long-acting sustained therapy • more effective in producing and maintaining a completely matured secretory endometrium • no androgenic effect • more concentrated solution requiring injection of less vehicle • unusually well-tolerated, even in large doses • fewer injections required • low viscosity makes administration easy

Complete information on administration and dosage is supplied in the package insert

Supply:
Vials of 2 and 10 cc., each containing 125 mg. of hydroxyprogesterone caproate in benzyl benzoate and sesame oil.

Also available: DELALUTIN 2X in 5 cc. multiple-dose vials. Each cc. contains 250 mg. hydroxyprogesterone caproate in castor oil, preserved with benzyl alcohol.

SQUIBB *Squibb Quality—The Priceless Ingredient*

'DELALUTIN'® IS A SQUIBB TRADEMARK



for the acute asthmatic attack elixir synophylate®

(Theophylline Sodium Glycinate)

RAPID ORAL CONTROL WITHOUT G.I. IRRITATION

ELIXIR SYNOPHYLATE relieves wheezing and dyspnea in 5 to 10 minutes after a single dose. Significant blood levels are achieved in 15 minutes, persisting for at least 4 hours.

Because of its built-in buffer, theophylline sodium glycinate [SYNOPHYLATE] is "tolerated in larger doses than are possible with other theophylline preparations,"[1] including aminophylline.[1-3]

the most potent theophylline elixir available . . . may avoid need for I.V. injection

1. A.M.A. Council on Drugs: New and Nonofficial Drugs 1959, Philadelphia, Lippincott, 1959, p. 389. 2. United States Dispensatory (Osol-Farrar), ed. 25, Philadelphia, Lippincott, 1955, p. 1412. 3. Grollman, A.: Pharmacology and Therapeutics, ed. 3, Philadelphia, Lea & Febiger, 1958, p. 208.

Each tablespoonful (15 ml.) contains 0.33 Gm. (5 gr.) equivalent to 0.16 Gm. (2½ gr.) Theophylline U.S.P. Supplied: Bottles of 1 pint and 1 gallon.

Literature on request.

. . . particularly useful for children

Products Born of Continuous Research

THE CENTRAL PHARMACAL COMPANY Seymour, Indiana

The Norbury Sanatorium

Established 1901 — Incorporated
Licensed — Jacksonville, Illinois

FRANK GARM NORBURY, A.M., M.D., Medical Director
HENRY A. DOLLEAR, M.D., Superintendent
FRANK B. NORBURY, M.D., Physician

Operating

Maplecrest—

Restful, congenial, homelike surroundings are combined with the most modern diagnostic and therapeutic equipment.

Maplewood—

Most comfortable home for individuals requiring rest, scientific diagnosis and treatment. Fireproof construction.

Wings Over the World

Continued from page 1649

miles long. I went back this time and here was a whole network of highways, a beautiful railroad system, a beautiful harbor.

There were two mountains there. We didn't know what was in them but every time an airplane flew over them the compass was deflected. Since the war we discovered that those two mountains are solid iron, with only a crust of two inches of soil on the outside. Two of the largest steel companies in the world are out there. They have opened up the mines and the iron is pouring out. It is the highest grade of iron ore ever found in the world outside of Sweden. Two and a half million tons of this iron were exported out of Liberia last year.

A million acres of rubber trees have been planted in there. This is the kind of thing that is happening out in West Africa.

Next, down the coast in Ghana is the largest manganese mine in the world. Put iron and manganese together and you have steel, and this is what is happening. Right while I am talking

℞

TO PHYSICIANS WHO RECOMMEND INFANT FORMULAE

✓A Check List✓
of Fine Evaporated Milk Quality

- ☑ Is it safe—pure?
- ☑ Does it contain all important natural food elements of whole cow's milk?
- ☑ Is it easily digestible?
- ☑ Is it uniform throughout?
- ☑ Does it contain full amount of Vitamin D needed for normal baby development?
- ☑ Is it inexpensive and available locally?



A Milk That Meets All These Requirements

. . . is Wilson's Evaporated Milk—a wholesome and nutritious baby food which you can recommend with complete confidence. Wilson's Milk has 400 extra USP units of pure Vitamin D. It is sterilized, homogenized.

WILSON'S MILK

THE RIGHT MILK FOR INFANT FEEDING

to you the riveting machines are hammering away in West Africa putting up gigantic steel mills and aluminum mills for the Kaiser plant.

Where are they getting the power for all of this? Africa has got the most ready source of power of any continent in the world. Up on this great plateau that runs for over 3,000 miles from the southern part of Egypt all the way to Johannesburg, itself elevated 5,200 feet, the same as Denver, Colorado—are two fabulous lakes, Lake Victoria, which is the source of the Nile River, running 2,000 miles to the Mediterranean, and Lake Tanganyika, which is the source of the Congo River, running into the Atlantic, and from east of this goes the Zambezi River into the Indian Ocean. All three of these rivers have been dammed with gigantic hydroelectric power projects. Not only that, but the Volta River, coming down through Ghana, has a $650 million project. When it is finished it will be turning out the same amount of electricity that is consumed by 42 cities the same size as Detroit, in one dam—one dam. This is being built almost entirely with private money. Nobody is going to put his private money into a dam to produce that much of a product, electricity, unless there is a market for that product, and they expect there will be 22 cities the size of Detroit in West Africa before the century ends. I, for one, will not be surprised to see it from what I have seen already.

African Dams Largest

Down in the Belgian Congo below Leopoldville is an India project on the Congo River. It will be a billion dollar project, the only billion dollar dam in the whole word, producing more electricity than the one on the Volta River. And they have just finished a dam on the Zambezi River, running east—you read about it in the *Saturday Evening Post*. The largest man-made lake in the whole world has already resulted from this dam. It will be turning out about the same amount of electricity as the one I mentioned on the Volta. Then on the Nile River is already one big dam, the Murchison Dam, just as it leaves this 6,000 foot plateau to plunge downwards going towards the Mediterranean, and of course there is the Aswan project which

Tested . . . and proved . . .

ORAL therapy in diaper rash!



Convenient . . . simply open a capsule and add the contents to the baby's daily formula, or to fruit juice or water. No lotions . . . no rinses . . . no ointments . . . just oral therapy.

Send for samples and literature.

S. F. DURST & CO., INC.
Philadelphia 20, Pa.

Effective therapy! Thousands of pediatricians and general practitioners prescribe Pedameth for ammonia dermatitis—and they continue to prescribe it. Clinical tests have proved its effectiveness. Pedameth is safe because it contains only dl-methionine (0.2 Gm.) one of the essential amino acids. When Pedameth is administered, the pH of the urine is lowered and an as-yet-unknown antibacterial agent appears in the urine. Pedameth works . . . it's the safe, effective, convenient answer to ammoniacal diaper rash.

Prescribe

PEDAMETH®

(dl-methionine DURST)

Wings Over the World

Continued

is going in and that will be another billion dollar dam. All the biggest dam projects in the world are within ten years' time going to be in Africa, all of the world's greatest projects of dammed hydroelectric power. We have nothing like it in the United States at all.

Aviation: there is more jet service and more international plane service into Africa right now than any other continent in the world. As I dropped down on Leopoldville a few weeks ago in a jet plane, a Boeing 707, I saw a gorgeous air terminal, three stories high, all plate glass windows, air-conditioned dining rooms, air-conditioned bar, air-conditioned substories, waiting rooms, anything you wanted. Then I took a look at the runways—three runways, each of them 15,000 feet of concrete. We haven't runways like that in the United States. Three of them, 15,000 feet long each.

I could tell you all afternoon about the fabulous developments going on in Africa, East Africa, North Africa—156 brand new hotels in the Belgian Congo this year, every one air-conditioned. I didn't stay at a single hotel in the whole of Africa this trip that wasn't air-conditioned. Some of them are as much as 22 stories high, with central air conditioning, beautiful swimming pools. And there are highways, super highways, anything you want.

Leopoldville has got 112 country clubs. Johannesburg has over 150 golf courses, 175 drive-in movies.

These are already the fantastic changes that have hit Africa and these people are leaping from prehistoric, Stone Age days right into this jet age.

Now, you say, "How long does it take to change a man anyway, from uncivilized to civilized?" Well, that is an interesting question about which there is a great deal of confusion. Most people think it takes much longer than it does. I thought it took a long time but one of the jobs I have worked in since the last war is to help build new airlines in eleven countries of the world we call underdeveloped areas until they are ready to operate themselves. One of these is Ethiopia. We are still working there and I go there every year, for 12 consecutive years.

Progress Leaps Forward

Now, in Ethiopia we have seen with our own eyes something you wouldn't have believed. We have taken these boys, first generation out of the bush. Their fathers and mothers are still uncivilized. These boys are flying four-engined airplanes through the skies day and night, 24 hours a day, over the most rugged mountainous range in the world. They have been doing it for 10 consecutive years with a 100% safety record. Believe me it takes brains to fly a four-engined aircraft.

They understand the machine, they know what they are doing, they have good judgment and in a crisis, they make the right decisions.

Not only do they fly them, they repair them. We built the largest airplane engine base in Africa in Addis Ababa, the capital of Ethiopia. There the planes are brought in from all over the continent—from all those beautiful airports, of which there are hundreds, the engines are taken apart, the worn portions are replaced and the engines are reassembled and put back into the airplane and off into the sky they go. If they made one mistake in this they wouldn't have that 100% safety record I told you about.

Continued



VISION STIMULATES KNOWLEDGE

Truly, the age we live in is the age of vision — of far-sighted plans for a future totally different from the past. Such vision must, however, be based on past performance . . . the foundation from which to build. Just as the more than a half-century of White-Haines experience in fine ophthalmic craftsmanship is your guarantee of professional performance in the years to come.

THE White-Haines OPTICAL COMPANY
34 Modern Laboratories
OHIO • PENNSYLVANIA • MARYLAND
KENTUCKY • W. VIRGINIA • INDIANA
MICHIGAN • ILLINOIS



6-10 HOURS
SUSTAINED THERAPY

ONE *and only ONE*

Timed AMO*dex* CAPSULE

PER DAY *will economically*

control appetite in weight reduction or relieve the nervous symptoms of anxiety and the underlying depression.

Timed AMO*dex CAPSULES* (Testagar) furnish a controlled uniform action. The medications provide prolonged, continuous therapeutic effect from active ingredients over a period of 6 to 10 hours.

Following ingestion of one *Timed* AMO*dex CAPSULE*, small amounts of the medication are released immediately.

Each *Timed* AMO*dex CAPSULE* contains a daily therapeutic dose of:

Dextro-amphetamine hydrochloride	15 mg.,
Amobarbital	60 mg.

AMO*dex* ADVANTAGES

- HIGH-LEVEL ANOREXIGENIC ACTIVITY WITHOUT NERVOUS EXCITATION
- SMOOTH, UNIFORM ACTION
- THERAPEUTIC EFFECT LASTING 6 TO 10 HOURS
- ONLY ONE DOSE DAILY
- CLINICALLY ECONOMICAL TO THE PATIENT

PROTRACTED THERAPEUTIC EFFECT

Before the development of *Timed* AMO*dex* (Testagar) the usual dose of Dextro-amphetamine hydrochloride, for the control of appetite, was one 5 mg. tablet two or three times a day. The usual dose of Amobarbital ranged from 20 to 40 mg., two or three times a day. On such a dosage regimen the absorption of the drugs, after ingestion, takes place quite rapidly. The therapeutic activity occurs within one-half to one hour. When the therapeutic peak is reached, a gradual decline takes place. At this point, the patient should receive another dose of medication . . . the cycle is then repeated.

Patients frequently fail to follow the physician's instructions. They take medication at irregular intervals. When this occurs with drugs such as dextro-amphetamine sulfate, phosphate or hydrochloride, excitation may result. A balanced combination of Dextro-amphetamine hydrochloride, **the preferred salt,** plus a balanced daily dose of Amobarbital will give the expected therapeutic results *without* excitation.

Timed AMO*dex*, after ingestion, releases Dextro-amphetamine Hydrochloride and Amobarbital steadily and uniformly over a period of 6 to 10 hours. Therefore, the physician may dispense with the usual dosage schedule thereby *attaining better control of therapy*. The patient will receive the benefits of even and sustained therapeutic effects. Side reactions such as anxiety and excitation are greatly minimized.

ACTION AND USES

Timed AMO*dex CAPSULES* (Testagar) supply the antidepressant and mood-elevating effects of Dextro-amphetamine hydrochloride and the calming action of Amobarbital. *Timed* AMO*dex* elevates the mood, relieves nervous tension, restores emotional stability and the capacity for mental and physical effort.

INDICATIONS

Timed AMO*dex* is the preferred treatment in anxiety states and in the management of obesity. *Timed* AMO*dex* may also be used in the treatment of Depressive states, Alcoholism, Nausea and Vomiting of Pregnancy.

DOSAGE The Daily Dose of *Timed* AMO*dex* (Testagar) IS ONE CAPSULE ON ARISING OR AT BREAKFAST.

SUPPLIED Bottles of 100 and 1000 capsules, available at all pharmacies. Also supplied in half strength as *Timed* AMO*dex*, Jr.

Timed AMO*dex CAPSULES* are manufactured under these patent numbers:
2,736,682 — 2,809,916
2,809,917 — 2,809,918
Which provide prolonged, continuous therapeutic effect over a period of 6-10 hours

SAMPLES AND LITERATURE UPON REQUEST

Testagar & co., inc. 1354 W. Lafayette Blvd. Detroit 26, Michigan

Wings Over the World

Continued

Not only do they repair them, they do the radios. They run the radio stations on the ground and do the navigation and now they are putting up a television station out there.

This is just a little of what is going on in Africa. They have leaped through 5,000 years in one single generation.

The truth of the matter is there won't be any primitive people after our day. Did you know that? We are the last people to live on this earth who have a chance to see an uncivilized man. It is awfully hard to find one even now.

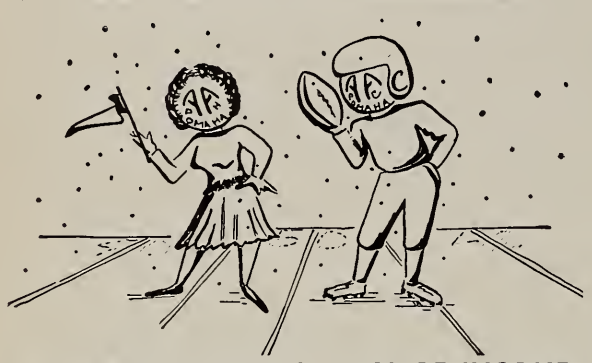
I was down in the Fiji Islands a few months ago and I said to the British Colonial Administrator, "Are there any really primitive people here?" He told me there were plenty of them, untouched by any phase whatsoever of civilization, living just like they did thousands of years ago.

The next morning he picked me up in his car and we drove over a paved highway—of course, you can't imagine they aren't touched by civilization when you drive over a paved highway—and we finally got to the end of it. We started walking up through the jungle trail and we came to a beautiful village. He said, "I am going to show you a village that is absolutely untouched by any civilization and living just as they lived 5,000 years ago." I looked at it. It was beautifully clean—all primitive villages are clean, They don't have paper to throw in the streets and things like that. They keep their places clean. The chief's house was higher than all the rest. Even the floor was six feet higher than the floors of any other house because when he is asleep his head has to be higher than anybody else's head—the old custom, you know. I asked my English friend, what was on the top of the chief's house?

"Oh," he said, "that is a radio antenna."

I said, "Holy smoke, you told me you were going to show me some people untouched by civilization."

You see, even we forget. We went inside and we met the old chief. He had a lot of sons and several wives and one of his older sons was fiddling with the radio. Right then while I was



PROTECTION AGAINST LOSS OF INCOME FROM ACCIDENT & SICKNESS AS WELL AS HOSPITAL EXPENSE BENEFITS FOR YOU AND ALL YOUR ELIGIBLE DEPENDENTS

ALL PREMIUMS COME FROM

PHYSICIANS SURGEONS DENTISTS

ALL BENEFITS GO TO

PHYSICIANS CASUALTY & HEALTH ASSOCIATIONS

OMAHA 31, NEBRASKA

Since 1902

Handsome Professional Appointment Book Sent to you FREE upon request.



WABASH VALLEY SANITARIUM—HOSPITAL

Lafayette, Indiana

Telephone Riverside 3-1679

A hospital for the treatment of neuro-psychiatric disorders.

Custodial cases are accepted in limited numbers.

— OPEN STAFF —

DONALD R. KINZER

Manager

in the room he brought in Lowell Thomas in the *Evening News*. Untouched by civilization!

There won't be any after us. I haven't seen any Eskimos—I have been 'way up above the Dew Line and I haven't seen any that didn't have radios in their villages.

They don't heat their houses with whale blubber any more. All of them heat their igloos with bottled gas. It is an amazing thing.

You go down the Amazon and you find every Indian village has got a radio. You go into Africa and every village has a radio. They have access to gasoline. This is why they are emerging so fast.

Oil-Rich Middle East

The Middle East—This place where we read about nothing but camel caravans over the sandy desert, in our lifetime—is nothing but a gigantic island floating in an ocean of oil. Outside technology and money and capital have come in and put the wells down. Now those wells are pouring out the oil and millionaires and multi-millionaires are being born overnight in the land of poverty of the Middle East. There are so many rich Arabs out there it is just fantastic.

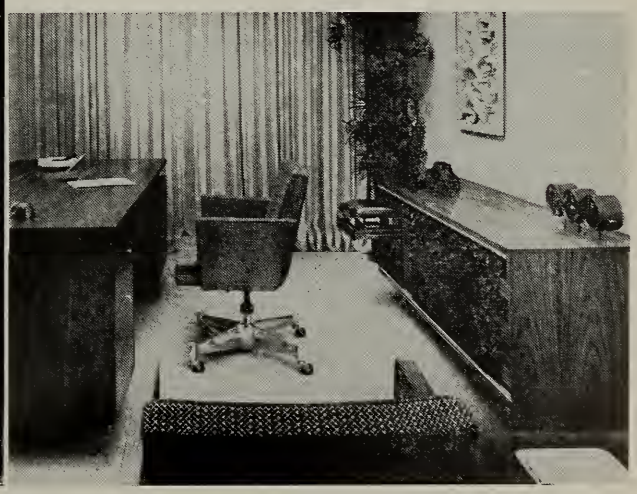
I met one Arab out there, an oil-rich Arab, who has got 102 air-conditioned Cadillacs—one guy—and he is not a surgeon! I don't know whether it is coincidence or not, but the same fellow has 102 wives. What a country!

Also in the Middle East is that little country of Israel, one of the most exciting countries in the whole world, and in my opinion, a country of enormous industry. No only have they raised enough to eat but they have completed a fabulous housing project, and it is a land of culture. They have built one of the finest opera houses and concert halls in the whole world in Tel Aviv. You can hardly ever get a seat. It is all sold out. Toscannini went out and conducted the first concert. Every major symphony conductor in the world has been there and conducted the Tel Aviv Symphony since they put it up—here, in the land where they arrived with nothing but their bare hands a few years ago, every one of them refugees from some place. Again some-

Continued on page 1661



Complete interiors — designed especially to create a feeling of relaxation . . . inspire confidence . . . provide comfort for patient and doctor.



This is a personal invitation to stop in and see our beautiful prestige showrooms.

BUSINESS FURNITURE CORPORATION

130 SOUTH PENNSYLVANIA STREET, INDIANAPOLIS 4, INDIANA

TELEPHONE • MELROSE 2-1474

Now —All cold symptoms can be controlled



Tussagesic

timed-release *tablets*

Controls congestion

with Triaminic,[1,2,3] the leading oral nasal decongestant.

Controls aches and fever

with well-tolerated APAP, non-addictive analgetic[4] and excellent antipyretic.[5]

Each TUSSAGESIC Tablet provides:

TRIAMINIC®	50 mg.
(phenylpropanolamine HCl	25 mg.
pheniramine maleate	12.5 mg.
pyrilamine maleate	12.5 mg.)
Dormethan (brand of dextromethorphan HBr)	30 mg.
Terpin hydrate	180 mg.
APAP (N-acetyl-p-aminophenol)	325 mg.

References: 1. Lhotka, F. M.: Illinois M. J. 112:259 (Dec.) 1957. 2. Fabricant, N. D.: E.E.N.T. Monthly 37:460 (July) 1958. 3. Farmer, D. F.: Clin. Med. 5:1183 (Sept.) 1958. 4. Bonica, J. J.: in Drugs of Choice, Mosby, St. Louis, 1958, p. 272. 5. Dascomb, H. E.: in Current Therapy, Saunders, Phila., 1958, p.78. 6. Bickerman, H. A.: in Drugs of Choice, Mosby, St. Louis, 1958, p.547.

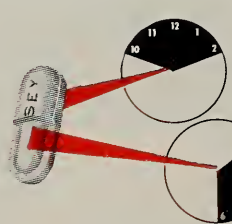
Controls cough centrally

with non-narcotic Dormethan, possessing "amply demonstrated" antitussive activity,[6] as effective as codeine.

Liquefies tenacious mucus

with terpin hydrate, classic expectorant.

Prompt and prolonged relief because of this special "timed release" design:



first — the outer layer dissolves within minutes to give 3 to 4 hours of relief

then — the inner core releases its ingredients to sustain relief for 3 to 4 more hours

Dosage: One tablet in the morning, midafternoon and at bedtime. Pediatric dosage chart for Tussagesic Suspension available on request.

TUSSAGESIC SUSPENSION provides palatability and convenience which make it especially attractive to children and other patients who prefer liquid medication.

SMITH-DORSEY • a division of The Wander Company • Lincoln, Nebraska



Dianabol: new, low-cost anabolic agent

By promoting protein anabolism, Dianabol builds lean tissue and restores vigor in underweight, debilitated, and dispirited patients. In patients with osteoporosis Dianabol often relieves pain and increases mobility.

As an anabolic agent, Dianabol has been proved 10 times as effective as methyltestosterone. Yet it has far less androgenicity than testosterone propionate, methyltestosterone, or norethandrolone.

Because Dianabol is an oral preparation, it spares patients the inconvenience and discomfort of parenteral drugs.

And because Dianabol is low in cost, it is particularly suitable for the aged or chronically ill patient who may require long-term anabolic therapy.

Supplied: *Tablets,* 5 mg. (pink, scored); bottles of 100.

Complete information sent on request.

Dianabol®
(methandrostenolone CIBA)

converts protein to working weight in wasting or debilitated patients

CIBA
SUMMIT, NEW JERSEY

2/2829MB

Wings Over the World

Continued from page 1657

thing is happening. A whole change-over is going on.

Japan's Fantastic Growth

You go on to the Far East and the fabulous developments in the Far East are, of course, in Japan. Japan tops anything in the Far East that the Chinese ever thought of. Japan has been growing at such a fantastic rate that her industrial output has increased 300% in the last 10 years. Krushchev talks about increasing 15%. The Japanese have gone up 300%. They have built their great factories and there are smokestacks now all the way from Tokyo to Yokohama, 40 miles. The city of Tokyo now is the largest city in the world with a population of 10 million. The streets are jam-packed with automobiles. There are no longer imitations of American products pouring out on the world markets. The Japanese are making a quality merchandise which nobody else can touch in many respects. I didn't realize this until I was in a camera store in Germany last year and I asked the German, where the lenses came from.

He said, "We import them from Japan."

I said, "Why in the world do you Germans import lenses from Japan?"

"Because they are making better lenses than we are now," he answered.

This can be told in many, many other areas. We can be very glad that they are still on our side and I hope they remain on our side, too, for a long time, because this is a great balance to the Chinese power in the Far East.

There are many other places—Australia and South America—where this boom has hit. I would say that the world is now in its biggest thrust forward that it has ever seen since man has been on earth. There is a bigger boom than man has ever witnessed in all of man's history on earth. There are more people living well than ever lived before and there is emerging slowly a middle class around the world.

And all of these booming spots that I have mentioned, you will observe, are outside the Iron Curtain. There is no such boom behind the Iron Curtain. There are some Government projects and that is all, nothing under its own spontaneous power behind the Iron Curtain.

Continued

Wings Over the World

Continued

Then this leads me to the second thing I wanted to observe about the world besides that it is in a great forward thrust economically, scientifically and culturally and in the field of civilization. Thirty-two new nations have been born in the last 12 years. There is another thing that I want to mention now: the world is split in two over political issues, Communism and the Free World. We call it the cold war. It has been going along pretty well up until recently when suddenly, suddenly, there began to spread around the world a note that America has slipped into second place in the world powers. I have met hundreds of Americans who told me that and the thing that amazes me is that people who tell me this have already started to accept the idea of America being second.

Well, in the first place it is not true that we have slipped into a second place. I never heard any talk about this until the Russians put that Sputnik into the sky.

Russia 30 Years Behind

The Russians are not ahead of us. They are so far behind us it isn't even funny—a whole generation behind us—30 years behind us in almost every field you could mention.

You know how it is in medicine. They are up with us in a few things, but in the vast majority of it they are behind us, and this is true, I would say, in 95% of the fields of science. If they are up with us in five percent that is even generous. If they have passed us, it is not more than one-half of one percent—but that one-half of one percent was Sputnik. They put it dramatically into the sky and they have kept it there and have followed it up with rockets until they have made the whole world forget about what is on the ground and how completely antiquated they are on the ground. They haven't even got a paved highway, not one, between Moscow and Leningrad, the two largest cities.

About 85% of all their airports are still grass runways and 90% of them can't even handle night flying. Housing is so pitifully obsolete that if we made a comparable situation in the

adult stable diabetics

•

sulfonylurea failures

respond to

DBI

trademark, brand of Phenformin HCl

adult stable diabetes

"In our experience the action of DBI on the adult stable type of diabetes is impressive . . . **88% were well controlled by DBI.**"[1]

"Most mild diabetic patients were well controlled on a biguanide compound [DBI], and such control was occasionally superior to that of insulin. This was true regardless of age, duration of diabetes, or response to tolbutamide."[2]

"DBI has been able to replace insulin or other hypoglycemic agents with desirable regulation of the diabetes when it is used in conjunction with diet in the management of adult and otherwise stable diabetes."[3]

sulfonylurea failures

Among those diabetics who responded to tolbutamide initially and became secondary failures **DBI "gave a satisfactory response in 55%."**[4]

"DBI is capable of restoring control in a considerable portion of patients in whom sulfonylurea compounds have failed, either primarily or secondarily."[5]

"All twelve secondary tolbutamide failures have done well on DBI."[6]

"34 out of 59 sulfonylurea primary failures were successfully treated with DBI."[7]



United States in housing we would have to wipe out 80% of our housing and then we would be on a par with Russia.

You go on the ground in Russia and this is the kind of thing you will see, such pitiful backwardness.

Just take another field, automobiles. Do you know that 95%of all of the Russians have never yet been in an automobile—haven't even been in one? We put in the junk yard every year more automobiles than they possess in Russia. Now, I am not saying automobiles make a civilization but I am saying they claim they are ahead of us and I say it is a lie, they are not, and there is no reason for us to get paralyzed because they spread these lies around and because they put one thing up in the sky. They were smart about that Sputnik. We should have been that smart. It wasn't having a Sputnik—we have got sputniks in the air, too, now. We came out very soon afterwards with ours. We could have been first but we didn't realize the tremendous impact on the world. It is in the history books now that Russia went into outer space first.

Charles Lindbergh was the first man in this world to fly alone across the Atlantic Ocean, wasn't he, but can anybody in this room tell me who the other two were who flew the Atlantic Ocean alone the same year Charles Lindbergh did? Nobody could tell me. You couldn't care less. It had already been done.

This is what happened with Sputnik. When we put ours in the sky only a few months later it didn't impress anybody. So what? Russia already did it.

Then they followed up with the rockets. They might beat us with a man on the moon, I don't know. But this is the way they did it and they have kept the spotlight on it for so long that they have fooled the world on how backward they are on the ground. They have made the world think that all Russia is like Sputnik.

And while they have put the spotlight on Sputnik and held it there, we have put the spotlight of publicity on Little Rock. Now, if you are going to sell your civilization you don't put the lousiest thing you have got into the sky and turn the spotlight on it, or in your front window.

Continued



DBI

lowers blood sugar in mild, moderate and severe diabetes, in children and adults

not a sulfonylurea... DBI

(N^1-β-phenethylbiguanide) is available as white, scored tablets of 25 mg. each, bottles of 100.

Send for brochure with complete dosage instructions for each class of diabetes, and other pertinent information.

1. Walker, R. S.: Brit. M. J. 2:405, 1959.
2. Odell, W. D., et al.: A.M.A. Arch. Int. Med. 102:520, 1958.
3. Pearlman, W.: Phenformin Symposium, Houston, Feb. 1959.
4. DeLawter, D. E., et al.: J.A.M.A. 171:1786 (Nov. 28) 1959.
5. McKendry, J. B., et al.: Canad. M. A. J. 80:773, 1959.
6. Miller, E. C.: Phenformin Symposium, Houston, Feb. 1959.
7. Krall, L. P.: Applied Therapeutics 2:137, 1960.

an original development from the research laboratories of

u. s. vitamin & pharmaceutical corp.

Arlington-Funk Laboratories, division
250 East 43rd Street, New York 17, N. Y.

Wings Over the World

Continued

Depends on the Spotlight

I have some friends in Little Rock. I have spoken down there several times to the Chamber of Commerce and other groups and they are wonderful people. What happened shouldn't have happened, but what I am saying is that we shouldn't have made the publicity out of Little Rock that we did and spread it around the world and round and round. It has been on the front pages of every newspaper in every language on earth for the last three years until everybody in the world almost thinks the whole United States is a Little Rock, just pulled and torn to pieces with racial strife. And most of the people thing that all of Russia is like this advanced Sputnik. It depends on what we put the spotlight on.

Let me tell you one story. Those of you who went to the Brussels Fair two years ago, remember those two fabulous pavilions, the American Pavilion and the Russian Pavilion? They simply outdid everything anybody had ever done at an exhibition. They were part of the cold war, to impress people who had never seen America, never seen Russia, and probably never would. It is this war for what people think that we call the cold war.

Brussels Fair 'Showdown'

There were lots of things written about this Fair and the only thing that made sense to me was written by a French journalist who decided to wait until the two exhibits closed at night and see if he could get a story. So he waited outside the American Pavilion the first night. After they closed up he saw a whole fleet of handsome young men come in with white coveralls on, they climbed onto electric machines and they started over that vast Pavilion, cleaning and polishing, and in about an hour and a half the place was spick and span and they climbed off their machines, took off their coveralls, which were still white, packed their machines, locked up the place, and went home.

The next night my friend the journalist said he waited outside the Russian exhibit and after they had closed up he said he counted 102 old women, who came in with buckets over their arms, got down on their knees, and with buckets

The Harding Sanitarium

WORTHINGTON
OHIO

For the Diagnosis and Treatment of Psychiatric Disorders
and with
Limited Facilities for the Aging

GEORGE T. HARDING, M.D.
HARRISON S. EVANS, M.D.
Medical Directors

CHARLES W. HARDING, M.D.
Clinical Director

DONALD H. BURK, M.D.
GEORGE T. HARDING, Jr., M.D.
HERNDON P. HARDING, M.D.
C. RICHARD JOHNSON, M.D.
ARNOLD L. NIELSEN, M.D.
R. EUGENE PROUT, M.D.

GRACE M. COLLET, Ph.D.
VERNON W. SHAFER, Ph.D.
Clinical Psychologists

MARY JANE McCONAUGHEY, M.S.W.
BENJAMIN E. WHEATLEY, M.S.W.
Psychiatric Social Workers

PAULINE L. TOOILL, R.R.L.
Medical Record Librarian

JAMES L. HAGLE, M.B.A.
Administrator

ESTHER L. SIMPSON, R.N.
Director of Nurses

Phone: Columbus TUXEDO 5-5381

and rags, started to scrub that vast—those acres almost—of Pavilion, and they scrubbed and they scrubbed and they scrubbed until dawn broke in the east and the sun was coming up. They finally got up and straightened their old, tired joints and put down their buckets and rags and went home.

"Now," said my journalist friend, "for the first time I understood the real difference between these two civilizations. You go in the daytime and see the propaganda and they are both terrific and so great that you can't tell one from the other," he said, "but at night, after they have closed the doors, each of these countries revert to the way they do things back home." This is the crux of the whole matter. The world has swallowed a lot of propaganda, which has frightened a lot of people and made a lot of us even think that we have slipped into number two place, and we have not.

Russia Has No Non-Stop Jets

They don't even have a jet airplane capable of flying the Atlantic Ocean non-stop. Did you know that? Mr. Krushchev did not arrive in a jet. He arrived in a turbo-prop, like the Vis-

COOK COUNTY
GRADUATE SCHOOL OF MEDICINE
INTENSIVE POSTGRADUATE COURSES

STARTING DATES—FALL, 1960

Surgical Technic, Two Weeks, November 7, December 5
Blood Vessel Surgery, One Week, November 28
Surgery of Colon & Rectum, One Week, November 28
Gallbladder Surgery, Three Days, October 17
Surgery of Hernia, Three Days, October 20
General Pediatrics, Two Weeks, October 3
Electrocardiography & Heart Disease, Two Weeks, October 3
Internal Medicine, Two Weeks, October 17
Respiratory Allergy, Two Weeks, September 9 & 10
Hematology, One Week, October 10
Diagnostic Radiology, Two Weeks, October 17
Board of Surgery Review, Part I, Two Weeks, November 7
Gynecology, Office & Operative, Two Weeks, October 31
Vaginal Approach to Pelvic Surgery, One Week, November 28
Obstetrics, General & Surgical, Two Weeks, October 3
Fractures & Traumatic Surgery, Two Weeks, October 24

TEACHING FACULTY—ATTENDING STAFF OF COOK COUNTY HOSPITAL

Address:
REGISTRAR, 707 South Wood Street, Chicago 12, Illinois



"JUST WHAT THE DOCTOR ORDERED"...

℞

A large dose of sunshine . . . stimulating atmosphere . . . tastefully furnished, air-conditioned accommodations . . . delicious meals . . . golf . . . swimming . . . riding . . . skeet shooting . . . rest and relaxation at the Midwest's Finest Resort Hotel.

the famous
FRENCH LICK-SHERATON HOTEL
FRENCH LICK, INDIANA

"I WEAR A HANGER LEG..."



. . . yet ride a bike and ice skate, and have learned to roller skate, skip, and walk down the steps foot-over-foot."

Marion Phillips, school girl, began weoring a Honger Hip Control Leg at the oge of 10. The correct fit and dependable performance of her Hanger Leg hove enabled Marion to take port in the normal activities of a teen-age girl. Her omazing rehobilitation is not unusual, others have been equally successful, ond most Hanger weorers are able to return to a normal active life.

Hanger PROSTHESES

1529-33 N. Illinois St., Indianapolis 2, Ind.
3108 Burnet Avenue, Cincinnati 29, Ohio
Fairfield at Pontiac, Fort Wayne, Ind.
418 N. Main St., Evansville, Ind.

Wings Over the World

Continued

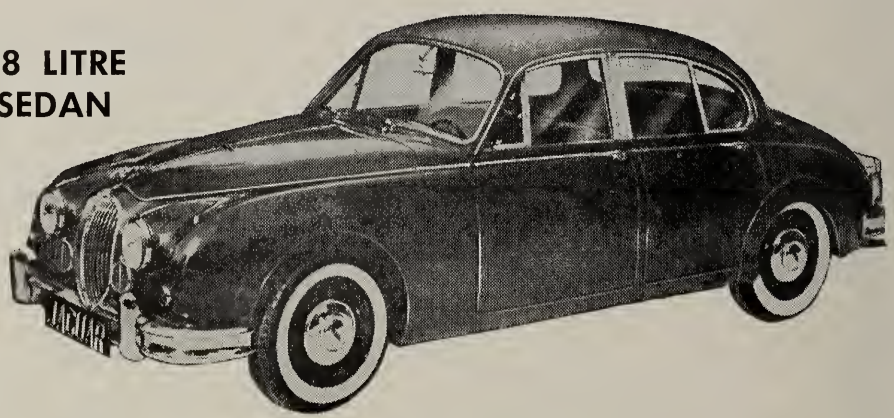
count or the Electra, and it was an especially souped-up job at that, the TU-114 and there were 32 blades on 8 propellers if you can imagine anything more obsolete. The blades were so long that they had to put the underpinning of the plane six feet higher than the average plane in order for the blades not to hit the ground. When the plane arrived in Washington they ran out the ordinary American ramps for our planes and they had to put a six-foot extension on them to get into the larger planes. A lot of our people went out and said, "Just look. What a wonderful thing. They have got a plane six feet higher than our planes." Holy smoke, they are 600 years behind us, you might say. Russia hasn't got a single jet capable of flying the Atlantic Ocean non-stop.

And yet a year ago we took Mr. Nixon to Moscow in that 707 non-stop.

Besides, they haven't got any crew members trained in international flying. They have no organization anything similar to SAC, the Strategic Air Command, nothing like it in Russia.

Continued

NEW JAGUAR 3.8 LITRE FAMILY SPORTS SEDAN



The only car in the world that unites the vitality and spirit of a sports car with the roominess and comfort of a family sedan!

The Jaguar 3.8 sedan is a supreme achievement in performance, comfort and modern, functional styling in the highest Jaguar tradition. Full competition sports car power COMBINED with 5-passenger sedan luxury and comfort. Blazing acceleration and speed, with the famous Jaguar XK engine that has won countless trophies round the globe. Maximum safety with road-race-proved disc brakes. Greater visibility with wrap-around windows, thinner pillars. New high-output heating and defrosting system. Automatic transmission and power steering are optional. Also see the luxurious Mark IX sedan and the classic XK 150 sports models. Convenient terms!

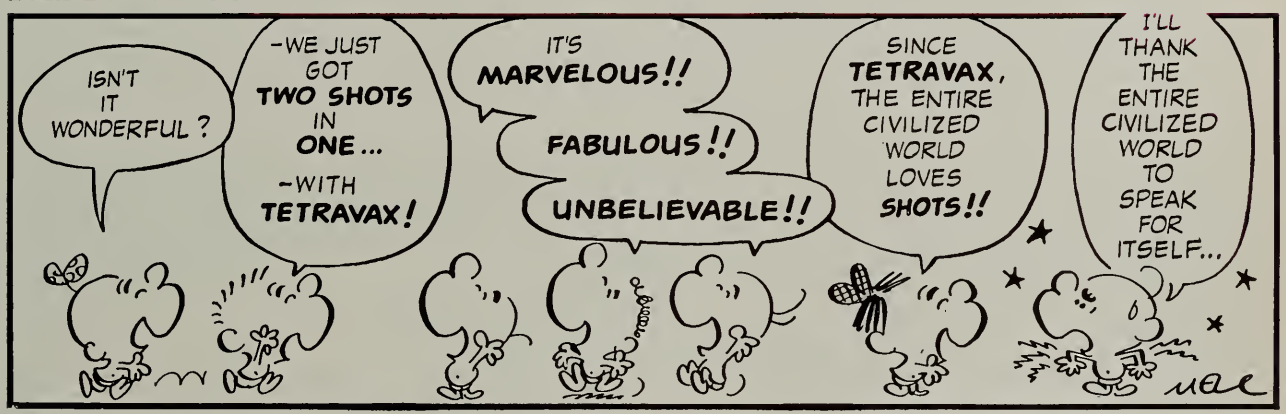
JAGUAR
2330 NORTH MERIDIAN STREET

MIDWEST DISTRIBUTORS, Inc.
• INDIANAPOLIS

FOR SIMULTANEOUS IMMUNIZATION AGAINST 4 DISEASES:

Poliomyelitis-Diphtheria-Pertussis-Tetanus

PEDI-ANTICS



TETRAVAX®

DIPHTHERIA AND TETANUS TOXOIDS WITH PERTUSSIS AND POLIOMYELITIS VACCINES

now you can immunize against more *diseases...with* fewer *injections*

Dose: 1 cc.
Supplied: 9 cc. vials in *clear plastic* cartons. Package circular and material in vial can be examined without damaging carton. Expiration date is on vial for checking even if carton is discarded.



For additional information, write Professional Services, Merck Sharp & Dohme, West Point, Pa.

TETRAVAX IS A TRADEMARK OF MERCK & CO., INC.

MERCK SHARP & DOHME, DIVISION OF MERCK & CO., INC., PHILADELPHIA 1, PA.

Yes Doctor

I am happy, thankful and glad you sent me and my family to Heid's for correct shoes—this eliminates one of our handicaps.



HEID'S 50th Year

Shoes for Men, Women, Children

411 N. Illinois, Indianapolis

Phone MElrose 5-4247 Drive-In Parking

Wings Over the World

Continued

As a matter of fact, they have practically no trained crew members that could fly internationally if they wanted to.

Let me tell you something: four years ago I went to Geneva with Ike for the Big Four Summit Conference. I was one of the four aviation people who accompanied him. We saw an amazing thing happen there on that July evening when the four great powers were to arrive at the beautiful Geneva airport, the first at six o'clock, the second at 6:30, the third at seven and the fourth at 7:30, thirty minutes apart.

Ike arrived in a beautiful four-engined plane, and two other Constellations were with it. The British arrived in a big four-engined plane. The French arrived in a big four-engined plane. And now the Russians were due to arrive, and they didn't show up, and everybody waited around that beautiful airport till the sun went down and darkness closed in and 50,000 people said, "To heck with the Russians. Let's go home." And it was the next day we found out what happened.

Hear What Lincoln Said About Too Much Government

Nearly 100 years ago, Abraham Lincoln said, "In all that the people can individually do for themselves, government ought not to interfere."

Professional men like doctors, and business men like those of our investor-owned electric utilities, are convinced Lincoln's words of advice need to be remembered today, when our government runs about 19,000 enterprises in direct competition with its own people.

It's up to all of us who are concerned about the alarming trend toward socialism and government control to continue telling everyone—including our Congressmen and other public officials—how we feel about it.

PUBLIC SERVICE COMPANY OF INDIANA, INC.

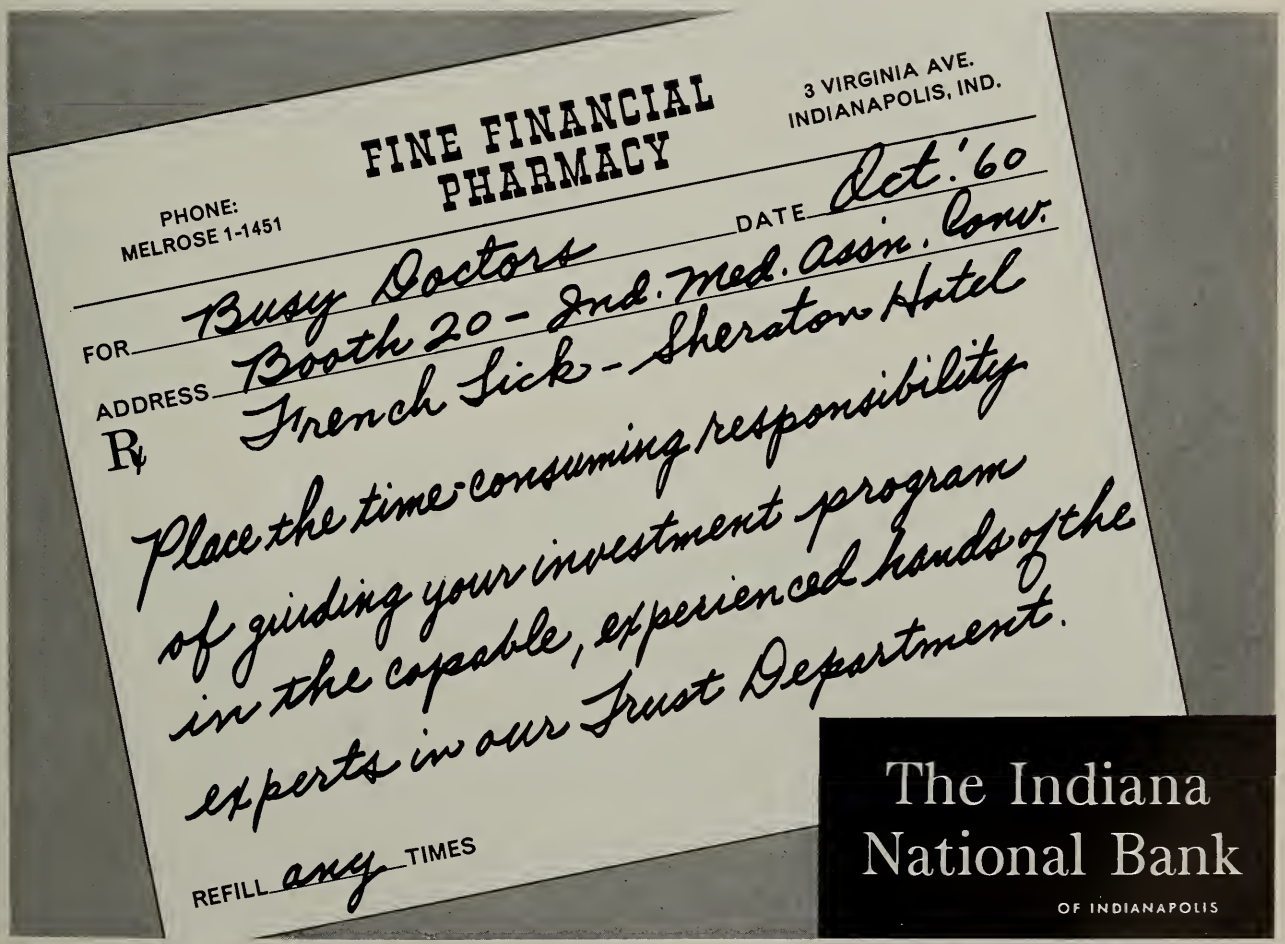
They had left Moscow in four two-engined planes, the best airplanes they had in Russia four years ago. They didn't have a single four-engined plane. They were copies of our old DC-3 we left behind at the end of the last war. They changed the name to Illusium-12 and -14. Krushchev was in one, Molotov in one, Zhukov in one and Bulganin in the other, each with his staff. They flew to East Berlin. There they had to cross the Iron Curtain. None of those pilots had ever flown outside the Iron Curtain. They couldn't even dig up four who had ever flown outside the Iron Curtain. The only one who ever had flown out didn't come back, you remember. They crossed the Iron Curtain in these old DC-3's and headed towards Geneva. They had no pressurization, so they couldn't fly high above the clouds, and it was cloudy that day. They had to stay down—visual—they had no radar whatsoever.

The pilot, never having flown outside the Iron Curtain, knew nothing about the terrain and so it happened. The Russians got totally and hopelessly lost on the way to Geneva four years ago. They turned around and they found their way back to East Berlin and they put down on the airport for the night.

Krush Gets Lost

The said Khrushchev was the maddest anybody had ever seen him and his vocabulary was terrific and he told his pilots, "You blankety-blank fools, if you can't get me to Geneva without getting lost, . . . get somebody who can, if you have got to go to West Berlin to get them." I am sure in the back of his head he thought, "My goodness, suppose this story gets out, that we got lost on the way to Geneva." And I don't know why we never made more out of that story, I really don't. Most of the people have never heard it. It was the great scoop of the whole Summit Conference four years ago, it should have been anyway.

They flew to West Berlin and they got four navigators. Two were Germans and two were Americans, and the two Americans were navigators I myself had helped to train for overseas posts of our own airline. They had been assigned to Lufthansa, the German airline, until Lufthansa were able to carry on themselves. These four went and they climbed the next



Wings Over the World

Continued

morning into the four Russian planes and led them to Geneva. When they arrived in Geneva the next afternoon, 17½ hours late, out of the airplane with Khrushchev and his people stepped the two German navigators and our two American navigators, whom I knew and shook hands with myself. That was only four years ago.

Now, how did Krushchev get over here last year? This was not properly publicized either. Half the people think he came in a jet when he didn't. The other thing that people think happened isn't true either. He couldn't get over here this time without help. Krushchev had on board his two planes four American navigators from the Strategic Air Command, SAC, when he came to visit us last time. That is how he got here.

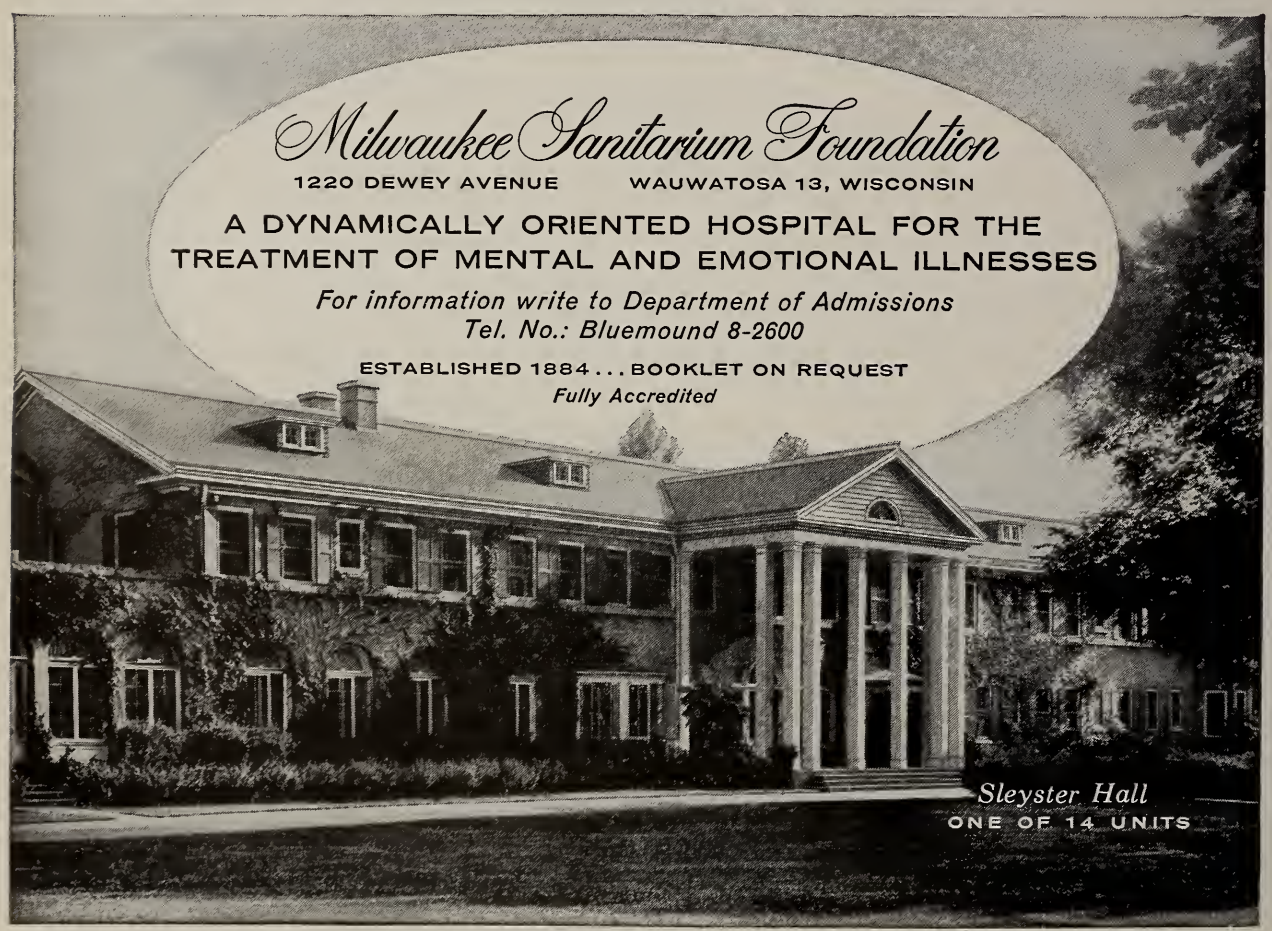
These are fundamental and simple facts. When you talk about air power you don't talk about machines, you talk about men, the experience of those men and the skill of those men, and you cannot get that skill without years and years of experience. Every time I think about SAC and those boys up in the sky day and night, when I am asleep or when I am awake, I thank God for that organization, which is the greatest thing of its kind in the world and nobody has anything to match it.

Krushchev knows this and he knows they can never catch up with us in this. This is one reason why he began to concentrate on those rockets, in order to make the world think that all airplanes had now become obsolete and he has now the ultimate weapon, which he hasn't, and we are not sure that he even has any long-range intercontinental ballistic missiles yet. We certainly have exceeded anything that they have with the ones that we have.

Even in this field we are probably up with them now and in the field of satellites we have passed them now. They only have two in the sky and I believe we have nine in the sky right now.

Well, now, why do I say this? Not to make you complacent. That would be bad, too, and I would be sorry I did if it would do that, but we must not be so afraid we let ourselves get paralyzed with these Russians. They are not

Continued on page 1676





no irritating crystals[1] · uniform concentration in each drop[2]

STERILE OPHTHALMIC SOLUTION

NEO-HYDELTRASOL®

PREDNISOLONE 21-PHOSPHATE-NEOMYCIN SULFATE

2,000 TIMES MORE SOLUBLE THAN PREDNISOLONE OR HYDROCORTISONE

"The solution of prednisolone has the advantage over the suspension in that no crystalline residue is left in the patient's cul-de-sac or in his lashes . . . . The other advantage is that the patient does not have to shake the drops and is therefore sure of receiving a consistent dosage in each drop."[2]

1. Lippmann, O.: Arch. Ophth. **57**:339, March 1957.
2. Gordon, D.M.: Am. J. Ophth. **46**:740, November 1958.

supplied: 0.5% Sterile Ophthalmic Solution NEO-HYDELTRASOL (with neomycin sulfate) and 0.5% Sterile Ophthalmic Solution HYDELTRASOL®. In 5 cc. and 2.5 cc. dropper vials. Also available as 0.25% Ophthalmic Ointment NEO-HYDELTRASOL (with neomycin sulfate) and 0.25% Ophthalmic Ointment HYDELTRASOL. In 3.5 Gm. tubes.

HYDELTRASOL and NEO-HYDELTRASOL are trademarks of Merck & Co., Inc.

MSD MERCK SHARP & DOHME Division of Merck & Co., Inc., Philadelphia 1, Pa.

Wings Over the World

Continued from page 1670

ahead of us. We are ahead of them. But if they work harder than we do over a long enough time the thing could change. There was the story, the famous story, of the hare and the tortoise. You remember that story. And the hare was so complacent he just decided to lie down and sleep. He could get up and win the race any time he chose to, he knew it, but he slept too long and when he got up and started to go, the tortoise was already there. So we dare not become complacent. Neither should we be the least bit paralyzed by fear.

Sell America!

Now I am going to close with a little story because we are going to have to sell our American way of life. The Communists have been out-selling us, that is the only thing that I can say. They out-smarted us by getting that Sputnik up there first, and a lot of other things, and we have been under-selling ourselves, vastly under-selling ourselves and what we have developed here in the United States, but if we sold our way of life the way we sold our businesses around the world we could win this thing.

I am going to close with a little story of what happened to me in Alaska. I was flying with an Eskimo pilot and we were flying in the middle of the winter above the Arctic Circle to the largest Eskimo village in Alaska, Kutzebue—some of you have perhaps been there. It was 40 or 50 below zero. I was up in the cockpit with the pilot and I was flying the plane part of the way and I asked the captain, What the cargo on the plane was. I had noticed that there were just a few seats and the cargo was all covered up with a big tarpaulin.



"The only way we could give you a face-lifting, Madam, is with a steam shovel!"

"Well," he said, "if I tell you you will probably laugh. I think it is a joke in your country."

"What do you mean?"

"Well, this airplane is completely loaded with refrigerators," he answered.

Then I looked under the tarpaulin and sure enough it was refrigerators and asked "Who is buying refrigerators at the North Pole at 40 below zero?"

"Eskimos."

"My goodness, what in the world does an Eskimo want with a refrigerator?"

"They use them to keep their fish warm."

"They use them to keep their fish warm. What in the world do you mean?"

"Well," he said, "you know, in the winter they cut holes in the ice, big square holes, and they fish and they bring the fish out from the deep sea water and it is so cold—40, 50 below zero—they freeze just like a piece of concrete and their fires aren't hot enough to thaw them out and they can't get them thawed out enough to eat them after they once get frozen like this." You know we have had trouble with steak in the deep freeze. And so they discovered that when they get them out of the water and they pop them in the refrigerator, this keeps them warm and they don't freeze up like they did."

This was the fourth load of refrigerators he had flown into that same Eskimo village within a month, all of them to be sold to Eskimos.

Ladies and gentlemen, if we can sell refrigerators to the Eskimos I don't think we are finished yet. ◄

The Young America, Ind., community recently honored Dr. Ed Lybrook for 50 years of service to the community. Over 300 persons attended a basket dinner, sponsored by the local Lions Club.

clinically proven safety

The efficacy of **PATHIBAMATE** has been confirmed clinically in **duodenal ulcer, gastric ulcer, intestinal colic, spastic and irritable colon, ileitis, esophageal spasm, anxiety neurosis** with gastrointestinal symptoms, and **gastric hypermotility.**

Pictured are the results obtained with the PATHILON (tridihexethyl iodide)–meprobamate combination† in a double-blind study of 303 ulcer patients, extending over a period of 36 months.* They clearly demonstrate the efficacy of **PATHIBAMATE** in controlling the symptoms.

SIDE EFFECTS	TRIDIHEXETHYL IODIDE† MEPROBAMATE	TRIDIHEXETHYL IODIDE†	METHANTHELINE BROMIDE	ATROPINE SULFATE	PLACEBO
DRY MOUTH	1%	5%	72%	46%	5%
STOMATITIS	1%	0%	28%	14%	0%
VISUAL DISTURBANCES	0%	0%	50%	34%	1%
URINARY RETENTION	0%	0%	18%	11%	1%
DROWSINESS	20%	0%	0%	0%	0%
COMPLICATIONS OR SURGERY					
HEMORRHAGE	0%	9%	3%	9%	10%
PERFORATION	0%	0%	0%	6%	0%
OPERATION	0%	5%	5%	14%	2%
RECURRENCES					
NONE	28%	23%	25%	17%	26%
FEWER AND MILDER	67%	62%	52%	37%	24%
SAME OR MORE	5%	15%	23%	46%	50%

*Atwater, J. S., and Carson, J. M.: Therapeutic Principles in Management of Peptic Ulcer. **Am. J. Digest. Dis.** 4:1055 (Dec.) 1959.

†PATHILON is now supplied as tridihexethyl chloride instead of the iodide, an advantage permitting wider use, since the latter could distort the results of certain thyroid function tests.

Lederle LEDERLE LABORATORIES, A Division of AMERICAN CYANAMID COMPANY, Pearl River, New York

control the tension — treat the trauma

New Light on 'Over 65' Protection

One of a series prepared by Blue Cross-Blue Shield

Many studies have been made dealing with the number of those "over 65" who are covered by Blue Cross-Blue Shield and by commercial insurance companies. A fundamental weakness in all of these studies is that they show how many have paid premiums. The important question is: how many are receiving benefits?

To obtain more information on this phase of the subject, the Actuarial Division of Blue Cross-Blue Shield conducted a special survey of daily hospital bed occupancy as of May 4, 1960. This census was made through the reporting form, mailed to all Indiana hospital administrators, asking a breakdown according to the table included at the end of this article.

Here are some significant facts obtained as a result of this survey:

Almost twice the number of over-65 patients in Indiana hospitals are receiving Blue Cross-Blue Shield benefits as are receiving benefits from all companies selling commercial health insurance.

On May 4 a total of 96 Indiana general and seven special hospitals reported that on that day 887 bed patients age 65 and over were receiving Blue Cross-Blue Shield benefits, 484 would file for commercial insurance benefits and 43 were expecting both.

Slightly less than 50% had no insurance protection. Of those persons without protection, 993 expected to pay from their own funds, and 445 would have to rely upon welfare or some outside source.

A total of 96 Indiana general hospitals reported, representing 87.5% of the general hospital beds in the state. Seven of the 12 tuberculosis and other specialized institutions also reported.

Of the general hospitals reporting, 2,835 persons aged 65 and over were patients in those hospitals on the date of the study. Persons 65 and over occupied about one-fourth of the total 12,104 beds available.

On the day of the study 77 patients in specialized institutions were age 65 and over. These patients were in hospitals having a total bed capacity of 308. Of these 77 patients, six were receiving Blue Cross-Blue Shield benefits and 11 commercial insurance company benefits. Sixteen were expected to pay privately, while the remaining 44 would rely on other sources.

Supplementing previous reports which have shown that Blue Cross-Blue Shield furnishes more adequate benefits, this special study demonstrates that Blue Cross-Blue Shield also is doing a far more effective job in covering the aged than the commercial insurance companies.

Blue Cross-Blue Shield will continue to make available *adequate* protection for the over 65 at *all* times—and aggressively attempt to enroll *all* segments of the population.

Hospital Bed Occupancy
May 4, 1960

	Total	Special	General
Covered by Blue Cross-Blue Shield	887	5	882
Covered by a commercial insurance company	462	11	451
Covered by both Blue Cross-Blue Shield and one or more commercial insurance companies	43	1	42
Covered by 2 or more commercial insurance companies	22	0	22
Not Covered:			
Private Pay	1,009	16	993
Other	489	44	445
Grand Total	2,912	77	2,835
No. of Hospitals	103	7	96
No. of Beds	12,412	308	12,104

W. C. Huddlestone
Public Relations Division ◄





1¼ Grs. Ea.
FLAVORED

Living up to a family tradition

There are probably certain medications which are special favorites of yours, medications in which you have a particular confidence.

Physicians, through ever increasing recommendation, have long demonstrated their confidence in the uniformity, potency and purity of Bayer Aspirin, the world's first aspirin.

And like Bayer Aspirin, Bayer Aspirin for Children is quality controlled. No other maker submits aspirin to such thorough quality controls as does Bayer. This assures uniform excellence in both forms of Bayer Aspirin.

You can depend on Bayer Aspirin for Children for it has been conscientiously formulated to be the best tasting aspirin ever made and to live up to the Bayer family tradition of providing the finest aspirin the world has ever known.

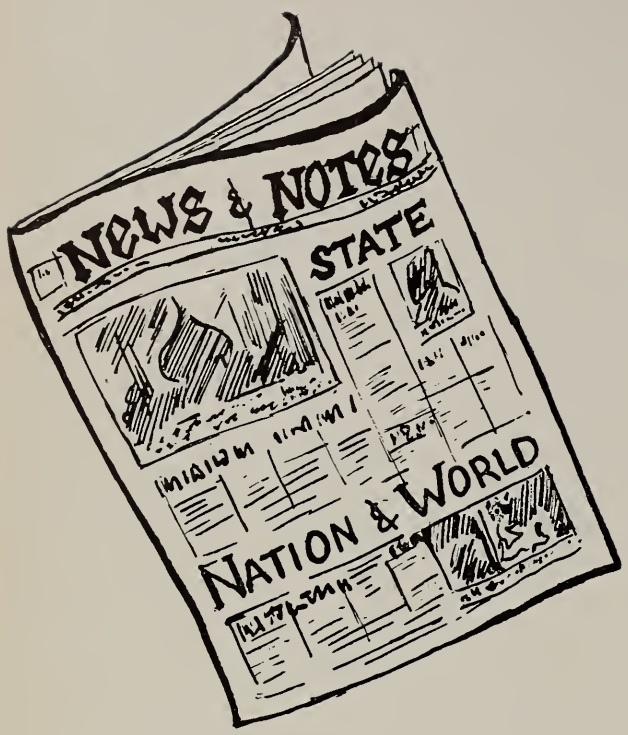
Bayer Aspirin for Children—1¼ grain flavored tablets—Supplied in bottles of 50.

● We welcome your requests for samples on Bayer Aspirin and Flavored Bayer Aspirin for Children.

New GRIP-TIGHT CAP for Children's Greater Protection



THE BAYER COMPANY, DIVISION OF STERLING DRUG INC., 1450 BROADWAY, NEW YORK 18, N. Y.



FDA Proposes Regulations Insuring Safety of New Drugs

Stronger regulations to insure that physicians receive adequate information about the drugs they prescribe and to insure the safety of new drugs were proposed July 22 by the Food and Drug Administration.

The new regulations would:

(1) Require changes in the labeling of prescription drugs. Virtually all prescription drug packages and printed matter distributed to physicians to promote sale of a drug would be required to bear complete information for professional use of the drug, including information about any hazards, side effects or necessary precautions.

Heretofore such fully detailed information has not been required in labeling when it was available in scientific literature, or, in certain cases, was available to the physician upon request. The only exception in the proposed regulations would apply to frequently used medicines that are commonly familiar to the doctor.

(2) Provide that when safety requires a new drug would be kept off the market until the manufacturer's representations regarding the reliability of manufacturing methods, facilities and controls have been confirmed by a factory inspection by the Food and Drug Administration.

Such an inspection would verify that the firm can insure the identity, strength, quality and purity of each batch of the drug, FDA said.

Other proposed labeling changes would require drugs for injection and for use in the eyes to bear a quantitative declaration of all inactive ingredients. Labels of all prescription drugs would be required to include an "identifying lot or control number from which it is possible to determine the complete manufacturing history of the drug." Exemptions are permitted where there is insufficient label space provided the information is given on other parts of the drug package. All labeling bearing information for use of a drug would be required to have the date of its issuance.

Bunts Institute Planning Symposium on Clinical Chemistry

The Frank E. Bunts Educational Institute, Cleveland, Ohio, has announced plans for a symposium postgraduate course entitled "Advances in Clinical Chemistry Methods." Five sessions are scheduled for Nov. 9-11. Further information is available from the Education Secretary of the Institute, 2020 E. 93rd St., Cleveland 6.

PUBLIC HEALTH ASSOCIATION SCHEDULES WEST COAST MEETING

The American Public Health Association's 88th Annual meeting scheduled for Oct. 31-Nov. 4 in San Francisco, will emphasize radiological health, food additives and genetic and environmental aspects of public health.

Many related health organizations are expected to hold meetings during the same week. Further information is available from APHA offices, 1790 Broadway, New York.

Military Surgeons to Meet

"The Military Role in Medical Progress" will be the theme of the Association of Military Surgeons, 62nd annual convention Oct. 31-Nov. 2 at Washington, D. C.

Special section meetings with panel discussions are scheduled for dentists, nurses, medical specialists and veterinarians. Registration begins Oct. 30; there is no fee and non-members are invited.

Preliminary Enrollment Figures Listed For New Federal Employee Program

At least 1,450,000 employees have enrolled in the Federal employees health benefits program, according to preliminary registration figures received from 35 of 38 carriers, the Civil Service Commission announced recently.

The new program went into effect in early July. Enrollment figures are based only on the number of registration forms received by participating carriers at the close of business on July 15. Final figures are not yet available.

The program, administered by the Commission's Bureau of Retirement and Insurance, was authorized by the Federal Employees Health Benefits Act of 1959. It is voluntary and contributary with the federal government paying up to one-half the cost of the subscription charges and employees paying the remainder through payroll deductions.

Continued

Reliable

PROFESSIONAL LIABILITY
INDIVIDUAL INSURANCE

with proficient defense that cuts the cost

Unparalleled Experience • Specialized Service • Saving in Cost

THE
MEDICAL PROTECTIVE COMPANY
FORT WAYNE, INDIANA

Professional Protection Exclusively since 1899

INDIANAPOLIS OFFICE: Kenneth W. Moeller, Rep.
P.O. Box 20132, Indianapolis 20 Tel. CLifford 5-6525

FORT WAYNE OFFICE: A. Russell Quilhot, Rep.
5814 Reed Road, Fort Wayne Tel. Trinity 1161

Board of Health Closes Columbus Branch Office

A. C. Offutt, M.D., Commissioner, Indiana State Board of Health, recently announced that the official health agency closed its branch office at Columbus as of July 31.

The branch office at Columbus has served a 21-county area in southeastern Indiana since 1947. Board action was taken to close the office for several reasons: (1) its geographic proximity to Indianapolis did not warrant its continued operation; (2) changing public health problems now make it possible for residents of the 21-county area to be served from the Indianapolis office and (3) administrative costs will be reduced, Dr. Offutt asserted.

Staff members of the branch office will continue to render public health services to the people of southeastern Indiana, but will be based in Indianapolis. Staff members include an engineer, three sanitarians, a health education consultant, a nutrition consultant, a consultant nurse and three clerks.

Counties included in the area are: Bartholomew, Brown, Clark, Dearborn, Decatur, Fayette, Floyd, Franklin, Harrison, Jackson, Jefferson, Jennings, Johnson, Ohio, Ripley, Rush, Scott, Shelby, Switzerland, Union and Washington.

Currently there are 15 part-time county health departments located in the southeastern branch area, 11 part-time city health departments, four full-time county health departments and one full-time multi-county health department. Such departments will continue to receive public health services from the State Board of Health, as they request such services.

Three other branch offices are operated by the State Board of Health at LaPorte, Fort Wayne and Washington.

Dr. Franklin B. Peck, Sr., associate professor of Medicine at Indiana University, was elected President of the American Diabetes Association at the group's annual meeting in Miami Beach, Fla.

Continued

ST. PAUL FIRE and MARINE • ST. PAUL MERCURY • WESTERN LIFE
The St. Paul Western Insurance Companies
FOUNDED 1853

CHOICE OF INDIANA
STATE MEDICAL ASSOCIATION
FOR PROFESSIONAL
LIABILITY INSURANCE

Indiana Head Office
400 Inland Building
Indianapolis 4, Indiana
MElrose 7-1516

for your complete insurance needs . . .

☆ PROFESSIONAL
☆ PERSONAL
☆ PROPERTY

THERE IS A SAINT PAUL AGENT IN YOUR COMMUNITY AS CLOSE AS YOUR PHONE

HOME OFFICE: 385 WASHINGTON ST., ST. PAUL, MINN.

New Amendment Rescinds Several Civil Air Standards

An alteration in physical standards of airmen and medical certificates rescinding certain existing standards was made effective on June 15 by an amendment to Civil Air Regulations, part 14 CFR 29.

In a notice published by the *Federal Register,* it was noted that existing vision standards and testing procedures applicable to civil airmen were carefully reviewed by the Bureau of Aviation medicine, and that it was found that present tests for depth perception, diplopia prism convergence and prism divergence do not satisfactorily provide necessary information in assessing visual proficiency of airmen.

Limiting values for these tests have seldom served as a basis for disqualification, despite their being standards to be met by applicants in the Civil Air Regulations. Vision standards more accurately limiting disqualification to rare applicants who would have significant alteration Medicine, and that it was found that present in a separate action.

The amendment rescinds existing standards for diplopia, depth perception, abduction and adduction, and thereby grants relief through eliminating various eye standards.



"Stop smirking, nurse, the gentleman is entitled to wear whatever sort of shorts he pleases!"

INDUSTRIAL HEALTH CONGRESS SCHEDULED FOR OCTOBER

All persons with an interest in occupational health are invited to attend the 20th annual Congress on Industrial Health, to be held at the Hotel Charlotte, Charlotte, N. C., Oct. 10-12.

The program will include three days of scientific sessions accepted for Category II credit for members of A.A.G.P. Dr. Vincent Askey, President of the AMA, is scheduled to speak at the annual banquet, Oct. 11.

Persons planning to attend the Congress are asked to make reservations directly with the hotel.

Colorado Technology Course Set for March 20-24 at Denver

The University of Colorado School of Medicine recently announced plans for a fourth postgraduate course in Medical Technology, March 20-24, 1961 at Denver.

Designed primarily for medical technologists, the general course will cover major phases of medical technology with emphasis on practical aspects of laboratory work and new developments in the field.

Detailed programs and further information may be obtained from the Office of Postgraduate Medical Education at the University, 4200 E. Ninth Ave., Denver 20.

Three Hoosiers Honored

Three Hoosier physicians received fellowship certificates from the American College of Chest Physicians at a recent meeting of the college in Miami Beach, Fla.

Among the 170 physicians who received certificates at a June 11 convocation were Drs. Pasquale J. Amico, Crown Point; Ralph F. Carlson, Evansville and Joseph E. Walther, Indianapolis.

The Atomic Energy Commission has announced renewal for one year of a research contract with Indiana University Foundation. A grant of $10,000 is involved and covers research by Dr. Felix Haurowitz on "Biosynthesis and Specificity of Normal and Immune Proteins."

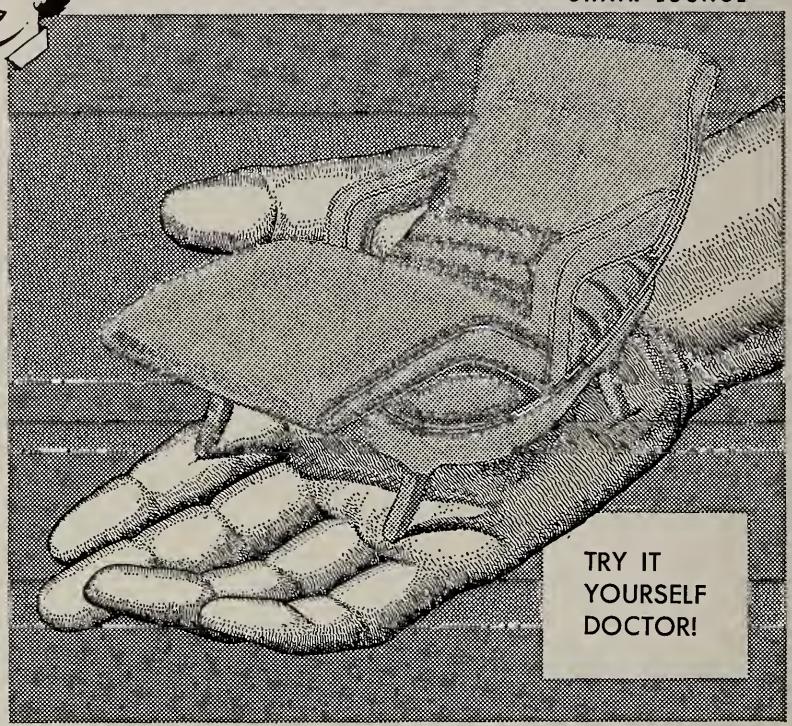
Continued on page 1694

"Unbelievable"

they say of THE GENUINE Contour® CHAIR LOUNGE

HOUSEWIVES
find periodic relaxation in a Contour® makes them feel years younger.







EXECUTIVES
can enjoy Contour's® benefits while conferring, dictating.

CAREER WOMEN
say Contour® relieves tiredness and tension in minutes.





CARDIAC CASES
find Contour® easily elevates head, legs and feet above heart-level to reduce strain.

RHEUMATICS
discover quick relief in Contour's® overall massage and Thermonic Heat.



SUFFERERS FROM EDEMA AND VARICOSE VEINS
take "their weight off their feet" in Contour's® cradle comfort design.



You'll agree when you know what a Contour® can do for you! Stretch out in a Contour® and see how it helps relieve tension and fight fatigue . . . makes you feel better . . . looks better . . . ***helps you get more out of life!*** Discover the way Contour's® exclusive Viveration, overall massage, seems to wash away tiredness . . . the wondrous way Thermonic Heat warms away your aches and pain. You owe it to yourself to come in and try a Contour® for just 10-minutes.

THE GENUINE Contour® CHAIR LOUNGE

2162 N. MERIDIAN STREET
10 NORTH ILLINOIS STREET
INDIANAPOLIS, INDIANA
WA 3-1526 ME 4-8219

Your Health IS YOUR MOST VALUABLE ASSET . . . PROTECT IT WITH A Contour®

stiffness and pain

"gratifying" *relief from stiffness and pain in 106-patient controlled study (as reported in J.A.M.A., April 30, 1960)*

"Particularly gratifying was the drug's [SOMA's] ability to relax muscular spasm, relieve pain, and restore normal movement . . . Its prompt action, ability to provide objective and subjective assistance, and freedom from undesirable effects recommend it for use as a muscle relaxant and analgesic drug of great benefit in the conservative management of the 'low back syndrome'."

Kestler, O.: Conservative Management of "Low Back Syndrome", J.A.M.A. 172: 2039 (April 30) 1960.

FASTER IMPROVEMENT—79% complete or marked improvement in 7 days (Kestler)

EASY TO USE—Usual adult dose is one 350 mg. tablet three times daily and at bedtime.

SUPPLIED: 350 mg., white tablets, bottles of 50.
For pediatric use, 250 mg., orange capsules, bottles of 50.

Literature and samples on request.

SOMA®

(CARISOPRODOL, WALLACE)

WALLACE LABORATORIES, CRANBURY, NEW JERSEY

INDIANA STATE BOARD OF HEALTH

Monthly Report—July, 1960

Disease	July 1960	June 1960	May 1960	July 1959	July 1958
Animal Bites	626	918	667	605	881
Chickenpox	56	335	467	35	94
Conjunctivitis	59	155	153	43	68
Diphtheria	1	0	1	1	0
Dysentery, Unspecified	9	10	10	3	33
Impetigo	82	86	90	57	114
Infectious Hepatitis	25	28	58	17	22
Infectious Mononucleosis	16	16	30	2	17
Influenza	287	393	437	88	122
Measles (Rubeola-Rubella)	411	1514	1934	141	570
Meningitis, Meningococcal	3	6	2	2	7
Meningitis, Other	5	13	16	15	10
Mumps	111	473	445	65	240
Pertussis	36	21	37	65	130
Pneumonia	131	189	175	54	130
Poliomyelitis	11	2	0	24	13
Streptococcal Infections	267	429	692	124	204
Tinea Capitis	1	33	43	0	4

Hoosier Hill-Burton Status Shows 68 Projects Completed

The Department of Health, Education and Welfare reports that as of June 30, status of all Hill-Burton grants for Indiana includes 68 projects completed and in operation, at a total cost of $72,673,449, federal share being $23,-816,458, and supplying 3,166 additional beds.

Also as of June 30, 25 projects, costing $27,812,680, with a $7,478,275 federal share and supplying 986 additional beds, were under construction.

Two projects were approved but not yet under construction. They will cost a total of $4,127,-445, including a $1,182,973 federal contribution, and will supply 151 additional beds.

Dr. Green Honored

Dr. William T. Green, who received the M.D. degree from Indiana University School of Medicine in 1925, and who is now co-chairman of the Department of Orthopedic Surgery of Harvard Medical School, was awarded the honorary degree of Doctor of Science by Indiana University at the annual Commencement ceremonies on June 6.

Cardiac Roentgenology Fellowship Offered

The Department of Medicine in cooperation with the Department of Radiology at Duke Medical Center has announced that a fellowship in Cardiac Roentgenology will be offered beginning Jan. 1, 1961, to residents who have completed at least two and preferably three years of radiology training.

Further information may be obtained from Dr. Henry D. McIntosh, Associate Professor of Medicine, Duke Medical Center, Durham, N. C.

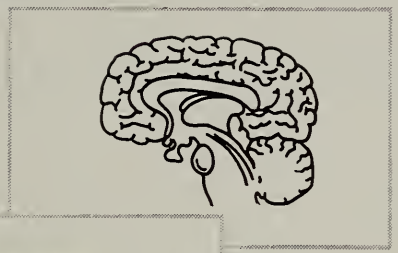
An Indianapolis pediatrician, Dr. John T. Young, was recently elected a fellow of the American Academy of Pediatrics.

Betty J. Foust, M.D., of Indianapolis, has accepted a full-time position with the Medical Department of Penn Mutual Life Insurance Co., of Philadelphia. She will reside in Collingswood, N. J.



basic in the care of the aging

℞ Metalex®



when body tone, mental and sensory faculties begin to fade—*she's irritable, confused, forgetful, apathetic*



when vision begins to dim—*in loss of visual acuity, in loss of peripheral vision*



when voices begin to fade—*in loss of auditory acuity, in tinnitus*

Metalex® *cerebral stimulant/vasodilator*

The stimulant—pentylenetetrazol—facilitates cerebral and reflex nerve activity.

The vasodilator—nicotinic acid—augments blood and oxygen supply to vital areas—

Thus, METALEX increases body tone and aids mental and sensory faculties.

Composition: Each teaspoonful (5 ml.) of the Elixir and each Tablet contains: Pentylenetetrazol 100 mg., Nicotinic Acid 50 mg.

Dosage: One or two teaspoonfuls of the Elixir or one or two Tablets four times a day—one-half hour before meals and before bedtime.

Available: Elixir: Pint and Gallon bottles. Tablets: Bottles of 100 and 1000.

References: 1. Goodman, L. S. and Gilman, A.: The Pharmacological Basis of Therapeutics, 2nd Ed., New York, Macmillan Company, 1955. 2. O'Reilly, P. O., Demay, M. and Kotlowski, K.: Cholesteremia and Nicotinic Acid. A.M.A. Arch. Int. Med. 100:797-801 (Nov.) 1957.

STORCK Pharmaceuticals, Inc.,
2326 Hampton Blvd., St. Louis 10, Mo.

EXECUTIVE COMMITTEE

July 9, 1960

Roll call showed the following present: Donald E. Wood, M.D., chairman; Wendell E. Covalt, M.D., Earl W. Mericle, M.D., Guy A. Owsley, M.D., Maurice E. Glock, M.D., Okla W. Sicks, M.D. and Mr. James A. Waggener. Robert Hollowell and Ralph Hamill, Association attorneys.

Treasurer's Office

The statement of income and budget balances as of June 15, 1960, were approved by consent.

The Treasurer's Report was approved upon motion of Doctors Glock and Covalt.

The Statement of the Auditors for the first nine months of the current fiscal year was reviewed and accepted by consent.

Membership Report

The membership report, as of July 8, was reviewed and accepted by consent.

Headquarters Office

A contract from Blue Cross-Blue Shield, covering the employees of the Headquarters Office was approved, upon motion of Drs. Glock and Mericle.

Unfinished Business

The secretary read a report from Dr. Frank Green, chairman of the Commission on Interprofessional Relations, concerning the matter which was referred to his commission by the Executive Committee at its previous meeting. The committee was highly complimentary of the commission's recommendations and they approved by consent.

Legislation

Dr. Donald Wood, Chairman of the Commission on Legislation, discussed matters that were currently before Congress of importance to the medical profession.

A letter from Dr. Harold E. Stadler, concerning changing from the current use of silver nitrate prophylaxis in the newborn infant, was read. Upon motion of Dr. Glock, seconded by Dr. Covalt, this is to be referred to the Commission on Public Health and to the Commission on Legislation for approval and implementation.

Annual Convention

The policy of determining who should be the chairman of the annual luncheon of the past-presidents during the Annual Convention was discussed, and upon motion of Drs. Glock and Covalt, it was determined that the immediate past president should automatically be the chairman of the annual past-presidents' luncheon.

Organization Matters

A letter of appreciation from Dr. Nora M. Arthur for her new Senior Membership Card was read.

A letter from the North Central District Blood Bank Clearing House, calling attention that it was time for the Association to nominate an advisory director to this organization, was read, and upon motion of Drs. Mericle and Glock, it was decided to re-nominate Dr. Jene R. Bennett, of South Bend, for re-election.

A motion adopted by the Commission on Medical Economics and Insurance, at its meeting on May 22, requesting that the association undertake a study of progressive patient care, was referred to the Executive Committee, and upon motion of Drs. Mericle and Covalt, the committee approved of the suggestion and ordered the matter referred to the appropriate commission.

A letter from Dr. Kenneth Neumann, addressed to Dr. Glock, as Chairman of the Council, was read, and upon motion of Drs. Mericle and Glock, the matter was referred to the Council.

A progress report was received from the Commission on Governmental Medical Services concerning the liaison activities with the Indiana State Department of Public Welfare and upon motion of Drs. Owsley and Mericle, the Executive Committee recommends that the Commission on Governmental Medical Services use all their influence to discourage the adoption of a regulation requiring the use of generic terms on welfare prescriptions.

A letter from Dr. Paul S. Connell, of Plymouth, Ind., was read for the information of the Committee.

A letter from the Indiana Hospital Association, enclosing a copy of a "Guide for the Release of Information from Medical Records" was presented and was referred to the association's legal counsel for review and recommendations.

The president reported on the activities of the Building Committee since its last meeting, and announced that the Indianapolis Zoning Board had granted a variance for the right to build its headquarters building at 3935 N. Meridian St.

A request of the Psychological Clinic of Indiana University for use of the association's mailing list for mailing a questionnaire to Indiana physicians in an effort to determine the approximate number of emotionally disturbed children, ages 6 through 16, was approved, upon motion of Drs. Mericle and Glock.

The request of the Department of Psychiatry of the Indiana University School of Medicine for use of the mailing list to send a questionnaire to physicians concerning their desires on post-graduate training programs was approved upon motion of Drs. Glock and Mericle.

A request of Dr. Edward A. Tyler, Director of the Riley Child Guidance Clinic, for use of the mailing list to distribute a reprint of an article which appears in the *Medical Times* on "Childhood Emotional Disorders" was approved, upon motion of Drs. Glock and Owsley.

A letter from Dr. S. S. Philbrook, concerning eye examinations in the school, was read and the secretary reported a format for an answer to the letter, and this was approved, upon motion of Drs. Owsley and Mericle.

New Business

A discussion of the Auxiliary dues structure was had and it was agreed that the dues of the Auxiliary were not sufficient for this organization to carry on an effective program. Upon motion of Drs. Owsley and

as it calms anxiety!

Smooth, balanced action lifts depression as it calms anxiety... rapidly and safely

Balances the mood – no "seesaw" effect of amphetamine-barbiturates and energizers. While amphetamines and energizers may stimulate the patient *–they often aggravate anxiety and tension.*

And although amphetamine-barbiturate combinations may counteract excessive stimulation*–they often deepen depression.*

In contrast to such "seesaw" effects, Deprol's smooth, *balanced* action lifts depression as it calms anxiety–both at the same time.

Acts swiftly – the patient often feels better, sleeps better, within a few days. Unlike the delayed action of most other antidepressant drugs, which may take two to six weeks to bring results, Deprol relieves the patient quickly – often within a few days. Thus, the expense to the patient of long-term drug therapy can be avoided.

Acts safely – no danger of liver damage. Deprol does not produce liver damage, hypotension, psychotic reactions or changes in sexual function–frequently reported with other antidepressant drugs.

Bibliography *(13 clinical studies, 858 patients)*: **1.** Alexander, L. (35 patients): Chemotherapy of depression – Use of meprobamate combined with benactyzine (2-diethylaminoethyl benzilate) hydrochloride. J.A.M.A. 166:1019, March 1, 1958. **2.** Bateman, J. C. and Carlton, H. N. (50 patients): Meprobamate and benactyzine hydrochloride (Deprol) as adjunctive therapy for patients with advanced cancer. Antibiotic Med. & Clin. Therapy 6:648, Nov. 1959. **3.** Beerman, H. M. (44 patients): The treatment of depression with meprobamate and benactyzine hydrochloride. Western Med. 1:10, March 1960. **4.** Bell, J. L., Tauber, H., Santy, A. and Pulito, F. (77 patients): Treatment of depressive states in affice practice. Dis. Nerv. System 20:263, June 1959. **5.** Breitner, C. (31 patients): On mental depressians. Dis. Nerv. System 20:142, (Section Two), May 1959. **6.** Gordan, P. E. (50 patients): Deprol in the treatment of depression. Dis. Nerv. System 21:215, April 1960. **7.** Landman, M. E. (50 patients): Clinical trial of a new antidepressive agent. J. M. Soc. New Jersey. In press, 1960. **8.** McClure, C. W., Papas, P. N., Speare, G. S., Palmer, E., Slattery, J. J., Konefal, S. H., Henken, B. S., Wood, C. A. and Ceresia, G. B. (128 patients): Treatment of depression – New technics and therapy. Am. Pract. & Digest Treat. 10:1525, Sept. 1959. **9.** Pennington, V. M. (135 patients): Meprobamate-benactyzine (Deprol) in the treatment of chronic brain syndrome, schizophrenia and senility. J. Am. Geriatrics Soc. 7:656, Aug. 1959. **10.** Rickels, K. and Ewing, J. H. (35 patients): Deprol in depressive conditions. Dis. Nerv. System 20:364, (Section One), Aug. 1959. **11.** Ruchwarger, A. (87 patients): Use of Deprol (meprobamate combined with benactyzine hydrochloride) in the office treatment of depression. M. Ann. District of Columbia 28:438, Aug. 1959. **12.** Settel, E. (52 patients): Treatment of depression in the elderly with a meprobamate-benactyzine hydrochloride combination. Antibiotic Med. & Clin. Therapy 7:28, Jan. 1960. **13.** Splitter, S. R. (84 patients): Treatment of the anxious patient in general practice. J. Clin. & Exper. Psychopath. In press, April-June 1960.

Dosage: Usual starting dose is 1 tablet q.i.d. When necessary, this dose may be gradually increased up to 3 tablets q.i.d.

Composition: 1 mg. 2-diethylaminoethyl benzilate hydrochloride (benactyzine HCl) and 400 mg. meprobamate.
Supplied: Bottles of 50 light-pink, scored tablets. Write for literature and samples.

Deprol®

WALLACE LABORATORIES / *New Brunswick, N. J.*

CD-2128

Glock, it is moved that the Executive Committee approve the idea of the Auxiliary increasing their dues.

Dr. Glock brought up the matter of relationships between organized medicine and the Governor's Commission on Aging, pointing out that this subject was of such prime importance that he felt that we should consider establishing two full-time commissions—one on aging—and one on rehabilitation. Following discussion, it was agreed, by consent, that the president should appoint an interim committee on aging, and that the Commission on Constitution and Bylaws should receive the recommendations that an appropriate amendment to the Bylaws be prepared for submission to the House of Delegates to create a standing committee, or commission, on aging.

Journal

The question of the sale of rosters, prepared by the Association, was reviewed and upon motion of Drs. Mericle and Glock, it was ruled that a flat charge of $3.00 shall be made for all copies of the Roster.

Future Meetings

The announcement of the Regional Meeting, being called by the AMA at French Lick, Aug. 12 and 13, was read and upon motion of Drs. Owsley and Glock, it was determined that the officers and councilors and members of the Legislative Commission be invited to attend.

An announcement of the AMA Public Relations Institute, to be held in Chicago, Aug. 31-Sept. 2, was read, and upon motion of Drs. Glock and Covalt, attendance by the president, president-elect, executive secretary and the field men was approved.

The announcement of the Ninth United States Civil Defense Council to be held in Minneapolis, Sept. 21-22, was made. Upon motion of Drs. Glock and Covalt it was moved that the Commission on Governmental Medical Services be authorized to name one delegate.

A notice of the 20th Annual Congress on Industrial Health, to be held in Charlotte, N. C., Oct. 10-12, was read. Upon motion of Dr. Glock, and taken by consent, it was agreed that no one be sent by the Indiana State Medical Association to this meeting.

Upon motion of Drs. Glock and Owsley, the meeting was adjourned to meet again at 6:30 p.m., Friday night, August 12, at the French Lick-Sheraton Hotel in French Lick.

BUDGET COMMITTEE

July 9, 1960

Roll call showed the following present: Donald E. Wood, M.D., Chairman, Wendell E. Covalt, M.D., Earl W. Mericle, M.D., Guy A. Owsley, M.D., Maurice E. Glock, M.D., Okla W. Sicks, M.D. and Mr. James A. Waggener.

The following requests for additional appropriations were received by the Budget Committee:

The Executive Committee requested an additional appropriation of $500.00. This was approved upon motion of Drs. Covalt and Owsley.

The Grievance Committee requested an additional $150.00. This was approved on motion of Drs. Glock and Owsley.

The Commission on Constitution and Bylaws requested an additional appropriation of $300.00. This was approved upon motion of Drs. Owsley and Mericle.

The Commission on Voluntary Health Agencies requested an increase in their budget of $600.00. This was approved upon motion of Drs. Covalt and Owsley.

A request of the Commission on Governmental Medical Services, taken by resolution at their meeting on April 13, requesting authority to spend $100.00 to help finance the regional meeting on Veterans Affairs at Indianapolis on Sept. 17, was approved, upon motion of Drs. Glock and Mericle.

There being no further business, the meeting was adjourned, upon motion of Drs. Mericle and Covalt.

THE COUNCIL

July 10, 1960

The Council of the Indiana State Medical Association convened for its summer meeting at 10:00 a.m., Sunday, July 10, 1960, in Room M-124, Indiana University Student Union Building, Indianapolis, with Dr. Maurice E. Glock, chairman, presiding.

Roll call showed the following present:

First District—William B. Challman, Mount Vernon

Second District—J. H. Crowder, Sullivan; Philip T. Holland, Bloomington, alternate

Third District—John M. Paris, New Albany

Fourth District—Not represented

Fifth District—V. Earle Wiseman, Greencastle, alternate

Sixth District—William R. Tindall, Shelbyville, alternate

Seventh District—Charles A. Jones, Franklin

Eighth District—Guy A. Owsley, Hartford City (also president-elect); Gordon B. Wilder, Anderson, alternate (also AMA delegate)

Ninth District—Kenneth O. Neumann, Lafayette; A. E. Stouder, Kempton, alternate

Tenth District—James P. Vye, Gary

Eleventh District—Max R. Adams, Flora

Twelfth District—Maurice E. Glock, Fort Wayne; Milton F. Popp, Fort Wayne, alternate

Thirteenth District—Burton E. Kintner, Elkhart

Officers:

Earl W. Mericle, Indianapolis, president

Okla W. Sicks, Indianapolis, treasurer

Harry Pandolfo, Indianapolis, assistant treasurer



even in allergic infants



FROM A CLINICAL STUDY* IN ANNALS OF ALLERGY

Patients	200 infants and children, ages 2 months to 14 years
Diagnosis	Perennial allergic rhinitis
Therapy	Dimetane Elixir
Results	in 149, *good* results / in 40, *fair* results
Side Effects	Encountered in *only* 7 patients (in all except one, the side effect was mild drowsiness)

In allergic patients *of all ages,* Dimetane has been shown to work with an effectiveness rate of about 90% and to produce an exceptionally low incidence of side effects. Complete clinical data are available on request to the Medical Department. *Supplied:* DIMETANE Extentabs® (12 mg.), Tablets (4 mg.), Elixir (2 mg./5 cc.), new DIMETANE-TEN Injectable (10 mg./cc.) or new DIMETANE-100 Injectable (100 mg./cc.).

Robins

*MC GOVERN, J. P., MC ELHENNEY, T. R., HALL, T. R., AND BURDON, K.D.: ANNALS OF ALLERGY 17:915, 1959.

A. H. ROBINS CO., INC., RICHMOND 20, VIRGINIA / ETHICAL PHARMACEUTICALS OF MERIT SINCE 1878

† PARABROMDYLAMINE MALEATE

Executive Committee:

Don E. Wood, Indianapolis, chairman (also co-chairman, Commission on Legislation)
Wendell E. Covalt, Muncie, member

Guests:

Cleon A. Nafe, Indianapolis, member, Board of Trustees, AMA
Harold C. Ochsner, Indianapolis, AMA delegate
E. S. Jones, Hammond, AMA delegate
Wendell C. Stover, Boonville, AMA delegate
Philip B. Reed, Indianapolis, chairman, Grievance Committee
Glen V. Ryan, Indianapolis, and Bernard D. Rosenak, Indianapolis, members of Executive Committee of Blue Shield Board
E. S. Rifner, Van Buren, councilor-elect, Eleventh District
A. C. Offutt, Indianapolis, State Health Commissioner
P. J. Rosenbloom, Gary

Staff:

Robert Hollowell, Indianapolis, attorney
Ralph Hamill, Indianapolis, attorney
Robert J. Amick, field secretary
Howard Grindstaff, field secretary
J. A. Waggener, executive secretary

On motion of Drs. Paris and Neumann, minutes of the April 10, 1960, Council meeting were approved as printed in the July, 1960 issue of *The Journal.*

AMA Regional Legislative Conference, August 12-13, 1960

The chairman announced that the Executive Committee, at its meeting on July 9, 1960, approved payment of the hotel bill of any members of the Council and the Commission on Legislation who plan to attend the AMA Regional Legislative Conference at French Lick on Aug. 12 and 13, 1960.

Reports of Councilors

The councilors reported that district meeting dates have been set as follows:

Third District—Huntingburg, May 11, 1961
Ninth District—Crawfordsville, May 18, 1961
Thirteenth District—Elkhart, Sept. 28, 1960. Dr. Paul Dudley White will speak at the evening meeting on "The Health of the Physician Himself."

The Council stood at this time in silent prayer in memory of Dr. Joseph E. Dudding of Hope, former councilor of the Fourth District, who died on May 20, 1960.

Reports of Officers

DR. EARL W. MERICLE, president: I didn't send a report to the Council this last period due to the fact that I was gone too much of the time to write one. Since last I talked to you I've been to the following:

I attended the County Medical Society meeting at Washington, Indiana. The sole purpose of my being invited to this meeting was to indoctrinate them into becoming a more active society and I hope I was successful. I learned there that one of the members of that Society thought I was a communist. I wish to say here and now that I am not.

Next, I attended the meeting of the Woman's Auxiliary at French Lick and this meeting seemed to be one of the most pleasantly toned meetings that I attended. The girls seemed to be having an excellent time and they had a good program.

Following this was the Medical-Legal Institute in Indianapolis and I represented the medical profession. There was a long discussion about a code of relationship between doctors and lawyers and they finally came to the realization that this had been worked out five years ago. They are studying their *Journals.*

I attended a Chamber of Commerce dinner at Washington, D. C., and there talked to many Congressmen and a report of this is in *The Journal.* I hope all of you have read it. Those of us who attended this meeting learned the facts of life very clearly there—if we are going to be of any political force we must begin to act like politicians.

Next was the District meeting in Shelbyville and this was well attended.

Then I went to Cleveland to the Ohio State meeting. I learned that they have a little different set-up —the Council of the Ohio State Medical Association is selected by the House of Delegates. They feel that in so doing they have a more effective control.

Following this I attended District meetings at both Lafayette and Franklin and also attended the State Dental Association meeting, representing the State Medical Association.

I also attended the Civil Defense meeting here in Indianapolis wherein a 200-bed hospital was set up in a trial run by an outfit of medical officers in the City of Indianapolis. Harry Becker is the commanding officer. I'd like to say that it looked very much like a typical military set-up and it would function quickly in case of need. This is something all of us should see because in case of disaster these units certainly would be of value.

I then went to Chicago to attend the Illinois State Medical meeting. Following this, I represented the State Medical Association at a cardiology meeting here; then I went to Anderson for a District meeting and this was a very fine meeting. They had a lot of people out.

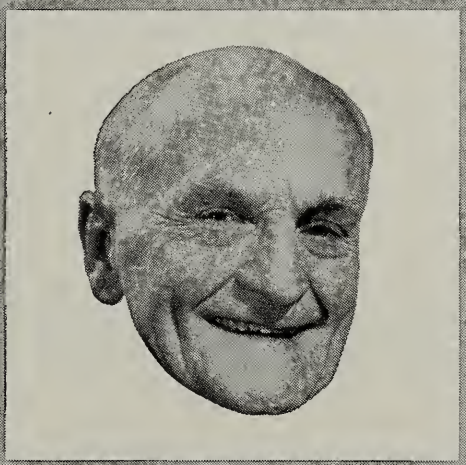
I went to the AMA meeting in Miami and that meeting was rather disappointing because, sitting where I was in back of the House of Delegates, I was rather amazed at the lack of discussion of the issues. I've seen a few of these meetings before and it is quite possible that all the issues were settled in reference committees but I would have felt better if there had been a little more discussion of the things that were going on. Dr. Owsley mentioned last night that most of the meeting was given over to reaffirmation of principles already laid down.

I then went to Evansville to attend the District meeting; the speaker was the Chinese Ambassador and he did a masterful job. Bill Challman certainly had a fine program that night.

for baby
for mother
for grandpa
all age groups







DESITIN®
OINTMENT

to soothe, protect,
lubricate, and stimulate healing in

rash • chafing • irritations
lacerations • ulcerations • burns

DESITIN OINTMENT...
the pioneer external cod liver oil therapy for
care of the skin in every member of the family

Request samples from...

DESITIN CHEMICAL COMPANY
812 Branch Avenue. Providence 4, R. I.

In regard to the purchase of a site for a building —I appeared with Mr. Hamill and Jim Waggener before the Zoning Board for a variance permitting us to construct a building at 3935 North Meridian and, if within eight days from last Friday the Metropolitan Planning Commission doesn't object to this, that property will be purchased.

One other thing that I would like to mention is the problem that is coming in regard to the medical care of the aging population. The AMA has a special committee and many of the state societies are appointing special committees for this study. I would like to present to the Council the thought that it might be wise if this association, by action of the House of Delegates or otherwise, would appoint a special commission or committee to study this problem because in scope it is so big that it shouldn't be left to a commission that is already in existence. Thank you, Dr. Glock.

Following discussion of Dr. Mericle's recommendation that a special committee or commission on Medical Care of the Aging Population be appointed:

On motion of Drs. Paris and Wilder the Council voted to "request the president of the Association to appoint this special committee and to recommend to the House of Delegates in October that it be made a special commission.

In accordance with the above action, Dr. Mericle appointed an Interim Committee on Aging consisting of the following members:

Nathan L. Salon, Fort Wayne, chairman
Andrew C. Offutt, Indianapolis
Walter U. Kennedy, New Castle
Frank M. Hall, Indianapolis
Okla W. Sicks, Indianapolis

DR. GUY A. OWSLEY, president-elect, announced that Dr. Gordon B. Wilder, Anderson, would succeed him as councilor of the Eighth District.

The chairman introduced Dr. E. S. Rifner of Van Buren, councilor-elect of the Eleventh District, announced that Dr. E. T. Edwards of Vincennes is councilor-elect of the Second District, and that Dr. V. Earle Wiseman of Greencastle is councilor-elect of the Fifth District.

DR. OKLA W. SICKS, treasurer: Dr. Glock and members: In addition to the auditor's report which you have here, I have some other information that might be of value. Since our last meeting, the securities in the safety deposit box have been reviewed, relisted, and brought up-to-date. That was done with Miss Bartley in our office and an auditor of Wolf and Company present. At the present time we have securities in the General Fund, the face value of which is $336,000.00, and the market value at the present time is $327,850.35. Now, breaking that down we have long-time securities with a face value of $236,000.00, and market value at the present time of $228,385.00. We have $100,000.00 in Treasury Bills with a market value at the present time of $99,465.35. Of these Treasury Bills, $55,000.00 will mature in August, $10,000 in September, $20,000 in December and $15,000 in January, which can be cashed for full value in late December, 1960.

Some of the long-term securities have come due and they have been transferred to the Treasury Bills. The purpose of this was to have ready money for the building program. In these short-term bills we've also invested money that came in from the dues. Of this $100,000.00, $35,935.00 is earmarked for AMEF and $18,000.00 is earmarked for the building fund, in accordance with a directive from the Budget Committee last year. Now that leaves $46,130 in Bills which will be our running expense money until the next dues are collected.

We are advised by the bank officials that any sale of long-term securities to buy more attractive recent issues would result in a loss.

On motion of Drs. Paris and Owsley the Council authorized "at least a monthly appraisal of what our portfolio (of securities) is worth."

REPORT OF DELEGATES TO THE AMA: Drs. E. S. Jones, Gordon B. Wilder, and Wendell C. Stover, AMA delegates, reported on the actions taken by the AMA House of Delegates at the annual convention held at Miami, June 13 to 17, 1960. (See pages 1533-38, August, 1960 *Journal* for complete report.)

Unfinished Business

1. *Building Committee.* In the absence of Dr. Everly, chairman, Mr. Hollowell reported that the lot had been purchased subject to zoning variance being obtained: "Zoning variance was obtained from the Park Board. It also has been obtained from the City Zoning Board. Eight days from last Friday the Metropolitan Zoning Commission may appeal. I think it is planned by the Building Committee to have a meeting immediately after eight days have expired. Application for a building permit must be made within 90 days from last Friday."

Dr. Pandolfo, member of the committee, reported that Lennox, Matthews, Simmons and Ford, Inc., of Indianapolis, had been selected as architects for the building.

DR. OWSLEY spoke on methods of financing the new building: I'm sure that none of you would want the Executive Committee to use all of your surplus funds in the building of this building. There are certain very definite reasons for that. The interest that we earn each year on this amount of money is considerable—over $7,000 now, and that could go a long ways toward paying interest on money that we might borrow if it isn't used. Now, we have to pay for the lot, because it's contracted for, providing the variance is not interfered with. There is enough money in short term notes to pay that without embarrassing the general fund.

After that then, comes the question how much should we borrow and how much should we pay and where should we get the money, etc.? Judge Hamill came up with the most novel idea I've heard in financing of this kind. We've thought, for example, in this kind of terms: that if we spent $125,000 of the State Association's fixed assets on the building and borrowed $125,000 over a 10-year period that that would be sufficient. The

Over ten thousand doctors have chosen it for their own use.

NOW *Sealy*
INVITES YOU TO ENJOY A
$39 Professional Discount
ON THE POSTUREPEDIC
MATTRESS & BOX SPRING

MAIL TO: SEALY MATTRESS COMPANY
666 Lake Shore Drive, Chicago 11, Illinois

☐ Enclosed is my check. Please ship the Sealy Posturepedic Set(s) indicated below

☐ Please send me the name of my nearest Sealy Posturepedic dealer

1 Full Size ☐ 1 Twin Size ☐ 2 Twin Size ☐

	RETAIL	PROFESSIONAL
Posturepedic Mattress each $79.50 (add state tax)		$60.00
Posturepedic Foundation each $79.50 (add state tax)		$60.00
Posturepedic in Foam Rubber $179.50 per set (add state tax)		$140.00

DOCTOR_____

RESIDENCE_____

CITY_____ ZONE____ STATE_____

(This is a saving of $39.00 per set over the regular $159.00 retail price for innerspring mattress and matching foundation)

For your professional discount, clip and mail this coupon.

LIMIT—ONE FULL OR TWO TWIN SIZE SETS

For you and for your patients...

Sealy Posturepedic®

NO MORNING BACKACHE from a too-soft mattress

Sealy Posturepedic is the *first* mattress designed in cooperation with leading orthopedic surgeons to promote normal, healthful sleep among *all* persons. As a "corrective device" it serves those chronically afflicted with lower back syndromes. As a preventive measure Sealy Posturepedic brings deep spring buoyancy without bedboard hardness to everyone. And it supplies level spine support for proper relaxation of the limbs and human musculatory system. We believe your investigation and *personal use* will firmly convince you of its distinctive benefits and, we would hope, merit your valued recommendation. *Why not prove it to yourself by taking advantage of this liberal professional discount plan now?*



Sealy Posturepedic®

world's largest selling mattress of its kind

© Sealy, Inc., 1960

interest on that amount of money at going rates, we are told, is not the lowest in the world and might run as high as six percent with a one percent service charge if it were procured locally. We know that there are probably other places where this could be procured somewhat cheaper but we haven't faced that yet so we don't know for sure.

Judge Hamill is a member of the Brookside Masonic Lodge and when they built their building an attempt was made to supply the funds through donations. They came up with this novel idea of issuing four percent certificates, for purchase by the members in denominations of $100 to $500 to $1,000, payable on hardship, death or in 10 years. It seems to me that this plan certainly deserves a lot of consideration.

We all know that we can't safely earn more than four percent generally on fixed investments. You know what the financial condition of the State Association is. It's excellent and you would have the added asset of the building, if it would be possible to put this idea across. It's conceivable that we might sell the whole lot to the doctors. Then we wouldn't have to dip into our fund.

Now how important is this? Let's take $250,000 at four percent, that's $10,000 interest a year. We are earning on our own money now approximately $8,000 interest, so the interest that we would have to pay out would be very minimal for this amount of money. I certainly think that this plan deserves a lot of consideration.

2. *Board of Impartial Medical Witnesses.* Dr. Vye, chairman of the Council Committee on Establishment of Panel of Impartial Medical Experts, reported that a committee of his county medical society (Lake) had had much discussion of this subject and had prepared the following resolution which the members of the committee asked him to read to the Council:

> WHEREAS, the impartial medical witness plan in the Federal Court in several cities outside the State of Indiana has been tried for periods up to seven years and has proven to be of value in these areas, and
>
> WHEREAS, Indiana Federal Court judges have indicated a desire to institute similar plans in their court, and
>
> WHEREAS, the study made by the Lake County Medical Society has determined that there is probably a need of such a program in Indiana, and
>
> WHEREAS, the formation of the necessary panel of qualified and impartial witnesses is difficult, if not impossible, on the county-wide basis;
>
> NOW THEREFORE BE IT RESOLVED, that the Indiana State Medical Association undertake to assist in bringing about an impartial medical witness plan on a regional basis corresponding with each Federal Court, or on a statewide basis, to serve all the Federal Courts in Indiana.

Discussed by Drs. Vye, Kintner, Neuman, Challman, Mericle, Judge Hamill, and Dr. Holland.

On motion of Drs. Mericle and Challman, the Council directed that this matter be referred to the Commission on Governmental Affairs for further study.

3. *Report of Commission on Medical Economics and Insurance on surgical assistants' fees.* Dr. Glen V. Ryan, member of the Executive Committee of the Blue Shield Board, presented the following rider recommended by the liaison committee made up of three members of the ISMA Council and three members of the Board of Directors of Blue Shield:

Blue Shield Endorsement for Cooperating Physicians' Fees

IT IS AGREED that in addition to all other indemnities and benefits provided in the Blue Shield Certificate of Membership, Blue Shield will provide payment for medical service rendered by an assistant or cooperating physician other than the operating surgeon as follows:

0470	Radical mastectomy	$37.50
0683	Skull fracture, depressed with operation	25.00
1008	Arthrotomy of knee	31.25
1454	Division of scalenus anticus, without resection of cervical rib	25.00
1951	Rhinoplasty, complete including grafts	37.50
2193	Total or subtotal lobectomy	43.75
2315	Valvulotomy	50.00
2471	Arterioplasty	50.00
2601	Splenectomy	37.50
2754	Plastic repair of harelip, unilateral	31.25
2988	Excision of branchial cyst	18.75
3115	Subtotal gasterectomy	43.75
3178	Colectomy	37.50
3261	Appendectomy	25.00
3380	Hemorrhoidectomy	18.75
3515	Cholecystectomy	37.50
3571	Exploratory laparotomy	25.00
3631	Inguinal, unilateral herniorrhaphy	25.00
3821	Nephrectomy	37.50
4321	Transurethral electrosection of prostate	37.50
4488	Colpoperineoplasty	25.00
4617	Panhysterectomy	31.25
4801	Caesarean section	25.00
4917	Thyroidectomy	31.25
5154	Excision of brain cyst	43.75
5412	Enucleation of eyeball with implantation	37.50
5975	Radical mastoidectomy unilateral	37.50

The maximum fees for surgical services which are included in the standard nomenclature of such services used by the American Medical Association, but which are not specifically included in the above list, will be paid in an amount which, on the basis of



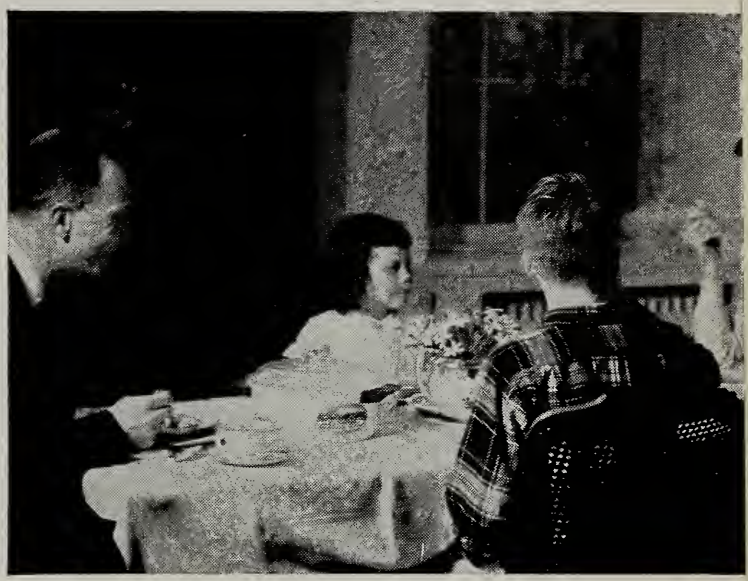
The physician listens to a tense, nervous patient discuss her emotional problems. To help her, he prescribes Meprospan® (400 mg.), the only continuous-release form of meprobamate.



The patient takes one Meprospan-400 capsule at breakfast. She has been suffering from recurring states of anxiety which have no organic etiology.



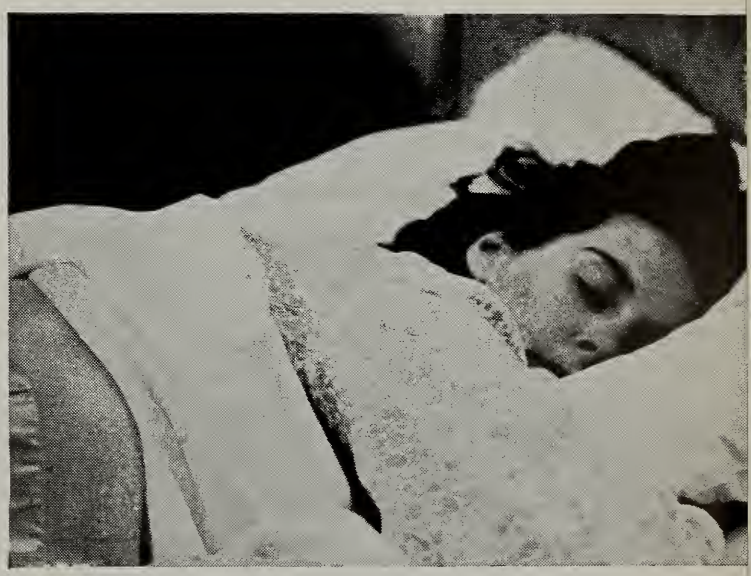
She stays calm while on Meprospan, even under the pressure of busy, crowded supermarket shopping. And she is not likely to experience any autonomic side reactions, sleepiness or other discomfort.



She takes another capsule of Meprospan-400 with her evening meal. She has enjoyed sustained tranquilization all day—and has had no between-dose letdowns. Now she can enjoy sustained tranquilization all through the night.



Relaxed, alert, attentive . . . she is able to listen carefully to P.T.A. proposals. For Meprospan does not affect either her mental or her physical efficiency.



Peacefully asleep . . . she rests, undisturbed by nervousness or tension. (Samples and literature on Meprospan available from Wallace Laboratories, Cranbury, N. J.)

skill, time and responsbility involved, would be consistent with the specific fees contained in the above list for comparable services. The exact amount to be paid for such services will be determined on the basis herein stated by the Executive Committee of the Board of Directors of Blue Shield.

For the guidance of physicians and members as to the amounts of indemnities which the Executive Committee has allowed in applying this provision of this Certificate where services other than those above set forth were rendered, a list of such services and amounts so allowed has been prepared and is available to members, physicians, and others having an interest in such information.

In consideration of the payment of an additional Membership Fee, in accordance with the following, this Endorsement forms a part of the Blue Shield Certificate of Membership.

Single Certificate--$0.15 Family Certificate—$0.28

IN WITNESS WHEREOF: Mutual Medical Insurance, Inc. has executed this Endorsement.

ATTEST:

MUTUAL MEDICAL INSURANCE, INC.

Secretary President

Countersigned by:

Executive Vice President

DR. RYAN: This is a rider that would be put up for sale that would pay 25% assistant fee or cooperating physician, as it says in the first paragraph, on those indemnities that pay $75.00 or more. Now it's the opinion of the members of the Blue Shield Executive Committee that this is probably a duplication since we have a rider already for sale which pays for medical services at the rate of $5.00, $4.00 or $3.00 per day according to what the member purchased.

This rider is on surgical cases. It has nothing to do with the regular in-hospital medical coverage.

DR. CHALLMAN: I have no comment except that this is the first I've seen of this. At our last meeting we requested that the Blue Shield Board prepare such a schedule. I think that it is a necessity for a lot of these people. Many of them can only pay the Blue Shield benefit; the cooperating physician in many cases is left completely out in the cold. I think something of this nature is badly needed.

Discussed also by Drs. Vye, E. S. Jones, Paris and Neumann.

Inasmuch as the Council Liaison Committee with Blue Shield had not seen the rider under discussion prior to this meeting of the Council:

It was taken by consent that this matter should be referred to the Liaison Committee between the Council and Blue Shield for study and report at the next meeting of the Council.

Discussed further by Drs. Nafe, Rosenak, member of the Executive Committee of Blue Shield and Dr. Paris.

4. *School Health Policies.* The chairman reported that two of the state medical association commissions had gone on record as approving the proposed School Health Policies which have already been printed by the Indiana State Board of Health, copy of which had been sent for perusal and study to each councilor.

Discussed in detail by Drs. Paris, Kintner, Vye, Rosenbloom, Crowder and Neumann.

On motion of Drs. Paris and Kintner, the Council went on record as approving the School Health Policies as printed.

5. *AMEF.* The chairman reported, in the absence of Dr. Francis L. Land, chairman of the Commission on Medical Education and Licensure, that $40,025.00 had been collected in Indiana in 1960 for AMEF. Dr. Owsley commented that a map displayed at the Miami meeting of the AMA in June showed that Indiana is sixth in the list of contributors.

1960 Annual Convention, French Lick, October 2-5, 1960

1. *Program.* The secretary outlined the program as compiled by the Commission on Convention Arrangements.

2. *Technical and scientific exhibits.* The secretary also reported on the sale of technical exhibit space and the assignment of scientific exhibit space.

Legislative Matters

DR. DON E. WOOD, co-chairman of the Commission on Legislation, reported on current legislative matters—Social Security legislation, the Jenkins-Keogh bill, and the osteopathic situation.

AMA Legislative Regional Meeting, French Lick, August 12 and 13, was discussed by Dr. Owsley.

New Business

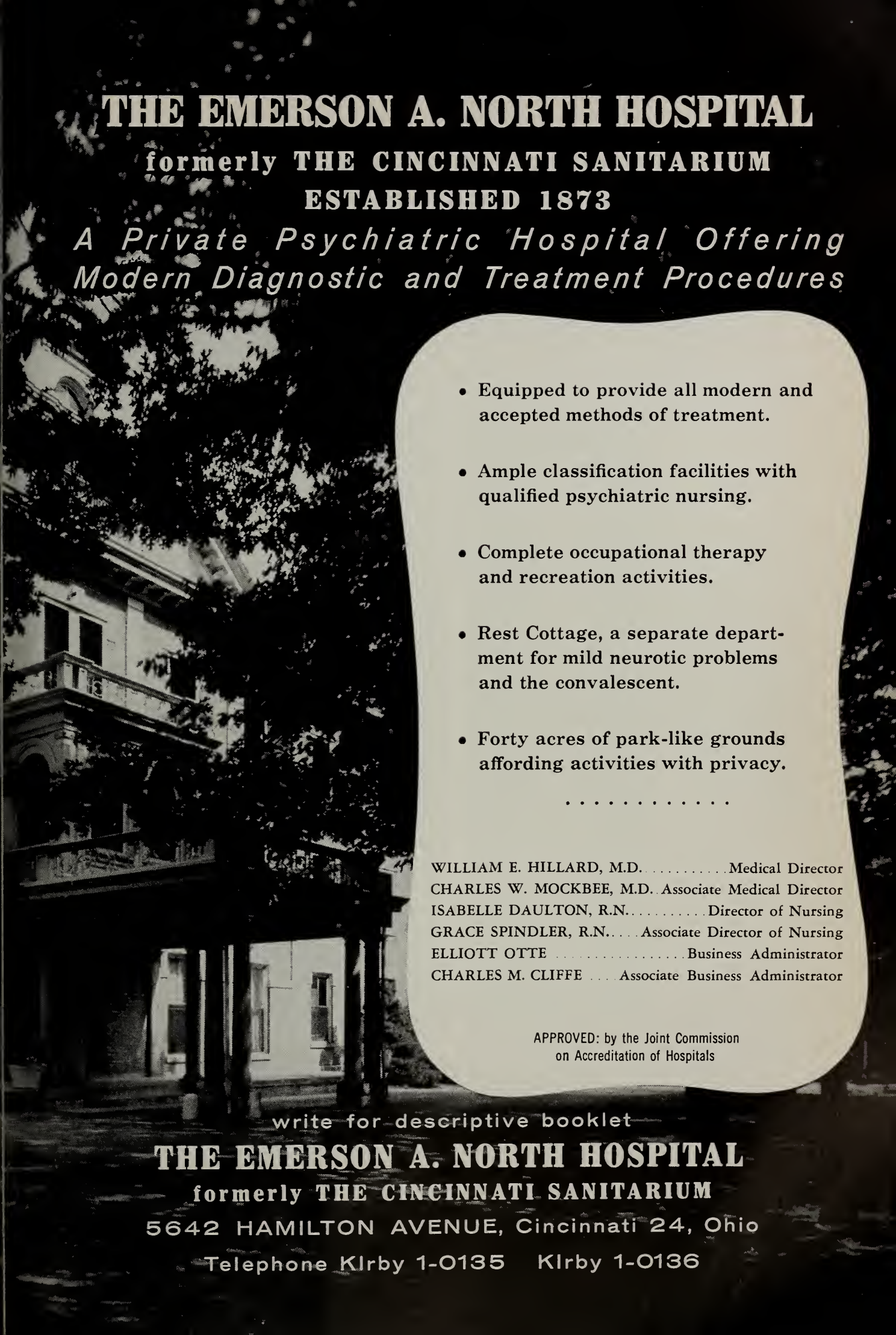
1. *Appointment of pathologist to Blue Shield Board.* The chairman read in part a letter he had received from the Indiana Association of Pathologists stating that "at a recent meeting of this group a resolution was passed requesting the Secretary to ask the Council of the State Medical Association to consider the appointment of a pathologist to the Board of Blue Shield at the next regular opportunity for such an appointment."

This letter was given to the secretary for presentation when the Council is hearing nominations for members of the Blue Shield Board of Directors.

2. *Election of two members to Trust Committee of Indiana Medical Education Foundation* for three-year term ending October 31, 1963, was postponed until the October meeting of the Council.

3. *Grievance Committee.* Dr. Philip Reed, chairman, reported that his committee had found that its business was expedited and brought to settlement for all concerned much more rapidly by the use of long distance telephone when letters are not answered by busy doctors.

Dr. Reed had no report on the osteopathic situation, it being the understanding of the members of the Grievance Committee that they are on a standby basis in this regard.



THE EMERSON A. NORTH HOSPITAL

formerly THE CINCINNATI SANITARIUM

ESTABLISHED 1873

A Private Psychiatric Hospital Offering Modern Diagnostic and Treatment Procedures

- Equipped to provide all modern and accepted methods of treatment.
- Ample classification facilities with qualified psychiatric nursing.
- Complete occupational therapy and recreation activities.
- Rest Cottage, a separate department for mild neurotic problems and the convalescent.
- Forty acres of park-like grounds affording activities with privacy.

. . . . . .

WILLIAM E. HILLARD, M.D. . . . . Medical Director
CHARLES W. MOCKBEE, M.D. Associate Medical Director
ISABELLE DAULTON, R.N. . . . . Director of Nursing
GRACE SPINDLER, R.N. . . . Associate Director of Nursing
ELLIOTT OTTE . . . . . Business Administrator
CHARLES M. CLIFFE . . . Associate Business Administrator

APPROVED: by the Joint Commission on Accreditation of Hospitals

write for descriptive booklet

THE EMERSON A. NORTH HOSPITAL

formerly THE CINCINNATI SANITARIUM

5642 HAMILTON AVENUE, Cincinnati 24, Ohio

Telephone KIrby 1-0135 KIrby 1-0136

AMA Disciplinary Committee: DR. REED: Regarding the Disciplinary Committee of the AMA and the suggestion that something be considered in this state, the Grievance Committee feels that it would need:

a. To ask permission from the Indiana State Medical Association Council to utilize ISMA legal counsel;

b. Would need to contact the AMA committee for more recent information;

c. Would need to have preferably a joint meeting with the State Council on Medical Registration and Examination to learn more accurately their experience in matters of medical discipline.

We're open for suggestions as to any other steps we should take prior to the meeting of the House of Delegates at French Lick, at which time we rather understood that we ought to have something to report.

4. *Cancer Education Project in Perry and Crawford Counties.* DR. A. C. OFFUTT, State Health Commissioner, explained that this is an educational project "actually to establish and conduct a program which will be based upon the recommendation of the physician as to what people should know about cancer and what the individual can do, within his own power, to decrease cancer mortality. It has been endorsed by the Crawford County Development Committee, by the Perry County Long Range Planning Committee, the Perry County Medical Society, Perry County Health Council, the Crawford County Health Department and Indiana Division of the American Cancer Society.

These two counties have been selected because of the type county that they represent and because they have very active rural development committees in each county. Both of them have already had countywide surveys. . . . The cost, as you may recall, was somewhere in the neighborhood of $14,000.00. The major portion of that cost would be borne by the State Board of Health.

"I am here this morning to specifically solicit your approval of such a project."

On motion of Drs. Vye and Crowder, the Council voted approval of this project.

5. *County Health Officers.* The chairman reported that Dr. Verne Harvey, Jr., representing the State Board of Health, had appeared before the Executive Committee in April to discuss the difficulty the State Board of Health is having in getting physicians to serve as county health officers.

DR. NEUMANN spoke of the failure of health officers to receive increases in pay when city and county employees had received several increases. The younger physicians are not willing to serve because the remuneration is not adequate for the work required. If the State Board of Health is having difficulty in persuading doctors to serve as part-time health officers, either city or county, it is probably due to the poor financial remuneration they receive. The only way that that can be corrected is by mandatory action in the legislature to increase the per capita fee that they will be paid.

DR. KINTNER pointed out that the law was changed so that a lot of the non-violent deaths fell to the health officer (instead of the coroner), and he got the extra load, which was considerable, without any increase in pay. In our county the coroner's salary has increased about four-fold in about 15 years.

DR. OFFUTT: "There has been no change in health officers' salaries since 1949. The only problem as we see it, and this may or may not be a problem in January, is whether or not we can make a significant change and still carry some of the counties; that is, whether or not some of the counties will object on the basis that they can't raise the additional funds. I would hope that with your support, as has been suggested here this morning, that we can get the job done and I hope relatively easily.

"One of the things that we must consider is the move that has been made twice, I believe, in the legislature to take birth and death records from the office of the health officer and place them in the clerk's office. We have, of course, objected rather violently to this, and successfully, to keep these very personal records out of a lay office and keep them in professional hands. . . . We have a number of physicians in the state, and I believe I can say this without contradiction, who are offering their services as health officers just as a public service to their communities.

"We can introduce a bill at the next session of the legislature in order to change the sections which now specify the salary for these part-time health department officers. . . . At the April meeting of the Health Officers Association a committee was named to actually investigate this and I believe to help us in coming to some figures on a bill."

Dr. Neumann said he believed the health officers association planned to take a resolution to the House of Delegates at French Lick along this same line for state action.

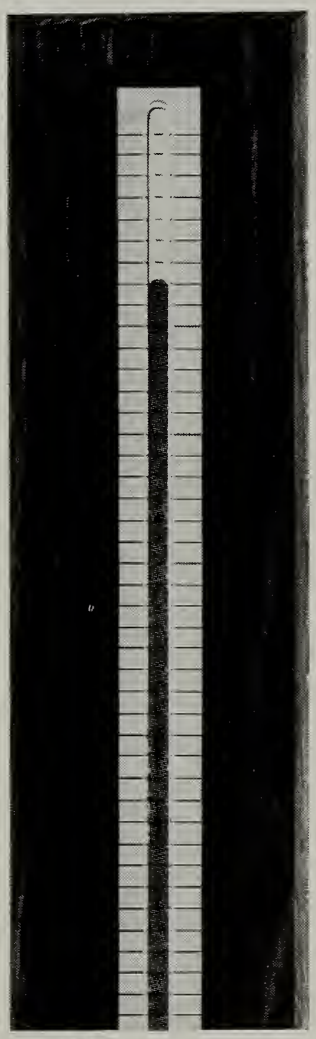
6. *Rheumatic Fever Prophylaxis Program.* DR. OFFUTT: "The Rheumatic Fever Committee of the Indiana Heart Association, under Dr. Richard Nay, has discussed the matter with us and they feel that we should encourage more activity in the area of rheumatic fever prophylaxis. The proposed method is to send to approximately 4,400 physicians in the State of Indiana a double postal card which would ask them to return the answers to three or four questions regarding the prophylaxis of rheumatic fever.

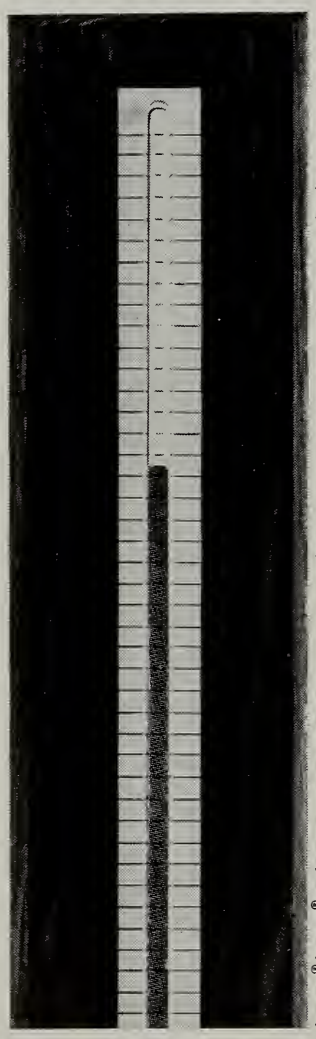
"One question would be to ask the physician to estimate the number of children that they have been currently supervising because that child has had some experience with rheumatic fever. Another would be how many children they personally think should be under a prophylaxis program and which method of prophylaxis do they prefer. This of course refers to either oral administration, or the monthly injection as

for a smooth downward curve

New Rautrax-N results in prompt lowering of blood pressure.[1] Rautrax-N, a new and carefully developed antihypertensive-diuretic preparation, provides improved therapeutic action[1] plus enhanced diuretic safety for all degrees of essential hypertension. A combination of Raudixin and Naturetin, Rautrax-N facilitates the management of hypertension when rauwolfia alone proves inadequate, or when prolonged treatment, with or without associated edema, is indicated.

Naturetin, the diuretic of choice, also possesses marked antihypertensive properties, thus complementing the known antihypertensive action of Raudixin. In this way a lower dose of each component in Rautrax-N controls hypertension effectively with few side effects and greater margin of safety.[1-16]





Other advantages are a balanced electrolyte pattern[1-16] and the maintenance of a favorable urinary sodium-potassium excretion ratio.[2-16] Clinical studies[1-5] have shown that the diuretic component of Rautrax-N—Naturetin—has only a slight effect on serum potassium. The supplemental potassium chloride provides additional protection against potassium depletion which may occur during long term therapy.

Rautrax-N may be used alone or in conjunction with other antihypertensive drugs, such as ganglionic blocking agents, veratrum or hydralazine, when such regimens are needed in the occasionally difficult patient.

Supply: Rautrax-N—capsule-shaped tablets providing 50 mg. Raudixin (Squibb Rauwolfia Serpentina Whole Root) and 4 mg. Naturetin (Squibb Benzydroflumethiazide), with 400 mg. potassium chloride.

Dosage: Initially-1 to 4 tablets daily after meals. Maintenance-1 or 2 tablets daily after meals; maintenance dosage may range from 1 to 4 tablets daily. For complete instructions and precautions see package insert. Literature available on request.

References: 1. Reports to the Squibb Institute, 1960. 2. David, N. A.; Porter, G. A., and Gray, R. H.: Monographs on Therapy 5:60 (Feb.) 1960. 3. Stenberg, E. S., Jr.; Benedetti, A., and Forsham, P. H.: Op. cit. 5:46 (Feb.) 1960. 4. Fuchs, M.; Moyer, J. H., and Newman, B. E.: Op. cit. 5:55 (Feb.) 1960. 5. Marriott, H. J. L., and Schamroth, L.: Op. cit. 5:14 (Feb.) 1960. 6. Ira, G. H., Jr.; Shaw, D. M., and Bogdonoff, M. D.: North Carolina M. J. 21:19 (Jan.) 1960. 7. Cohen, B. M.: M. Times, to be published. 8. Breneman, G. M. and Keyes, J. W.: Henry Ford Hosp. M. Bull. 7:281 (Dec.) 1959. 9. Forsham, P. H.: Squibb Clin. Res. Notes 2:5 (Dec.) 1959. 10. Larson, E.: Op. cit. 2:10 (Dec.) 1959. 11. Kirkendall, W. M.: Op. cit. 2:11 (Dec.) 1959. 12. Yu, P. N.: Op. cit. 2:12 (Dec.) 1959. 13. Weiss, S.; Weiss, J., and Weiss, B.: Op. cit. 2:13 (Dec.) 1959. 14. Moser, M.: Op. cit. 2:13 (Dec.) 1959. 15. Kahn, A., and Grenblatt, I. J.: Op. cit. 2:15 (Dec.) 1959. 16. Grollman, A.: Monographs on Therapy 5:1 (Feb.) 1960.

Squibb Quality—the Priceless Ingredient

SQUIBB

'RAUDIXIN'® 'RAUTRAX'® AND 'NATURETIN' ARE SQUIBB TRADEMARKS.

new

The proved, effective antihypertensive—now combined with a safer, better diuretic

RAUTRAX-N*

Squibb Standardized Whole Root Rauwolfia Serpentina (Raudixin) and Benzydroflumethiazide (*Naturetin) with Potassium Chloride

is currently being offered. It is further suggested that we provide a block on this card so that the physician who is not in this field, or not interested in it, could so indicate.

"Presently we are considering, and I bring them to you this morning, five questions which we believe will do this job of evaluation:

(1) Estimated number now under prophylaxis for rheumatic fever.
(2) Estimated number that should be under prophylaxis for rheumatic fever.
(3) Type of penicillin used—Oral _____ or Injectable _____.
(4) Penicillin furnished by the health department—Yes _____ No _____.
(5) Such treatment not part of my practice of medicine _____."

Dr. Offutt asked approval of this "because it does involve the matter of soliciting information directly from the physicians in the state."

On motion of Drs. Neumann and Vye the Council went on record as approving of the State Board of Health sending out the abovementioned postal card questionnaire.

7. *Polio Vaccination.* Dr. Crowder asked for a discussion of the system of advertising polio shots for a dollar.

Dr. Vye introduced Dr. P. J. Rosenbloom, health officer of the City of Gary, who spoke on Lake County procedure in this matter.

DR. ROSENBLOOM: We assume this, that everybody in our city can get polio shots. Those who are in township can get it through the township trustee; those who are on welfare certainly can be taken care of. Those who can pay for it, should pay for it. And those in between, the hardship cases, we usually furnish this vaccine through the Board of Health. . . . Ordinarily most of these communities where they make a dollar charge, it's usually somebody seeking publicity, seeking something in the newspapers. In most counties, especially in Lake County, we have had a lot of trouble with publicity seekers. I have put it back into the hands of the physician wherever it is possible; he can best judge each case.

8. *AMA Matters.* Dr. Cleon Nafe, member of the Board of Trustees of the AMA, spoke on matters with which the Board of Trustees of the AMA are concerned at this time:

(1) Platforms that the Democratic and Republican conventions will adopt;
(2) Increase in AMA dues, probably $10.00 to $15.00. Recommendation to be made at December meeting.
(3) Compilation of file of physicians who are particularly interested in and capable of performing certain activities on the AMA level, who are recommended from the various areas for membership on AMA councils and committees.

9. *Journal Publication of AMA Activities.* Dr. Nafe suggested that the Indiana State Medical Association *Journal* publish, after each AMA meeting, a review of some of the activities of Indiana physicians who attend the AMA meeting. "I think sometimes we don't recognize that Indiana has had a good bit of activity at the AMA meetings."

There being no further business, the Council adjourned to meet again at noon, Sunday, Oct. 2, in the Mural Room at the French Lick-Sheraton Hotel, French Lick, Ind.

111th
Annual Convention

INDIANA STATE MEDICAL ASSOCIATION

October 2, 3, 4 and 5, 1960
All Time—Central Standard Time
French Lick-Sheraton Hotel
French Lick, Indiana

Complete Program and Annual Reports on Following Pages

September 1960 1725

Official Call to the House of Delegates

The next annual session of the Indiana State Medical Association will be held at the French Lick-Sheraton Hotel, French Lick, Ind., Oct. 2, 3, 4 and 5, 1960.

The House of Delegates will be constituted as follows: Marion County, 21 delegates; Lake County, eight delegates; Allen County, five delegates; St. Joseph County, four delegates; Vanderburgh County, four delegates; Delaware-Blackford, three delegates; Bartholomew-Brown, Daviess-Martin, Dearborn-Ohio, Elkhart, Fayette-Franklin, Fountain-Warren, Harrison-Crawford, Jasper-Newton, Jefferson-Switzerland, LaPorte, Madison, Owen-Monroe, Parke-Vermillion, Tippecanoe, Vigo and Wayne-Union County Societies, each two delegates.

The other 59 county societies, each one delegate; 13 councilors and the ex-presidents, namely George R. Daniels, F. S. Crockett, R. L. Sensenich, Herman M. Baker, Karl R. Ruddell, M. A. Austin, Carl H. McCaskey, Cleon A. Nafe, Augustus P. Hauss, Alfred Ellison, Paul D. Crimm, William Harry Howard, Walter L. Portteus, Walter U. Kennedy, Elton R. Clarke, M. C. Topping, Kenneth L. Olson, and ex officio, the president, president-elect, executive secretary and the treasurer of the association, and the delegates to the American Medical Association, all without power to vote, except in the case of a tie vote, when the president shall cast the deciding vote.

Blank credentials have been sent by the secretary to each county society, and the properly executed credentials should be mailed to the Indiana State Medical Association, 1021 Hume Mansur Building, Indianapolis 4, Indiana, or brought to the session. No delegate will be seated unless wearing the official badge.

The House of Delegates will convene promptly at 6:00 p.m., Sunday, Oct. 2, in the West Dining Room, French Lick-Sheraton Hotel and again at 9:00 a.m., Wednesday, Oct. 5, in the West Dining Room, French Lick-Sheraton Hotel.

The order of business will be as follows:

1. Call to order by the president.
2. Roll call and seating of qualified delegates.
3. Tribute to members of House who have died since the 1959 session.
4. Reading of the minutes of previous meetings.
5. Introduction of guests.
6. Appointment of Reference Committees and assignment of meeting rooms.
7. Unfinished business.
   (a) Constitutional amendments.
   (b) Report of House Building Committee.
8. Address of president-elect.
9. Report of President of the Woman's Auxiliary.
10. Report of Indiana Chapter Student AMA.
11. Report by President of Blue Shield.
12. Report of executive secretary.
13. Report of treasurer
14. Report of the chairman of the Council.
15. Reports of councilors.
16. Report of *Journal* Editor.
17. Reports of committees and commissions:
    COMMITTEES:
    (1) Executive
    (2) Grievance
    (3) Student Loan
    (4) Medical-Legal Review
    COMMISSIONS:
    (1) Convention Arrangements
    (2) Constitution and Bylaws
    (3) Legislation
    (4) Public Information
    (5) Governmental Medical Services
    (6) Public Health
    (7) Voluntary Health Agencies
    (8) Medical Economics and Insurance
    (9) Inter-Professional Relations
    (10) Medical Education and Licensure
    (11) Special Activities
18. New business.
    (1) Resolutions from the floor.

The election of officers will be the first order of business at the second meeting of the House of Delegates. In addition to the regular officers, the terms of the following officers expire Dec. 31, 1960, and their successors must be elected at the session: Delegates to the American Medical Association to succeed Harold C. Ochsner, Indianapolis; E. S. Jones, Hammond, and Francis L. Land, Fort Wayne; and alternates, James H. Gosman, Indianapolis; Robert M. Brown, Marion and George W. Willison, Evansville.

Delegates from the Second, Fifth, Eighth and Eleventh districts are reminded that the terms of their councilors will expire Oct. 5, 1960, and new councilors should be elected to succeed the following:

Second District—J. H. Crowder, Sullivan
Fifth District—Robert K. Webster, Brazil
Eighth District—Guy A. Owsley, Hartford City
Eleventh District—Max R. Adams, Flora

Some of these elections already may have been held, but they should be reported to the House of Delegates at this session for confirmation.

JAMES A. WAGGENER, *Executive Secretary*

HOUSE OF DELEGATES

Indiana State Medical Association

French Lick, Indiana—October 2-5, 1960

County and Delegates	Alternate
ADAMS	
Richard K. Parrish 238 S. Second St., Decatur	Arthur Girod, Decatur
ALLEN	
Emory D. Hamilton 228 Medical Center Bldg., Fort Wayne	F. A. Bryan, Fort Wayne
Francis Land 4628 S. Calhoun, Fort Wayne	J. W. McCallister, Fort Wayne
Frederic L. Schoen 902 Wayne St., Fort Wayne	V. C. Moeller, Fort Wayne
Frederick W. Brown 2521 Fairfield, Fort Wayne	H. A. Stellner, Fort Wayne
Eugene F. Senseny 2902 Fairfield Ave., Fort Wayne	J. F. Jackson, Fort Wayne
BARTHOLOMEW-BROWN	
David L. Adler County Hospital, Columbus	Robert Jacobs, Columbus
Robert Seibel Nashville	Kenneth Schneider, Nashville
BENTON	
V. L. Turley, Fowler	Charles E. Rutherford Otterbein
BOONE	
Clarence G. Kern 1720 N. Lebanon, Lebanon	Hardin B. Grigsby, Lebanon
CARROLL	
T. Neal Petry 111 E. Franklin St., Delphi	Robert M. Seese, Delphi
CASS	
Lowell J. Hillis 203 S. Third St., Logansport	Donald K. Winter, Logansport
CLARK	
George M. Wolverton 647 Eastern Blvd., Clarksville	Walter Thompson, Jeffersonville
CLAY	
Charles Moon Center Point	Walter C. Bond, Clay City
CLINTON	
Robert A. Hedgcock 259 E. Clinton St., Frankfort	Charles E. Bush, Kirklin
DAVIESS-MARTIN	
C. Philip Fox 305 Peoples Bank Bldg., Washington	Robert H. Rang, Washington
Emory B. Lett 408 E. Main St., Loogootee	Robert E. Chattin, Loogootee
DEARBORN-OHIO	
Lowell G. Hunter 370 Bielby Rd., Lawrenceburg	Fred D. Houston, Lawrenceburg
Gordon Fessler Rising Sun	George Morrison, Lawrenceburg
DECATUR	
William Shaffer 214 N. Franklin, St., Greensburg	
DEKALB	
Bonnell Souder 206 W. Seventh St., Auburn	E. E. Rogers, Auburn
DELAWARE-BLACKFORD	
Thomas Brown 412 White River Blvd., Muncie	Glynn Rivers, Muncie
Francis E. Stout 2423 W. Jackson St., Muncie	Donald Taylor, Muncie
Dean Jackson 401 W. Washington St., Hartford City	George Parks, Hartford City
DUBOIS	
ELKHART	
S. T. Miller 506 S. Second St., Elkhart	Floyd Martin, Goshen
Jack Hannah 1906 E. Jackson Blvd., Elkhart	Frederick Bigler, Goshen
FAYETTE-FRANKLIN	
William Kerrigan 718 Central, Connersville	George M. Ellis, Connersville
H. N. Smith Brookville	Perry Seal, Brookville
FLOYD	
Donald R. LaFollette 1000 E. Spring St., New Albany	Nelson A. Wolfe, New Albany
FOUNTAIN-WARREN	
Lee J. Maris 201 Brady, Attica	Carl A. Nelson, West Lebanon
James W. Crain Williamsport	Lowell R. Stephens, Covington
FULTON	
Dean K. Stinson 816 Main St., Rochester	
GIBSON	
Robert S. McElroy 116 S. Main St., Princeton	John K. Folck, Princeton

County and Delegates	Alternate
GRANT	
Robert M. Brown 522 Marion National Bank Bldg., Marion	Max Long, Marion
GREENE	
Sam Rotman Jasonville	H. B. Turner, Bloomfield
HAMILTON	
Joe R. Lloyd 148 N. Ninth St., Noblesville	Ray Shanks, Noblesville
HANCOCK	
Dee Dar Gill 1001 N. State St., Greenfield	Wayne H. Endicott, Greenfield
HARRISON-CRAWFORD	
William E. Amy Corydon	Richard Jordan, Corydon
Novy E. Gobbel English	Jesse Benz, Marengo
HENDRICKS	
O. T. Scamahorn Pittsboro	
HENRY	
W. S. Robertson Spiceland	John E. Fisher, New Castle
HOWARD	
Garvey Bowers 210 W. Mulberry St., Kokomo	
HUNTINGTON	
Richard W. Wagner 1355 Guilford, Huntington	Carl Ray, Warren
JACKSON	
Jack E. Shields Brownstown	John W. Ripley, Seymour
JASPER-NEWTON	
K. R. Ockerman 119 W. Harrison St., Rensselaer	
R. S. Yegerlehner Kentland	
JAY	
William H. Cripe 302 N. Meridian St., Portland	F. E. Keeling, Portland
JEFFERSON-SWITZERLAND	
Robert O. Zink 722 W. Main St., Madison	Francis Prenatt, Madison
Antha A. Hamilton Vevay	Noel Graves, Vevay
JENNINGS	
D. W. Matthews North Vernon	Shaffer B. Berkshire, North Vernon
JOHNSON	
Robert H. K. Foster 301 E. Jefferson St., Franklin	Charles A. Jones, Franklin
KNOX	
E. T. Edwards 34 S. 7th St., Vincennes	V. C. McMahan, Vincennes
KOSCUISKO	
John J. Johnson Court House, Warsaw	Dan Urschel, Mentone
LAGRANGE	
Philip E. Yunker Howe	Kenneth M. Lehman, Topeka

County and Delegates	Alternate
LAKE	
William R. Troutwine 224 S. Court St., Crown Point	A. F. Gregoline, Gary
Peter Stecy 1900 Indianapolis Blvd., Whiting	C. F. Bradley, Hobart
Nicholas Egnatz 820 Highland, Hammond	J. B. Nicosia, East Chicago
Philip Rosenbloom 571 Lincoln, Gary	George M. Young, Gary
Ray Elledge 6415 Forest, Hammond	F. F. Premuda, Hammond
Harry R. Stimson 504 Broadway, Gary	Michael Shellhouse, Gary
F. F. Boys 4712 Magoun, East Chicago	
R. N. Bills 504 Broadway, Gary	
LAPORTE	
T. D. Armstrong 120 W. 9th St., Michigan City	G. O. Larson, LaPorte
J. C. Richter 808 Michigan Ave., LaPorte	R. A. Fargher, LaPorte
LAWRENCE	
Howard T. Hammel Citizens Nat'l Bank Bldg., Bedford	William Robinson, Bedford
MADISON	
P. T. Lamey 423 Citizens Bank Bldg., Anderson	S. W. Ellis, Anderson
Gordon B. Wilder 338 W. 8th St., Anderson	J. L. Larmore, Anderson
MARION	
John W. Beeler 712 Hume Mansur Bldg., Indianapolis 4	Sam J. Davis, Indianapolis
Floyd A. Boyer 442 N. Drexel Ave., Indianapolis 1	James H. Gosman, Indianapolis
Charles F. Gillespie 3400 N. Meridian St., Indianapolis 8	Robert M. Hansell, Indianapolis
James M. Leffel 1633 N. Capitol Ave., Indianapolis 2	Donald H. McCartney, Indianapolis
D. S. Megenhardt 1633 N. Capitol Ave., Indianapolis 2	Frederic A. Rice, Indianapolis
Earl W. Mericle 1633 N. Capitol Ave., Indianapolis 2	Warren S. Tucker, Indianapolis
Russell J. Spivey, Chairman 2616 N. Pennsylvania St., Indianapolis 5	Kenneth R. Woolling, Indianapolis
Ted Grisell 5317 E. 16th St., Indianapolis 18	John M. Young, Indianapolis
Lester H. Hoyt, Vice-Chairman Methodist Hospital, Indianapolis 7	Paul A. Des Jean, Indianapolis
Francis P. Jones 4212 E. Michigan St., Indianapolis 1	Rex M. Joseph, Indianapolis

County and Delegates	Alternate
Hunter F. Kennedy 1105 Prospect St., Indianapolis 3	Kenneth G. Kohlstaedt, Indianapolis
Harry Pandolfo 234 E. Southern Ave., Indianapolis 25	William T. Leffler, Indianapolis
Irvin W. Wilkens 1743 Shelby St., Indianapolis 3	William M. Matthews, Indianapolis
Howard S. Williams 115 E. 16th St., Indianapolis 2	Ray Tharpe, Indianapolis
Richard H. Appel 320 Hume Mansur Bldg., Indianapolis 4	Harry D. Aldrich, Indianapolis
Howard W. Beaver 8 E. Troy Ave., Indianapolis 3	Warren E. Coggeshall, Indianapolis
John O. Butler 234 E. Southern Ave., Indianapolis 25	A. D. Dennison, Jr., Indianapolis
Irvin Caplin 3120 N. Meridian St., Indianapolis 8	Donald R. Hampshire, Indianapolis
Joseph B. Quigley 817 Hume Mansur Bldg., Indianapolis 4	John A. Hetherington, Indianapolis
E. K. Stuckey 1349 Madison Ave., Indianapolis 25	I. J. Kwitny, Indianapolis
Harold Thornton 301 E. 38th St., Indianapolis 5	J. Wm. Wright, Jr., Indianapolis
MARSHALL	
James Kubley 304 N. Walnut St., Plymouth	Paul Connell, Plymouth
MIAMI	
Donald W. Ferrara 16 W. Fifth St., Peru	Lloyd L. Hill, Denver
MONTGOMERY	
James M. Kirtley 416 Ben Hur Bldg., Crawfordsville	F. N. Daugherty, Crawfordsville
MORGAN	
Loren F. Taylor 60½ E. Morgan St., Martinsville	Leon Gray, Martinsville
NOBLE	
Q. F. Stultz Ligonier	Robert Bryan, Kendallville
ORANGE	
C. X. McCalla Paoli	B. E. Sugarman, French Lick
OWEN-MONROE	
Dillon Geiger 300 E. Fifth St., Bloomington	William Link, Bloomington
Donald Blackwell 2121 Allison Ave., Indianapolis 24	M. S. Brown, Spencer
PARKE-VERMILLION	
B. M. Merrell 110 E. York St., Rockville	R. S. Bloomer, Rockville
Milton Herzberg 222 Elm St., Clinton	F. J. Evans, Clinton
PERRY	
Noel Neifert 507 Main St., Tell City	J. M. James, Tell City
PIKE	
Milton Omstead Petersburg	Donald Hall, Petersburg
PORTER	
POSEY	
Frank W. Oliphant 701 Mulberry, Mt. Vernon	John Crist, Mount Vernon
PULASKI	
William R. Thompson 111 N. Monticello, Winamac	Henry R. Eshelman, Monterey
PUTNAM	
Dick Steele Alamo Building, Greencastle	Anne Nichols, Greencastle
RANDOLPH	
Harvey E. White Farmland	B. D. Wagoner, Union City
RIPLEY	
B. E. Freeland Batesville	
RUSH	
Frank H. Green 134 E. Second St., Rushville	
ST. JOSEPH	
R. A. Ganser 111 S. Race St., Mishawaka	William McCraley, South Bend
David L. Dunlap 203 J M S Bldg., South Bend	C. F. Martin, Mishawaka
F. R. N. Carter 605 Sherland Bldg., South Bend	B. J. Dolezal, South Bend
Merle E. Whitlock 123 W. Fourth St., Mishawaka	Stephen Phelps, South Bend
SCOTT	
Marvin L. McClain Scottsburg	Carl R. Bogardus, Austin
SHELBY	
Paul R. Tindall 20 N. Pike St., Shelbyville	W. L. Dalton, Shelbyville
SPENCER	
STARKE	
Guy B. Ingwell Knox	J. R. Matthew, North Judson
STEUBEN	
SULLIVAN	
Joe E. Dukes Dugger	
TIPPECANOE	
Harry E. Klepinger 824 Lafayette Life Bldg., Lafayette	R. W. Vermilya, Lafayette
R. B. Dubois 23 N. 25th St., Lafayette	Forrest J. Babb, Stockwell
TIPTON	
A. E. Stouder Kempton	George L. Compton, Tipton

County and Delegates	Alternate
VANDERBURGH	
John E. Alexander 609 Hulman Bldg., Evansville	
R. Case Hammond 701 Chestnut St., Evansville	
Daniel M. Hare 706 Walnut St., Evansville	
Charles P. Schneider 2211 W. Franklin St., Evansville	
VIGO	
Norman Silverman 1634 S. 7th St., Terre Haute	James V. White, Terre Haute
Stuart R. Combs 3050 Popular St., Terre Haute	A. W. Cavins, Terre Haute
WABASH	
Lloyd H. Smith 1118 N. Wayne St., North Manchester	J. T. Steffen, Wabash
WARRICK	
Wendell Stover 125½ S. Second St., Boonville	Dan E. Woodson, Boonville
WASHINGTON	
A. R. Episcopo 308 N. Main St., Salem	Eddie R. Apple, Salem
WAYNE-UNION	
Glen Ward Lee 139 Medical Arts Bldg., Richmond	Thomas Shields, Richmond
J. F. Lewis Liberty	Clarence G. Clarkson, Liberty
WELLS	
Truman E. Caylor 303 S. Main St., Bluffton	Robert G. Cook, Bluffton
WHITE	
Jesse P. Galbreth Burnettsville	
WHITLEY	
C. Jules Heritier 116 S. Chauncey, Columbia City	John Langohr, Columbia City

COUNCILORS

1st District—William B. Challman, 431 W. Third St., Mount Vernon
2nd District—J. H. Crowder, Sullivan
3rd District—John M. Paris, 602 E. Spring St., New Albany
4th District—Joseph M. Black, 502 W. Second St., Seymour
5th District—Robert K. Webster, 28 N. Franklin St., Brazil
6th District—Harry P. Ross, 220 S. 19th St., Richmond
7th District—Ralph V. Everly, 668 E. 38th St., Indianapolis 5
8th District—Guy A. Owsley, 214 N. High St., Hartford City
9th District—Kenneth O. Neumann, 618 Lafayette Life Bldg., Lafayette
10th District—James P. Vye, 607 Broadway, Gary
11th District—Max Adams, Flora
12th District—Maurice E. Glock, 229 Medical Center Bldg., Fort Wayne
13th District—Burton E. Kintner, 506 S. Second St., Elkhart

OFFICERS

Earl W. Mericle, 1633 N. Capitol Ave., Indianapolis 2—President
Guy A. Owsley, 214 N. High St., Hartford City—President-elect
Don E. Wood, 6325 Guilford, Indianapolis 20—Chairman, Executive Committee
Wendell E. Covalt, 305 Western Reserve Bldg., Muncie—Member, Executive Committee
Maurice E. Glock, 229 Medical Center Bldg., Fort Wayne—Chairman, The Council
Okla W. Sicks, 606 Hume Mansur Bldg., Indianapolis 4—Treasurer
Frank B. Ramsey, 1802 N. Illinois St., Indianapolis 2—Editor, *The Journal*

PAST PRESIDENTS

George R. Daniels, 324 Glass Block, Marion
Franklin S. Crockett, 424 Littleton St., West Lafayette
R. L. Sensenich, 128 S. Scott St., South Bend
Herman M. Baker, 402 Hulman Bldg., Evansville
Karl R. Ruddell, 3202 N. Meridian St., Indianapolis 8
M. A. Austin, 3900 Washington Ave., Evansville
C. H. McCaskey, 608 Guaranty Bldg., Indianapolis 4
Cleon A. Nafe, 822 Hume Mansur Bldg., Indianapolis 4
A. P. Hauss, 212 Elsby Bldg., New Albany
Alfred Ellison, 7304 Encelia Dr., LaJolla, Calif.
Paul D. Crimm, Boehne Hospital, Evansville
William Harry Howard, 5231 Hohman Ave., Hammond
Walter L. Portteus, 1551 N. Main St., Franklin
Walter U. Kennedy, Union Block, New Castle
Elton R. Clarke, 304 West Taylor St., Kokomo
M. C. Topping, 3050 Popular St., Terre Haute
Kenneth L. Olson, 615 Sherland Bldg., South Bend

AMA DELEGATES

Harold C. Ochsner, Indianapolis
E. S. Jones, Hammond
Francis L. Land, Fort Wayne
Gordon B. Wilder, Anderson
Wendell C. Stover, Boonville

FIFTY YEAR CLUB — 1960

ALLEN
Merlin H. Draper, St. Petersburg, Fla.
Wilkie B. Rice, Fort Wayne

CLARK
Thomas J. Marshall, Charlestown

CASS
Daniel E. Lybrook, Young America

ELKHART
Samuel T. Miller, Elkhart
David D. Todd, LaJolla, Calif.

HARRISON-CRAWFORD
Guy D. Baker, Crandall

HOWARD
Earl M. Shenk, Kokomo
Homer B. Shoup, Greentown

JACKSON
William K. Adair, Crothersville

JAY
George V. Cring, Portland

LAKE
John T. Bolin, Mountain Home, Ark.
Calvin C. Brink, Gary
Herbert W. Detrick, Sarasota, Fla.
George W. Gannon, Gary
David R. Johns, East Chicago

LAPORTE
David D. Oak, Sr., LaCrosse

MADISON
Ernest E. Brock, Anderson
Henry W. Gante, Anderson
Virgil G. McDonald, Anderson

MARION
A. M. Hetherington, Indianapolis
J. Wm. Hofmann, Indianapolis
Frederick E. Jackson, Indianapolis
James W. Jackson, Indianapolis

MARSHALL
George L. Marshall, Bourbon

MIAMI
Edward A. Carlson, Peru

PARKE-VERMILLION
William A. Johnson, Perrysville

ST. JOSEPH
Clyde M. Fish, Deerfield, Fla.
William H. Hillman, South Bend

VANDERBURGH
Herman M. Baker, Evansville

VIGO
Samuel A. Smoots, Terre Haute

REFERENCE COMMITTEES — 1960

Sections and Section Work
Norman Silverman, Terre Haute (Vigo), chairman
Truman E. Caylor, Bluffton (Wells)
A. E. Stouder, Kempton (Tipton)
Charles P. Schneider, Evansville (Vanderburgh)
Robert A. Hedgcock, Frankfort (Clinton)

Rules and Order of Business
Frank H. Green, Rushville (Rush), chairman
Charles F. Gillespie, Indianapolis (Marion)
R. N. Bills, Gary (Lake)
Robert S. McElroy, Princeton (Gibson)
V. Earle Wiseman, Greencastle (Putnam)

Medical Education and Hospitals
Eugene F. Senseny, Fort Wayne (Allen), chairman
John W. Beeler, Indianapolis (Marion)
F. R. N. Carter, South Bend (St. Joseph)
Dillon Geiger, Bloomington (Owen-Monroe)
R. Case Hammond, Evansville (Vanderburgh)

Legislation
Jack Shields, Brownstown (Jackson), chairman
Floyd A. Boyer, Indianapolis (Marion)
P. J. Rosenbloom, Gary (Lake)
Paul T. Lamey, Anderson (Madison)
George Willison, Evansville (Vanderburgh)

Public Relations
Harry R. Stimson, Gary (Lake), chairman
J. C. Richter, LaPorte (LaPorte)
Irvin W. Wilkens, Indianapolis (Marion)
Frank W. Oliphant, Mt. Vernon (Posey)
Glen Ward Lee, Richmond (Wayne-Union)

Hygiene and Public Health
O. T. Scamahorn, Pittsboro (Hendricks), chairman
Robert Seibel, Nashville (Bartholomew-Brown)
Lee J. Maris, Attica (Fountain-Warren)
William R. Thompson, Winamac (Pulaski)
Lowell J. Hillis, Logansport (Cass)

Amendments to Constitution and Bylaws
M. C. Topping, Terre Haute (Vigo), chairman
Kenneth L. Olson, South Bend (St. Joseph)
Walter L. Portteus, Franklin (Johnson)
Clarence G. Kern, Lebanon (Boone)
Joseph M. Black, Seymour (Jackson)

Reports of Officers
Harry E. Klepinger, Lafayette (Tippecanoe), chairman
Marvin L. McClain, Scottsburg (Scott)
Harry Pandolfo, Indianapolis (Marion)
Howard T. Hammel, Bedford (Lawrence)
Ray Elledge, Hammond (Lake)

Credentials
William E. Amy, Corydon (Harrison-Crawford), chairman
John E. Alexander, Evansville (Vanderburgh)
Howard S. Williams, Indianapolis (Marion)
E. B. Lett, Loogootee (Daviess-Martin)
James W. Crain, Williamsport (Fountain-Warren)

Insurance
James M. Leffel, Indianapolis (Marion), chairman
Gordon B. Wilder, Anderson (Madison)
David L. Adler, Columbus (Bartholomew-Brown)
R. B. Dubois, Lafayette (Tippecanoe)
Stuart R. Combs, Terre Haute (Vigo)

Miscellaneous Business
William B. Challman, Mt. Vernon (Posey), chairman
Francis L. Land, Fort Wayne (Allen)
Russell J. Spivey, Indianapolis (Marion)
Basil M. Merrell, Rockville (Parke-Vermillion)
Wendell C. Stover, Boonville (Warrick)

1959-1960

Officers of the ISMA



Earl W. Mericle, M.D.
Indianapolis

PRESIDENT
INDIANA STATE MEDICAL ASSOCIATION
1959-1960



GUY A. OWSLEY, M.D.
President-Elect
Hartford City



OLKA W. SICKS, M.D.
Treasurer
Indianapolis



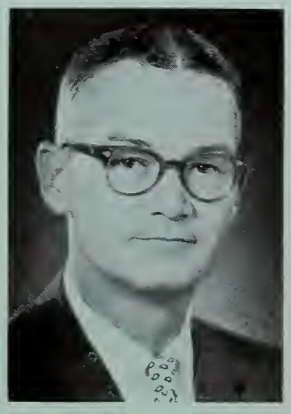
JAMES A. WAGGENER
Executive Secretary
Indianapolis



MAURICE E. GLOCK, M.D.
Chairman of Council
Fort Wayne



DON E. WOOD, M.D.
Chairman
Executive Committee
Indianapolis



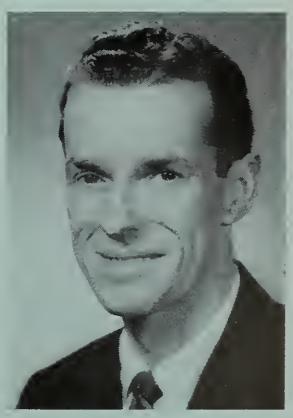
WENDELL E. COVALT, M.D.
Executive Committee
Muncie



MRS. EDWARD RIGLEY
President, Auxiliary
South Bend



ROBERT J. AMICK
Field Secretary
Scottsburg



HOWARD GRINDSTAFF
Field Secretary
Indianapolis

The Journal



FRANK B. RAMSEY, M.D.
Editor
Indianapolis



A. W. CAVINS, M.D.
Associate Editor
Terre Haute



L. G. MONTGOMERY, M.D.
Associate Editor
Muncie



DAVID A. BICKEL, M.D.
Associate Editor
South Bend



STEPHEN L. JOHNSON, M.D.
Associate Editor
Evansville



GEORGE M. JOHNSON, M.D.
Editorial Board
Richmond



IRVIN W. WILKENS, M.D.
Editorial Board
Indianapolis



HAROLD D. LYNCH, M.D.
Editorial Board
Evansville



JENE R. BENNETT, M.D.
Editorial Board
South Bend



SAMUEL R. MERCER, M.D.
Editorial Board
Fort Wayne



FRANKLIN F. PREMUDA, M.D.
Editorial Board
Hammond

Section Officers

Surgery

CHAIRMEN



TED L. GRISELL, M.D.
Indianapolis

VICE-CHAIRMEN



PIERRE C. TALBERT, M.D.
Bluffton

SECRETARIES



RICHARD DAVIS, M.D.
Marion

Medicine



V. BROWN SCOTT, M.D.
Shelbyville



STEPHEN L. JOHNSON, M.D.
Evansville



CHARLES E. JACKSON, M.D.
Bluffton

Ophthalmology and Otolaryngology



M. P. CUTHBERT, M.D.
Indianapolis



JOHN R. SWAN, M.D.
Indianapolis



M. R. HARDING, M.D.
Indianapolis

Anesthesiology

CHAIRMEN



PAUL A. LITTLEFIELD, M.D.
Indianapolis

VICE-CHAIRMEN



JOSEPH H. STAMPER, M.D.
Anderson

SECRETARIES

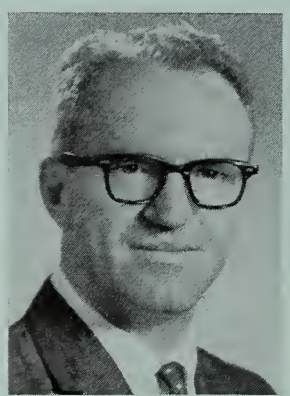


MURWYN L. HICKS, M.D.
Indianapolis

General Practice



EDWARD C. VOGES, M.D.
Terre Haute

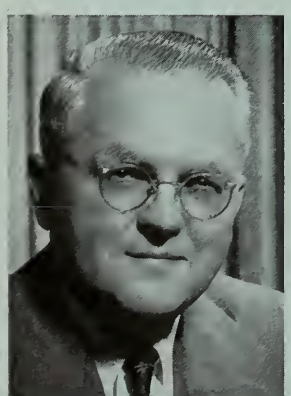


BURTON E. KINTNER, M.D.
Elkhart



JOE M. BLACK, M.D.
Seymour

Obstetrics and Gynecology



MAHLON F. MILLER, M.D.
Fort Wayne



JOHN E. MACKEY, M.D.
Indianapolis



JOHN F. SPAHR, JR., M.D.
Indianapolis

Radiology

CHAIRMEN



JOHN R. LIONBERGER, M.D.
South Bend

VICE-CHAIRMEN



C. A. STAYTON, JR., M.D.
Indianapolis

SECRETARIES

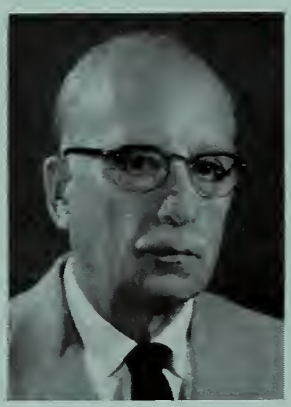


DAVID E. WHEELER, M.D.
Indianapolis

Public Health and Preventive Medicine



HENRY G. NESTER, M.D.
Indianapolis



PAUL H. MARTIN, M.D.
Elkhart



A. L. MARSHALL, JR., M.D.
Indianapolis

PROGRAM

111th Annual Convention Indiana State Medical Association

French Lick-Sheraton Hotel French Lick, Indiana

October 2, 3, 4 and 5, 1960 (CST)

(Instructional Courses are approved for Category No. 1 by the Indiana Academy of General Practice for its members.)

Sunday, October 2

10:00 a.m. Executive Committee meeting, Hoosier Jr. Room.

12 noon Council meeting, Mural Room.

6:00 p.m. Meeting of House of Delegates, west dining room. (Dinner meeting).

Monday Morning, October 3

8:00 a.m. Registration begins, mezzanine floor.

8:00 a.m. Opening of technical exhibit, lobby, main floor, and mezzanine floor.

8:00 a.m. Opening of scientific exhibit, foyer, Convention Hall.

8:00 a.m. Annual golf tournament. Eighteen holes, low gross, low net and blind bogie medal play. French Lick Hill Course.

8:00 a.m. Council Breakfast, Mural Room.

9:00 a.m. Annual trap and skeet shoot, French Lick Springs Trap and Skeet Club.

9:00 a.m. Reference Committees meet. Meeting Rooms, ground floor, Convention Hall.

10:00-12 N. Instructional courses, main Convention Hall.

11:00 a.m. Editorial Board meeting, Room 107. Luncheon at 12.

11:30 to 1:30 p.m. Time allowed to view technical and scientific exhibits.

Monday Noon, October 3

12 noon Luncheon meeting of Past Presidents of the Indiana State Medical Association, TV Room.

12 noon Phi Rho Sigma luncheon meeting, Roost Room.

12 noon Phi Beta Pi luncheon meeting, Terrace Room.

12 noon Phi Chi luncheon meeting, Hoosier Jr. Room.

12 noon Nu Sigma Nu luncheon meeting, Tag Room.

Monday Afternoon, October 3

GENERAL MEETING

(Convention Hall)

1:30 p.m. Call to order by Earl W. Mericle, M.D., Indianapolis, president, Indiana State Medical Association.

1:30-5 p.m. PANEL DISCUSSION — *Advances in vances in Understanding, Diagnosis, and Treatment of Coronary Artery Disease.* Moderator: JOHN B. HICKAM, M.D., Indianapolis

1:30 p.m. *Survey of Coronary Disease*
JAMES V. WARREN, M.D., Galveston, Texas

1:45 p.m. *Coronary Blood Flow*
CHARLES W. CRUMPTON, M.D., Madison, Wis.

2:00 p.m. *Coronary Arteriography*
J. STAUFFER LEHMAN, M.D., Philadelphia, Pa.

2:15 p.m. Panel discussion on *Causative Factors and Diagnostic Features.*

2:45 p.m. Time allowed to view technical and scientific exhibits.

3:15 p.m. *Metabolic Approach to Treatment of Coronary Disease*
EDGAR S. GORDON, M.D., Madison, Wis.

3:30 p.m. *Attractive Low Fat Diets*
GLORIA K. WARREN, Galveston, Texas

3:45 p.m. *Long-Term Anti-Coagulant Therapy and General Management of the Coronary Patient*
BENJAMIN MANCHESTER, M.D., Washington, D. C.

4:00 p.m. *Surgical Approach to Coronary Disease*
CLAUDE S. BECK, M.D., Cleveland, Ohio

4:15 p.m. Panel discussion on *Treatment of Coronary Disease*

Monday Evening, October 3

7:00 p.m. Dinner for members, their wives, and guests, main dining room.
Award of golf and trap-skeet shoot prizes
Entertainment: Green County Boys, Missouri

Dance for members, their wives and guests, Convention Hall. (Special orchestra.)

Tuesday Morning, October 4

8:00 a.m. Registration continues, mezzanine floor

8:00 a.m. Technical exhibit, lobby, main floor and mezzanine floor.

8:00 a.m. Scientific exhibit, foyer, Convention Hall.

8:00 a.m. Council Breakfast, Mural Room.

GENERAL MEETING
(Convention Hall)

Earl W. Mericle, M.D., Indianapolis, president, Indiana State Medical Association, chairman.

9-11:30 a.m. PANEL DISCUSSION — *Surgical Diseases of the G I Tract*
Moderator: OSCAR T. CLAGETT, M.D., Rochester, Minn.
DONALD E. MARION, M.D., Miami Fla.

10-10:30 Time allowed to view technical and scientific exhibits

10:30-11:30 SHELDON C. SOMMERS, M.D., Boston, Mass.
HAROLD O. PETERSON, M.D., Minneapolis, Minn.

11:30-2 p.m. Time allowed to view technical and scientific exhibits.

Tuesday Noon, October 4

12 noon SECTION ON SURGERY luncheon meeting, Roost Room.
Election of section officers for 1961.

12 noon SECTION ON RADIOLOGY and Indiana Roentgen Society luncheon meeting, Mural Room.
Speaker: HAROLD O. PETERSON, M.D., Minneapolis, Minn.
Subject: "*The Roentgen Diagnosis of Benign Gastric Ulcer.*"
Election of section officers for 1961

12 noon SECTION ON PUBLIC HEALTH AND PREVENTIVE MEDICINE, and Indiana Health Officers' Association luncheon meeting, Terrace Room.
Henry G. Nester, M.D., Indianapolis, presiding.
Election of officers for 1961.

12 noon SECTION ON MEDICINE, luncheon meeting, South Room.
Election of section officers for 1961.

12 noon SECTION ON GENERAL PRACTICE luncheon meeting, Tag Room.
Election of section officers for 1961.

12 noon INDIANA ASSOCIATION OF PATHOLOGISTS luncheon meeting, Hoosier Jr. Room.

Tuesday Afternoon, October 4

1:00 p.m. SECTION ON OBSTETRICS AND GYNECOLOGY meeting, Room 107. (Not a luncheon meeting.)
Election of section officers for 1961.

1:00 p.m. Flying Physicians Association, Indiana Chapter, TV Room. (Not a luncheon meeting.)

SPEAKERS



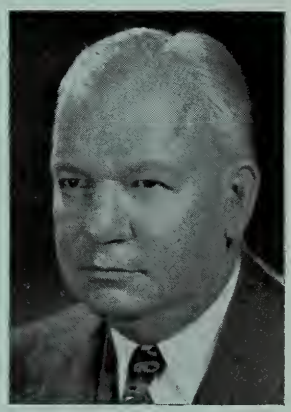
JOHN B. HICKAM, M.D.
Indianapolis

Professor of Medicine and Chairman, Department of Medicine, Indiana University School of Medicine; specialist in internal medicine and pulmonary physiology; Fellow, American College of Physicians; Diplomate, American Board of Internal Medicine; M.D. from Harvard University School of Medicine, 1940.



CHARLES W. CRUMPTON, M.D.
Madison, Wis.

Assoc. Prof. of Medicine and Director, Cardiovascular Research Laboratory, Univ. of Wis.; Consultant, V.A. Hospitals; specialty in cardiology and internal medicine; M.D. from Tulane Univ., 1942.



CLAUDE S. BECK, M.D.
Cleveland, Ohio

Prof. of Cardiovascular Surgery and Assoc. Surgeon, Western Reserve Univ. and University Hospitals; Consultant, Cardiovascular Surgery, Mount Sinai Hospital; M.D. from Johns Hopkins Univ., 1924.



J. STAUFFER LEHMAN, M.D.
Philadelphia, Penn.

Prof. and Chairman, Dept. of Radiology, Hahnemann Medical College and Hospital, Visiting Lecturer, Graduate School of Medicine, Univ. of Penn.; Consultant, V.A. Hospital; M.D. from Hahnemann Medical College, 1931.



HAROLD O. PETERSON, M.D.
Minneapolis, Minn.

Prof. and Head of Radiology, Univ. of Minn.; Consultant, Veterans Hospital and Minneapolis Gen. Hospital; Member, Board of Chancellors, American College of Radiology; Trustee, American Board of Radiology; M.D. from Univ. of Minn., 1934.



SHELDON C. SOMMERS, M.D.
Boston, Mass.

Pathologist, Mass. Memorial Hospitals; Assoc. Prof. Pathology, Boston Univ. School of Medicine; Alt. Pathologist, Pondville Hospital, Walpole, Mass.; Consultant in Pathology, Lemuel Shattuck Hospital, Jamaica Plain, Mass.; M.D. from Harvard Medical School, 1941.



GLORIA K. WARREN
Galveston, Tex.

Dietician; former chief, therapeutic dietetics, Duke Univ. Medical Center; consultant to commercial manufacturer of vegetable oils; B.S. in Nutrition, Univ. of Georgia, 1946.



EDGAR S. GORDON, M.D.
Madison, Wis.

Prof. of Clinical Medicine and Chief, Metabolism and Endocrinology Clinic, Univ. of Wis.; Consultant for U.S. AEC at Oak Ridge Institute for Nuclear Studies; M.D. from Harvard Univ. School of Medicine, 1932.

GENERAL MEETING

(Convention Hall)

Earl W. Mericle, M.D., Indianapolis, president, Indiana State Medical Association, chairman.

2 to 5 p.m. SOCIO-ECONOMIC program.

The Doctor and How to Keep His Money.

ALLISON SKAGGS, Battle Creek, Mich.

Medical Politics on a Nationwide Basis, RUFUS B. ROBINS, M.D., Camden, Ark.

3:15-3:45 Time allowed to view technical and scientific exhibits.

Malpractice and How It Can Be Avoided, R. CRAWFORD MORRIS, Cleveland, Ohio.

5:15 p.m. Reception for members of Fifty-Year Club, Mural Room.

Chairman: LILLIAN B. MUELLER, M.D., Indianapolis.

Speaker: M. A. AUSTIN, M.D., Evansville.

From Soup to Nuts

Tuesday Evening, October 4

6:00 p.m. President's reception, formal gardens.

7:00 p.m. President's Night and Annual Dinner, main dining room.

Presiding officer, EARL W. MERICLE, M.D., President Indiana State Medical Association

Invocation.

Recognition of Fifty-Year Club members. Address: EARL W. MERICLE, M.D., Indianapolis, President.

Presentatation of plaque to EARL W. MERICLE, M.D., Indianapolis, President, 1960, by GUY A. OWSLEY, M.D., Hartford City, President, 1961.

Entertainment.

Wednesday Morning, October 5

8:00 a.m. Registration continues, mezzanine floor.

8:00 a.m. Technical exhibit, lobby, main floor, and mezzanine floor.

8:00 a.m. Scientific exhibit, foyer, Convention Hall.

8:00 a.m. Council Breakfast, Mural Room.

9:00 a.m. Final meeting of House of Delegates, west dining room.

Meeting of Council and Executive Committee immediately following adjournment of House of Delegates.

10-12 N. Instructional courses, Main Convention Hall.

Wednesday Noon, October 5

12 noon Indiana Chapter of American College of Chest Physicians luncheon meeting, Mural Room.

Speaker: JOHN D. MILLER, M.D., Indianapolis.

Subject: *Changes in Medical Problems of the Sanatorium.*

12 noon I. U. Class of '35 luncheon meeting, Terrace Room.

1:00 p.m. Organization meeting of 1960-61 commission and committee members of the Indiana State Medical Association, Roost and TV Rooms. (Luncheon meeting.)

SPEAKERS



CRAWFORD MORRIS, LL.B.
Cleveland, Ohio

Trial attorney specializing in defense of medical malpractice cases; author of many medical-legal papers; LL.B. from Harvard Law School, 1941.



ALLISON E. SKAGGS
Battle Creek, Mich.

President of a management consultant firm serving thousands of physicians; ten years of hospital and clinic management.



R. B. ROBINS, M.D.
Camden, Ark.

Past-president, A.A.G.P.; former Democratic National Committeeman from Ark.; Prof. of Medical Economics, Univ. of Ark. School of Medicine; FACS; Member, Board of Trustees, AMA; M.D. from Univ. of Chicago, 1925.



DONALD F. MARION, M.D.
Miami, Fla.

Specialist in Gastroenterology and Assoc. Prof. of Clinical Medicine, Univ. of Miami School of Medicine; FACP; M.D. from Duke Univ. School of Medicine, 1935.



JAMES V. WARREN, M.D.
Galveston, Tex.

Prof. of Medicine and Chairman, Dept. of Internal Medicine, Univ. of Texas Medical Branch; former president, American Federation for Clinical Research; M.D. from Harvard Medical School, 1939.

1960 INSTRUCTIONAL COURSES

Order your tickets now!!

The schedule of classes for the 1960 Instructional Courses, offered as a special feature of the Annual Convention of the Indiana State Medical Association at French Lick, is published below. Classes will be held on Monday morning, Oct. 3, 1960, from 9 to 12 noon, and on Wednesday morning, Oct. 5, 1960, from 9 to 12 noon.

Instructional courses are approved for Category No. I credit by the Indiana Academy of General Practice for its members.

Admission to each class will be by ticket. Cost, $1.00 for each course, or $5.00 for all six courses. Plan to include all six courses—they will not conflict with the general scientific program. Make your check payable to the Indiana State Medical Association.

Monday, October 3, 1960

Course 1— 9:00 to 10:00 a. m.: "Psycho-Prophylaxis in Obstetrics,"
BILL E. FREELAND, Batesville.
(A discussion of hypnotic measures and experiences in over 300 deliveries in a small Indiana community.)

Course 2—10:00 to 11:00 a. m.: "A Complete Review of Intravenous Fluid Therapy,"
WILLIAM D. SNIVELY, Jr., Evansville.
(This will include fluid and electrolyte replacements—nutrition—aspects—usage of milliequivalents.)

Course 3—11:00 to 12 noon: "A Review of Endocrinology,"
GLENN W. IRWIN, Jr., Indianapolis.
(Discussion of the normal physiology of the endocrine system—disease aspects—diagnosis and treatments.)

Wednesday, October 5, 1960

Course 4— 9:00 to 10:00 a. m.: "A Concise Review of EKG Interpretations,"
J. HAL DORAN, Indianapolis.
(Tracings will be available. A practical review and summary of EKG readings.)

Course 5—10:00 to 11:00 a. m.: "A Review of Management of Pediatric Emergencies,"
GEORGE F. PARKER, Indianapolis.
(This will cover the commonly encountered emergencies occuring in children, their diagnosis and emergency management.)

Course 6—11:00 to 12 noon: "A Review of Physical Therapy,"
L. BURTON PARKER, Indianapolis.
(Discussion of modern therapy measures available in hospitals and office management.)

APPLICATION BLANK

Instructional Course Committee
Indiana State Medical Association
1021 Hume Mansur Building
Indianapolis 4, Indiana

Enclosed find check for $_____. Please reserve tickets for me for the following Instructional Courses:

Classes, $1.00 each; 6 for $5.00.

Monday, October 3, 1960	**Wednesday, October 5, 1960**
Course 1 _____	Course 4 _____
Course 2 _____	Course 5 _____
Course 3 _____	Course 6 _____

I will pick up my tickets at the Registration Desk at the convention.

Signed_____, M.D.

Address_____

Next year please include classes on these topics_____

_____

Entertainment

Feature



THE GREENE COUNTY BOYS

Melodies such as "Hemorrhoids," "Halitosis Beats No Breath At All," "Keep Your Eye on Medicare" and the "P.R. Man" aren't currently listed on the top twenty hit-parade tunes, but they bring smiles to the faces of professional men who hear the Greene County, Missouri Medical Society members perform.

The group's records, "Borborygmi" and "Placenta Preview" have netted over $12,000 in profits to provide medical scholarships and loans. Records are sold at the Society office, Medical Arts Building, Springfield, Missouri for $3.25 each.

Lyrics for the shows were written by Dr. James T. Brown. The cast, besides Dr. Brown, includes, Drs. Charles E. Lockhart, Don F. Gose, Harold H. Lurie, Wilfred E. Wooldridge, F. T. H'Doubler, Jr. and Fred C. Coller, all members of the Greene County Medical Society.

The "Medical Hit Parade" show was originally presented at the 1958 Annual Installation Banquet of the Society and then at the Missouri State Medical Association Annual Session and at the 1958 AMA PR Institute in Chicago. New versions of the show were presented in 1959 and 1960. The group performs before national, state and local medical organizations throughout the country.





Convention Arrangements Committees

GENERAL CONVENTION ARRANGEMENTS: Ray H. Burnikel, Evansville, chairman; Jack G. Weinbaum, Terre Haute, vice-chairman; Howard E. Hill, Muncie, secretary; Irvin H. Scott, Sullivan; Jesse Benz, Marengo; Robert Zink, Madison; John Mader, Richmond; James M. Leffel, Indianapolis; Robert Harris, Noblesville; Michael Shellhouse, Gary; Max Long, Marion; Donald G. Mason, Angola; Bernard E. Edwards, South Bend; Ray Tharpe, Indianapolis; Edward B. Smith, Indianapolis.

RECEPTION: Charles X. McCalla, Paoli, chairman.

GOLF: John K. Spears, Paoli, chairman.

TRAP-SKEET SHOOT: William E. Schoolfield, Orleans, chairman.

FIFTY-YEAR CLUB RECEPTION: Lillian B. Mueller, Indianapolis, chairman.

WOMEN'S ENTERTAINMENT: Mrs. Wendell Stover, Boonville, chairman.

Photo Credits

R. S. & M. Studio, Bluffton; Bill Ehrich, Indianapolis; Fabian Bachrach, Chicago; Morton Photo, Hammond; Tom Toy, Elkhart; Lavergne, Chapel Hill, N. C.; Merrill Crase; Trout-Ware.

FRENCH LICK-SHERATON HOTEL

Rates American Plan (Include 3 Meals)

— Please Make The Following Reservations —

Single	$20.00 ☐	$22.00 ☐	$26.00 ☐	$30.00 ☐
Twin or Double	34.00 ☐	36.00 ☐	40.00 ☐	45.00 ☐
Parlor	25.00 ☐	25.00 ☐	30.00 ☐	30.00 ☐
Roll-away in double occupied room		13.00 ☐		

Will Arrive Date .....
After Breakfast ☐ Lunch ☐ Dinner ☐

Will Depart Date .....
After Breakfast ☐ Lunch ☐ Dinner ☐

Organization .....

Name .....

Street ..... City ..... State .....

If room at the rate desired is not available, the nearest rate will be reserved.

— All Rooms Air-Conditioned —

(Rates are subject to change without notice)

Calling All

Artists – Hobby Enthusiasts – Antique Car Owners



As has been the custom during the past two years, the 1960 ISMA meeting will feature an art and hobby show. This year, a new feature has been added. Doctors who are collecting early forms of medical transportation (right after horse and buggy days, that is) will don the old duster, load Mom in, and drive to French Lick to enter high-spirited steeds in the antique club show.

Protection is available for the mounts, and lots of fun is planned. Dr. Philip T. Holland, 108 West Seventh St., Bloomington, is in charge of the art and hobby show; entries can also be mailed to the Association headquarters. All ISMA members are urged to participate.

Auxiliary Program

Mrs. Wendell C. Stover, general chairman; Mrs. Weston Heinrich, chairman, and Mesdames William Harlan, L. B. Miller, Ray Nicholson, Tuesday luncheon; Mrs. John Sterne, table decorations; Mrs. Joseph Lawrence, bridge and canasta, and Mrs. Ray Burnikel, golf.

Sunday, October 2

6:30 p.m. Past Presidents Club, Hoosier Jr. Room.

6:30 p.m. Dinner in conjunction with the meeting of the House of Delegates of the Indiana State Medical Association, west dining room.

Monday, October 3

8:00 a.m. Registration begins, mezzanine floor.

8:00 a.m. Golf tournaments, Flat Course. Choice of 9 or 18 holes.

12:30 p.m. Luncheon meeting — President and State Chairmen, Mural Room.

1:30 to 3:30 p.m. Round table discussions, conducted by State Chairman, North Convention Hall. All ladies invited.

7:00 p.m. Dinner, entertainment and dance, in conjunction with Indiana State Medical Association, main dining room.

Tuesday, October 4

8:00 a.m. Registration continues, mezzanine floor.

9:30 to 10 a.m. Coffee — pre-Board meeting, North Convention hall.

10:00 to 12 noon General Board meeting, North Convention Hall. All doctors' wives invited.

12 to 1:00 p.m. Social hour (individual's expense), west dining room.

1:00 p.m. Luncheon, Woman's Auxiliary to the Indiana State Medical Association, west dining room. Vanderburgh County, hostesses.

2:30 p.m. Bridge and Canasta, Porch, French Lick-Sheraton Hotel. Prizes.

6:00 p.m. I. S. M. A. President's reception, formal gardens.

7:00 p.m. I. S. M. A. President's Night and Annual Dinner, main dining room.

Wednesday, October 5

8:00 a.m. Registration continues, mezzanine floor. Morning open — golf — mineral baths — visiting.

NOTES

Amendments to the Constitution and Bylaws

To Be Voted on at the French Lick Session

At the 1959 annual convention at Indianapolis, the House of Delegates adopted the report of the Reference Committee on Amendments to the Constitution and Bylaws in which the following changes in the Constitution and Bylaws were ordered submitted to the House for final action at the 1960 annual convention. These were presented in open meeting on Oct. 9, 1959, and published in *The Journal* of the Indiana State Medical Association, issues of December, 1959, and September, 1960.

Amendments to the Constitution

(1) BE IT RESOLVED, that that part of Section 3 of Article IX of the Constitution of the ISMA which now reads "and no person shall be elected to any such office who is not in attendance on that Annual Convention and who has not been a member of the Association for the preceding two years," be amended by substituting therefor the following: "and no person shall be elected to any such office who has not been an active member of the Association for the preceding two years."

As amended, the section would then read:

ARTICLE IX—OFFICERS

Sec. 3—The officers of this Association with the exception of the executive secretary shall be elected by the House of Delegates as the first order of business of the last day of the Annual Convention, and no person shall be elected to any such office who has not been an active member of the Association for the preceding two years.

(2) BE IT RESOLVED, that Article IX, Section 1, of the Constitution of the Indiana State Medical Association be amended by inserting in Line 3 of Section 1, after the word "Treasurer" and before the word "and" the following words: "a Speaker and a Vice-Speaker of the House of Delegates;"

This section, amended, would then read:

ARTICLE IX—OFFICERS

Sec. 1—The officers of this Association shall be a President, a President-elect, an Executive Secretary, a Treasurer, a Speaker and a Vice-Speaker of the House of Delegates, and thirteen Councilors, each of whom shall be a member, except the Executive Secretary, who need not necessarily be either a physician or a member.

(3) Your committee is in agreement with this amendment if it be implemented by also amending Article V of the Constitution as follows: by inserting the words, "the Speaker and Vice-Speaker of the House of Delegates," after the words, "The Treasurer of this Association," and before the words, "and the Delegates," and by amending Article VI of the Constitution as follows: add after the word "vote," in sentence one, "and the Speaker and Vice-Speaker without power to vote."

Articles V and VI, as amended, would then read:

ARTICLE V—HOUSE OF DELEGATES

The House of Delegates shall be the legislative and business body of the Association and shall consist of (1) Delegates elected by the component county societies; (2) the Councilors; and (3) the ex-presidents of the Indiana State Medical Association. The following shall be *ex officio* members: the President, the President-elect, the Executive Secretary, the Treasurer of this Association, the Speaker and Vice-Speaker of the House of Delegates, and the delegates to the American Medical Association, all without power to vote, except in case of a tie vote, when the President or person presiding shall cast the deciding vote.

ARTICLE VI—THE COUNCIL

The Council shall consist of (1) the Councilors, and (2) *ex officio* the President, President-elect, and Treasurer with power to vote, and the Speaker and Vice-Speaker without power to vote. Besides its duties mentioned in the Bylaws, it shall constitute the Board of Trustees of this organization, having full charge and control of all the property of the Association. It shall have full authority and power of the House of Delegates between sessions of the House of Delegates, except that it shall not make changes in the laws governing the Association nor exercise legislative functions, except as stated in the Bylaws, and at all times shall be the finance committee of the Association. Seven Councilors shall constitute a quorum.

Amendments to Bylaws

(1) BE IT FURTHER RESOLVED, that Chapter VI, Section 1, of the Bylaws of the Indiana State Medical Association be amended by deleting the first sentence of Section 1;

Your reference committee recommends that paragraph 2 of the resolution, on page —, be amended to read as follows:

"Be It Further Resolved, that Chapter VI, Section 1, of the Bylaws of the Indiana State Medical Association be amended by deleting the phrase at the end of the first sentence, reading, 'and of the House of Delegates'."

This section, as amended, would then read:

CHAPTER VI—DUTIES OF OFFICERS

Sec. 1—The President, or a member designated by him, shall preside at all general meetings of the Association. The President shall appoint all committees not otherwise provided for; he shall deliver an annual address at such time as may be arranged by the Executive Committee, and shall perform such other duties as custom and parliamentary usage may require. He shall be the real head of the profession of the state during his term of office, and as far as practicable, shall visit by appointment the various sections of the state and assist the Councilors in building up the county

societies and in making their work more practical and useful.

(2) Section 12, Chapter VII of Bylaws be amended as follows: delete the word, "and" after the word "Treasurer." Add, after the words "Chairman of the Council," the words, "and the Speaker and Vice-Speaker of the House."

This section, as amended, would then read:

CHAPTER VII—COUNCIL

Sec. 12—The Council shall at its meeting following the close of the House of Delegates elect two members of the Association, at large, or of the Council, who, with the President, the President-elect, the Treasurer, the Chairman of the Council and the Speaker and Vice-Speaker of the House, shall constitute and be known as the Executive Committee. If such members of the Executive Committee be not members of the Council they shall not have the power of vote in the Council.

(3) BE IT FURTHER RESOLVED, that Chapter VI of the Bylaws of the Indiana State Medical Association be amended by adding a new section, to be designated as Section 4, to read as follows:

"SECTION 4. The Speaker of the House of Delegates shall preside at all meetings of the House of Delegates and shall appoint all Reference Committees. He shall organize and conduct the business of the House of Delegates, but shall not have a vote therein except in case of a tie. He shall be an officer of the Association with the right to participate in the discussion in the meetings of the Council and of the Executive Committee but without power to vote in either of such meetings. If the Speaker is absent or unable to perform his duties, the Vice-Speaker shall perform them";

Your reference committee further recommends that the proposed new Section 4 of Chapter VI be amended to read as follows:

"The Speaker and Vice-Speaker of the House of Delegates shall be elected by the House of Delegates from its members at that time and shall remain a member of the House during his term by virtue of that office. He shall preside at all meetings of the House of Delegates and shall conduct the business of the House of Delegates, but shall not have a vote therein except in case of a tie. He shall be an officer of the Association with the right to participate in the discussion in the meetings of the Council and of the Executive Committee, but without power to vote in either of such meetings. If the speaker is absent, or for other reason wishes to delegate his duties, the Vice-Speaker shall perform them."

This section, as adopted, would then read as follows:

CHAPTER VI—DUTIES OF OFFICERS

Sec. 4—The Speaker and Vice-Speaker of the House of Delegates shall be elected by the House of Delegates from its members at that time and shall remain a member of the House during his term by virtue of that office. He shall preside at all meetings of the House of Delegates and shall conduct the business of the House of Delegates, but shall not have a vote therein except in case of a tie. He shall be an officer of the Association with the right to participate in the discussion in the meetings of the Council and of the Executive Committee, but without power to vote in either of such meetings. If the speaker is absent, or for other reason wishes to delegate his duties, the Vice-Speaker shall perform them.

(4) BE IT FURTHER RESOLVED, that the Bylaws of the Indiana State Medical Association be amended by renumbering the sections of Chapter VI of the Bylaws, so that the present Section 4 of Chapter VI shall be numbered Section 5 of Chapter VI, and that the present Section 5 of Chapter VI shall be numbered Section 6 of Chapter VI;

These sections, as amended, will then read:

Sec. 5—The Executive Secretary shall be the directing manager of the Association's headquarters and *Journal* offices, and shall supervise the work of all salaried employees in the Association offices. Such supervision shall be subject to directives from the House of Delegates, the Council, the Executive Committee, and the President of the Association. He shall discharge the administrative functions of the Association not within the duties of other officers or of committees to perform. He shall assist, at their request, all officers and committees, and shall keep himself informed in regard to non-professional matters affecting the medical profession, for the purpose of keeping himself qualified to perform the services herein mentioned. He shall be responsible for the execution and carrying out of the policies of the Association and in that connection shall perform all specific tasks committed to him by the committees, the Council, and the officers of this Association. The amount of his salary shall be fixed by the Executive Committee on approval of the Council.

Sec. 6—The necessary expenses of the above officers incurred in the line of duty herein imposed may be allowed by the Council, but excepting the Executive Secretary, this shall not include the expenses of attending the Annual Convention

(5) BE IT FURTHER RESOLVED, that the Bylaws of the Indiana State Medical Association be amended by changing Section 4 of Chapter V Election of Officers, to read as follows:

Sec. 4—The President, President-elect, Treasurer, Speaker and Vice-Speaker shall serve from the termination of the annual meeting of the House of Delegates in which the President-elect and Treasurer are elected until the termination of the succeeding annual meeting of the House of Delegates;

(6) BE IT FURTHER RESOLVED, that the Bylaws of the Indiana State Medical Association be amended by substituting the word "Speaker" for the word "President" whenever the word "President" occurs in Sections 1 and 2 of Chapter XXIV of the Bylaws.

These sections, as amended, would then read:

CHAPTER XXIV—REFERENCE COMMITTEES

Sec. 1—Immediately after the organization of the House of Delegates at each Annual Convention, the Speaker shall announce the membership of the reference committees to serve during the convention for which they are appointed. Appointments to these reference committees shall be made by the Speaker in time for them to be published in *The Journal* and the Handbook prior to such Annual Convention.

The Speaker shall have the power to appoint substitutes from among the members present for absent appointees.

Each committee shall consist of five members, at least three of whom shall be members of the House of Delegates. The chairman shall be named by the Speaker from among those who are members of the House of Delegates.

To these committees shall be referred all reports, resolutions, measures and propositions presented to the House of Delegates, except such matters as properly come before the Council, and the recommendations of these committees shall be submitted to the next meeting of the House of Delegates for acceptance in the original or modified form or for rejection.

Sec. 2—The following Reference Committees are hereby constituted to which shall be referred all matters as indicated by the titles of the committees:

(1) Sections and Section Work
(2) Rules and Order of Business
(3) Medical Education and Hospitals
(4) Legislation
(5) Public Relations
(6) Hygiene and Public Health
(7) Amendments to the Constitution and Bylaws
(8) Reports of Officers
(9) Credentials
(10) Insurance
(11) Miscellaneous Business

Where a report, resolution, measure, or proposition deals with more than one subject matter, reference thereof may, in the discretion of the Speaker, be made (a) to as many reference Committees as are necessary to cover all subjects included therein; or (b) to only one Reference Committee which the Speaker deems has within the scope of its reference the most important part of the matter referred.

No report of any Reference Committee shall be rejected on the ground that it covers something not included in the matters which such Committee was created to consider.

Reports of Officers

Executive Secretary

The headquarters office and staff have been busy throughout the year carrying out the duties and the responsibilities assigned to them by the officers and committees of the Association.

I am sure the reports which this House of Delegates will receive from the various committees and commissions give evidence of the fact that the year just closed has not only been one of the most active in the Association but also one of the most productive.

The field men have traveled more than 40,000 miles during the past year, working with the component societies and members of our Association, and it appears that the demands are going to be such as to intensify their work in the coming year.

It may also be of interest to you to know that the membership in the Association continues to show a steady growth, and in the 10 years just passed we have had a net increase of 500 members in the Association.

I want to join with the other officers of the Association in stating that trying times are ahead for organized medicine and many issues which will have a far-reaching effect upon the practice of medicine deserve the attention of every physician during the coming months.

JAMES A. WAGGENER, *Executive Secretary*

Treasurer's Report

Following is an itemized statement of the securities in the General Fund and the Medical Defense Fund as of Aug. 1, 1960:

THE GENERAL FUND

	Face Value	Market Value
U. S. Treasury Bonds	$145,000.00	$139,528.00
U. S. Treasury Note	10,000.00	10,180.00
U. S. Savings Bonds	81,000.00	78,677.00
U. S. Treasury Bills	100,000.00	99,465.35
Total, General Fund	$336,000.00	$327,850.35
U. S. Treasury Bonds and Notes maturity dates:		
1960-65	$ 3,000.00*	$ 3,000.00
* (It may be possible to reinvest these this year at a higher rate of interest)		
1961	62,000.00	61,312.00
1962	10,000.00 (note)	10,180.00
1964	5,000.00 (note)	5,005.00
1967-72	20,000.00*	17,448.00
* (It may be possible to reinvest these this year at a higher rate of interest)		
1978-83	60,000.00	57,768.00
	$160,000.00	$154,713.00
U. S. Savings Bonds maturity dates:		
1961	$ 6,000.00*	$ 5,916.00
* (These probably can be exchanged this year for higher interest bearing bonds than the present 2½%)		
1962	1,000.00	979.00
1963	4,000.00	3,892.00
1964	35,000.00	33,845.00
1966	30,000.00	29,040.00
	$ 76,000.00	$ 73,672.00
U. S. Treasury Bills maturity date:		
1960	$100,000.00	$ 99,465.35
	$336,000.00	$327,850.35

MEDICAL DEFENSE FUND

	Face Value	Market Value
U. S. Treasury Bonds	$ 14,000.00	$ 13,905.40
U. S. Treasury Bills	3,000.00	3,000.00
U. S. Savings Bonds	9,000.00	8,804.00
Total, Medical Defense Fund	$ 26,000.00	$ 25,709.40
Maturity dates:		
U. S. Treasury Bonds:		
1960-1965	$ 3,000.00	
1961	11,000.00	
	$ 14,000.00	$ 13,905.40
U. S. Savings Bonds:		
1961	$ 2,000.00	
1962	6,000.00	
1964	1,000.00	
	$ 9,000.00	$ 8,804.00
U. S. Treasury Bills:		
1960	$ 3,000.00	$ 3,000.00
	$ 26,000.00	$ 25,709.40

In case we should sell any long-term securities the bank officials inform us that there necessarily would be a loss.

Another statement of the value of the long-term securities will be presented at the time of the convention.

Cash balances in the respective funds as shown on the books of the Association:

General Fund	$11,537.25
Petty Cash in office	5.00
Medical Defense Fund	3,993.25
Journal Fund	2,266.88
Petty Cash in office	1.00
Student Loan Fund	1,870.23
Petty Cash Fund	1,785.01
Total cash on hand, July 30, 1960	$21,458.62

Following is the audit of Wolf and Company, Indianapolis, for the nine months ending September 30, 1959.

OKLA W. SICKS, M.D., *Treasurer*

The Council
Indiana State Medical Association
Indianapolis, Indiana

Gentlemen:

We have examined the financial records of Indiana State Medical Association for the period January 1 to September 30, 1959. Our examination was made in accordance with generally accepted auditing standards, and accordingly included such tests of the accounting records and such other auditing procedures as we considered necessary in the circumstances.

The accounts of the association, previously maintained on a cash receipts and disbursements basis, were converted to the accrual basis on January 1, 1959, a change which we approved. The adjustments to net assets arising from the change are detailed in Exhibit B, Statement of Net Assets.

In our opinion, the accompanying financial statements present fairly the position of Indiana State Medical Association at September 30, 1959, and the results of its operations for the nine months then ended, in accordance with generally accepted accounting principles.

Respectfully submitted,
WOLF AND COMPANY
Certified Public Accountants

Exhibit A

INDIANA STATE MEDICAL ASSOCIATION
Statement of Funds
September 30, 1959

ASSETS

General fund:			
Cash		25,480.66	
Note receivable	1,857.62		
Loan receivable	1,000.00	2,857.62	
Deposits:			
Postmaster	284.14		
Insurance	56.80	340.94	
Expense advances		238.33	
Accrued interest receivable		1,862.29	
Due from medical defense fund	1,947.80		
Due from student loan fund	5,101.29	7,049.09	
Reimbursement due for Medicare expenses		1,670.87	
Investments, at cost, less amortization:			
U. S. Treasury bonds	145,544.39		
U. S. Treasury bills	49,665.10		
U. S. Savings bonds	96,000.00		
	291,209.49		
Less accumulated amortization	336.08	290,873.41	
Office furniture and equipment:			
General office	15,692.30		
Medicare office	4,437.52		
	20,129.82		
Less accumulated depreciation	4,882.68	15,247.14	345,620.35
The Journal:			
Cash		5,311.95	
Accounts receivable:			
Advertising	14,871.34		
Other	225.06	15,096.40	
Due from general fund		19,913.48	
Postal deposits		303.09	40,624.92
Medical defense fund:			
Cash		3,293.51	
Accrued interest receivable		121.96	
Investments, at cost, less amortization:			
U. S. Treasury bonds	14,235.94		
U. S. Treasury bills	4,950.30		
U. S. Savings bonds	9,000.00		
	28,186.24		
Less accumulated amortization	189.49	27,996.75	31,412.22
Student loan fund:			
Cash		1,470.06	
Notes receivable		18,964.40	20,434.46
			438,091.95

LIABILITIES

General fund:			
Liabilities:			
Accounts payable		4,858.98	
Accrued payroll taxes		102.66	
Due American Medical Education Fund		34,370.00	
Due The Journal		19,913.48	
Unrealized convention income		17,073.89	
Dues collected in advance		32,249.25	
Deposits on tape recordings		377.00	
		108,945.26	
Net assets (Exhibit B)		236,675.09	$345,620.35
The Journal:			
Accounts payable		8,162.00	
Net assets (Exhibit B)		32,462.92	40,624.92
Medical defense fund:			
Due to general fund		1,947.80	
Net assets (Exhibit B)		29,464.42	31,412.22
Student loan fund:			
Due to general fund		5,101.29	
Net assets (Exhibit B)		15,333.17	20,434.46
			438,091.95

Exhibit B

INDIANA STATE MEDICAL ASSOCIATION
Statement of Net Assets
For the Nine Months Ended September 30, 1959

General fund:		
Balance, December 31, 1958		$217,642.83
Adjustment arising from change in accounting method, January 1, 1959 (Note):		
Add:		
Note receivable	2,372.79	
Prior year billing—Medicare	2,425.42	
Refund prior year expenses	120.57	
Premium on bond purchases (net)	206.45	
Furniture and equipment (net)	12,774.72	
Postal deposit	199.47	
	18,099.42	

Deduct:			
Accounts payable—trade	3,049.53		
Accrued expenses	4,369.36		
Employe payroll deductions	258.75		
Deposits on tape recordings	638.01		
Current year dues received in prior year	5,507.00	13,822.65	4,276.77
Adjusted balance, January 1, 1959			221,919.60
Net revenues (Exhibit C)			14,755.49
Balance, September 30, 1959			236,675.09
The Journal:			
Balance, December 31, 1958			4,152.96
Adjustment arising from change in accounting method, January 1, 1959 (Note)—accounts receivable (net)			21,779.82
Adjusted balance, January 1, 1959			25,932.78
Net revenues (Exhibit D)			6,530.14
Balance, September 30, 1959			32,462.92
Medical defense fund:			
Balance, December 31, 1958			26,639.90
Net revenues (Exhibit E)			2,824.52
Balance, September 30, 1959			29,464.42
Student loan fund:			
Balance, December 31, 1958			15,293.29
Adjustment of student notes receivable related to prior year transaction			2.83
Net revenues			37.05
Balance, September 30, 1959			15,333.17

Note:

The accounts of the association, previously maintained on the cash basis, were converted to the accrual basis at January 1, 1959.

Exhibit C

INDIANA STATE MEDICAL ASSOCIATION

Statement of Revenues and Expenditures
For the Nine Months Ended September 30, 1959

GENERAL FUND

	Amount	Estimated (Annual)	Unrealized
Revenues:			
Dues	147,796.75	179,966.00	32,169.25
Less dues allocated:			
The Journal	11,934.00	11,920.00	12.00*
Medical defense fund	4,745.00	4,742.50	2.50*
American Medical Education Fund	34,370.00	34,360.00	10.00*
	51,049.00	51,024.50	24.50*
Dues available for operations	96,747.75	128,941.50	32,193.75
Interest on investments	7,291.72	7,000.00	291.72*
Received from A.M.A.	734.38		734.38*
Other income	735.62	1,000.00	264.38
Total revenues	105,509.47	136,941.50	31,432.03

	Amount	Budgeted (Annual)	Unexpended
Expenditures:			
Committees and commissions (Schedule C-1)	16,038.95	23,100.00	7,061.05
Officers and council (Schedule C-2)	6,912.14	13,095.00	6,182.86
Headquarters office (Schedule C-3)	57,750.66	75,255.00	17,504.34
Women's auxiliary	1,005.25	1,005.25	
Employes retirement fund	4,682.66	5,475.00	792.34
Management service	4,364.32	4,364.32	
Total expenditures	90,753.98	122,294.57	31,540.59
Net revenues	14,755.49	14,646.93	

* Indicates revenue in excess of estimate.

Schedule C-1

INDIANA STATE MEDICAL ASSOCIATION

Statement of Operating Expenditures
For the Nine Months Ended September 30, 1959

COMMITTEES AND COMMISSIONS

	Amount	Appropriated (Annual)	Unused
Standing committees:			
Grievance	252.15	300.00	47.85
Student loan	14.00	100.00	86.00
Medical legal review		50.00	50.00
Commissions:			
Constitution and by-laws	146.06	150.00	3.94
Interprofessional relations	339.92	350.00	10.08
Legislation	4,524.63	5,000.00	475.37
Public health	1,213.00	2,500.00	1,287.00
Public information	5,141.62	7,000.00	1,858.38
Special activities	73.37	200.00	126.63
Voluntary health agencies	150.12	200.00	49.88
Medical economics and insurance	1,409.29	1,500.00	90.71
Medical education and licensure	939.65	3,000.00	2,060.35
Building	1,432.39	1,750.00	317.61
Governmental medical services	402.75	1,000.00	597.25
Totals	16.038.95	23,100.00	7.061.05

Schedule C-2

OFFICERS AND COUNCIL

	Amount	Budgeted (Annual)	Unexpended
President	882.13	1,500.00	617.87
President elect	182.16	500.00	317.84
Council chairman	124.27	300.00	175.73
A.M.A. delegates	1,261.17	4,000.00	2,738.83
A.M.A. meetings	945.12	2,000.00	1,054.88
Treasurer, auditing and bookkeeping	1,000.00	1,125.00	125.00
Council travel	709.16	1,100.00	390.84
Council meetings	1,366.07	1,700.00	333.93
Better Business Bureau	150.00	150.00	
Executive committee:			
Travel	84.12	120.00	35.88
Meetings	207.94	600.00	392.06
Totals	6,912.14	13,095.00	6,182.86

Schedule C-3

HEADQUARTERS OFFICE

	Amount	Budgeted (Annual)	Unexpended
Salaries	35,000.76	47,000.00	11,999.24
Supplies	1,270.55	1,250.00	20.55*
Telephone and telegraph	2,199.66	3,000.00	800.34
Postage	1,252.70	1,600.00	347.30
Printing and stationery	1,306.03	1,300.00	6.03*
Travel	7,245.61	8,800.00	1,554.39
Rent and electricity	3,175.48	4,500.00	1,324.52
Organization memberships	420.50	300.00	120.50*
Donations	69.66	80.00	10.34
Insurance:			
Hospitalization	383.14	600.00	216.86
Other	1,078.00	300.00	778.00*
Photographic equipment expense	5.83	25.00	19.17
Extra help	591.81	800.00	208.19
Payroll taxes	776.27	1,200.00	423.73
Depreciation	1,117.84	1,400.00	282.16
Interest	51.64	100.00	48.36
Unallocated	1,805.18	3,000.00	1,194.82
Totals	57,750.66	75,255.00	17,504.34

* Indicates expenditure in excess of budget.

Schedule D

INDIANA STATE MEDICAL ASSOCIATION
Statement of Revenues and Expenditures
For the Nine Months Ended September 30, 1959

THE JOURNAL

	Amount	Estimated (Annual)	Unrealized
Revenues:			
Subscriptions:			
Members	11,934.00	11,925.00	9.00*
Nonmembers	370.17	275.00	95.17*
Advertising	56,517.40	68,000.00	11,482.60
Other	816.79	1,100.00	283.21
Total revenues	69,638.36	81,300.00	11,661.64

	Amount	Budgeted (Annual)	Unexpended
Expenditures:			
Salaries	6,777.70	14,500.00	7,722.30
Extra help	143.75	220.00	76.25
Office expense	530.34	760.00	229.66
Printing and reprints	46,858.15	54,400.00	7,541.85
Engraving	3,836.99	5,130.00	1,293.01
Travel and meetings	423.45	350.00	73.45**
Bulk mailing	1,012.51	1,330.00	317.49
Other publishing expense	1,341.87	1,640.00	298.13
Payroll taxes	175.16	250.00	74.84
Employe group insurance	30.00	60.00	30.00
Telephone	200.89	260.00	59.11
Rent and electricity	1,596.50	2,150.00	553.50
Unallocated	180.91	250.00	69.09
Total expenditures	63,108.22	81,300.00	18,191.78
Net revenue	6,530.14	—	

* Indicates revenue in excess of estimate.
** Indicates expenditures in excess of budget.

Schedule E

MEDICAL DEFENSE FUND

Revenues:		
Transfer of applicable portion of dues	4,745.00	
Interest earned—U. S. Treasury bonds	657.49	
Amortization of discount—U. S. Treasury bonds	56.60	
Total revenues		5,459.09
Expenditures:		
Malpractice fees	1,211.61	
Legal fees	1,417.50	
Stationery and printing	5.46	
Total expenditures		2,634.57
Net revenues		2,824.52

Exhibit F

STUDENT LOAN FUND

Cash balance, December 31, 1958		48.27
Revenues:		
Collection of student loans	1,933.45	
Interest earned	38.34	
Transfer from general fund	5,000.00	6,971.79
		7,020.06
Expenditures—loans made to students		5,550.00
Cash balance, September 30, 1959		1,470.06

Chairman of the Council

The Council convened for its first session of the new year, immediately following the final session of the House of Delegates on Oct. 9, 1959. By ballot vote, Dr. Maurice E. Glock was elected chairman for the year. The Council then elected Dr. Don E. Wood, Indianapolis and Dr. Wendell E. Covalt, Muncie, as members of the Executive Committee.

The Reference Committee has been given detailed copies of all minutes of the Council meetings, and inasmuch as these have also been published in *The Journal* during the past year, I shall only touch upon some of the highlights of our meetings.

January 10, 1960, Meeting

Dr. Frank B. Ramsey, editor of *The Journal,* informed the Council of the fact that the Indiana *Journal* was classed among the seven most outstanding medical journals in the nation, the announcement being made during the State Journal Advertising Conference. He also urged the Councilors to take upon themselves the responsibility of preparing a scientific or medico-economic article for *The Journal* during the coming year, or urging some member of their district society to write an article as *The Journal* was in need of more original articles.

In accordance with the action taken by the House of Delegates, the chairman with the concurrence of the Council, named the following to constitute the Building Committee: Ralph V. Everly, Indianapolis, chairman; Harry Pandolfo, Indianapolis; Jack E. Shields, Brownstown; R. Case Hammond, Evansville and Frederick K. Brown, Fort Wayne. The Council also adopted a resolution for this committee to proceed with the purchase of a site and the construction of a headquarters building.

The Council elected three directors to the Blue Shield Board for terms ending March 1963. They were: W. L. Portteus, Franklin, general practitioner; Cleon A. Nafe, Indianapolis, general surgery; Bernard D. Rosenak, Indianapolis, internal medicine. All these are representatives "at-large" on the board.

A fact-finding committee in the area of osteopathy was named by the Council. Members of this special committee are as follows: Robert K. Webster, Brazil, chairman; William B. Challman, Mount Vernon; K. O. Neumann, Lafayette and Burton E. Kintner, Elkhart.

Physician of the Year Award. The Council voted to not make a "Physician of the Year Award" at the 1960 convention. Upon motion of the Council, the chairman was ordered to refer this matter to the House of Delegates with the recommendation that the Indiana State Medical Association discontinue the "Physician of the Year Award."

The above constitutes the recommendation of the Council, and we hereby request the House of Delegates to either approve or disapprove the discontinuance of this annual award.

The Council took note of the poor attendance at the annual meetings of the Association, and heard of a plan used in some of the states where specialty groups meet in unison with the state medical associations. The Council concurred that a strenuous effort should be made to improve our attendance and that specialty groups should be encouraged to hold their 1961 meetings in conjunction with the annual meeting of the Indiana State Medical Association.

The Council approved of the idea of establishing a Board of Impartial Medical Witnesses and referred this matter to a special committee of the Council for further study.

Other actions taken at this meeting included approval of establishing a liaison committee with the Indiana AFL-CIO; issuance of life membership cards to all senior members of the Association; approval of the establishment of annual Albert Stump Memorial lecture to be given before the students of Indiana University School of Medicine and establishment of a liaison committee with Indiana University School of Medicine. Membership of this liaison committee is as follows: Earl W. Mericle, Indianapolis, president, (1 year); Guy A. Owsley, Hartford City, president-elect, (two years); Maurice E. Glock, Fort Wayne, Council chairman, (1 year); Don E. Wood, Indianapolis, chairman, Executive Committee, (1 year) and Joseph M. Black, Seymour, Councilor, (3 years).

April 10, 1960, Meeting

The Council approved the principle of conducting a building fund campaign, and gave to the Building Committee the responsibility of setting up the machinery, in which the Auxiliary would participate. The Council also:

—Approved the renewal of the Home Town Fee Schedule of the Veterans Administration.

—Approved the study of coverage of welfare recipients under Blue Cross-Blue Shield.

—Approved the establishment of a Board of Impartial Medical Witnesses for the areas served by the Northern District Federal Courts.

—Approved the Mantoux testing in schools as the procedure of choice in surveying students in tuberculosis case finding programs.

—Discussed the statement prepared by the American Medical Association on Guide for Industrial Immunization Programs and voted the matter be referred to the House of Delegates.

As chairman of the Council, I therefore refer the following statement to the House of Delegates for their consideration, approval or disapproval as to whether it will or will not constitute also the policy of the Indiana State Medical Association in industrial immunization programs:

"Health maintenance is primarily the responsibility of the individual person; however, the employer has an obligation to provide a safe work environment for his employees, and he has a valid interest in the prevention of loss of work time and of work efficiency from his employees' ill health. Definitive diagnosis and therapy of nonoccupational injury or illness is not a responsibility of the employer; but he may provide certain preventive health measures in a given situation where the employee, the employer, and the community stand to benefit. While it is impossible to foresee every situation which might occur locally where an employer might properly make immunization procedures available to his employees, the following principles are offered as a guide.

"1. Toward fulfillment of his obligation to provide a safe work environment, or to take appropriate precautionary measures, an employer should provide immunization procedures to employees who, by reason of their occupation or job assignment, may be exposed to significant hazards against which immunization procedures are available.

"2. In keeping with his legitimate right to operate efficiently and profitably in a free enterprise system, with his responsibility to the community, and in demonstration of his good corporate citizenship and concern over his employees' health, an employer may provide immunization procedures in the face of an impending epidemic which threatens to disable so large a proportion of his employees as to interfere materially with operations and against which immunization procedures could not be applied by community health resources in a short enough period of time to afford the optimum protection. The component medical society's approval of company immunization programs conducted under these circumstances should be sought, and to the extent feasible and practicable local physicians should be afforded an opportunity to participate in them.

"3. Additionally, an employer may wish to participate in community-wide immunization programs at the request of and in cooperation with a local medical society and community health agencies."

The Council decided not to participate in naming representatives to the National Board Scholarship Committee.

The Council reviewed the policies of the American Medical Association Disciplinary Committee and approved the Grievance Committee's continuous study of medical discipline in Indiana.

July 10, 1960, Meeting

The Council heard the report of the delegates to the American Medical Association covering the activities of the annual meeting held in Miami, Fla., in June 1960.

The Council received the report that the Building Committee had purchased a site at 3935 North Meridian Street, Indianapolis for the future home of the Association. Purchase was subject to the Zoning Board granting a variance for the construction of this building.

The Council heard a report that the special committee appointed to consider the establishment of a panel on Impartial Medical Witnesses adopted the following resolution on this subject:

> WHEREAS, the impartial medical witness plan in the Federal Court in several cities outside the State of Indiana has been tried for periods up to seven years and has proven to be of value in these areas, and
>
> WHEREAS, Indiana Federal Court judges have indicated a desire to institute similar plans in their court, and
>
> WHEREAS, the study made by the Lake County Medical Society has determined that there is probably a need of such a program in Indiana, and
>
> WHEREAS, the formation of the necessary panel of qualified and impartial witnesses is difficult, if not impossible, on the county-wide basis;
>
> NOW THEREFORE BE IT RESOLVED, that the Indiana State Medical Association undertake to assist in bringing about an impartial medical witness plan on a regional basis corresponding with each Federal Court, or on a statewide basis, to serve all the federal courts in Indiana.

The Council heard a report concerning the establishment of a fee schedule for Blue Shield for the assisting physician or the cooperating surgeon and this matter was referred to the liaison committee for further study and a report to the Council meeting in October 1960.

The Council approved a statement concerning School Health Policies for distribution throughout the state. These policies were prepared by our Commission on Medical Education and Licensure in cooperation with the Department of Public Instruction and the State Board of Health.

The Council approved the proposed cancer education project to be carried on in Perry and Crawford Counties.

Also approved was a survey to be conducted by the State Board of Health concerning the rheumatic fever prophylaxis program.

The Council heard a report from Dr. Cleon A. Nafe, Indianapolis, a member of the Board of Trustees of the American Medical Association.

MAURICE E. GLOCK, M.D., *Chairman*

First Councilor District

The First District Medical Society held its annual meeting at the Indiana Farm Bureau Refinery picnic grounds, Mount Vernon, Ind., on June 23, 1960. A delicious meal was served, courtesy of the Indiana Farm Bureau Refinery, and refreshments were supplied by Mead Johnson and Company of Evansville.

Dr. George Yea, ambassador from the Republic of China to the United States, was guest speaker and gave a very interesting and informative talk on the Far Eastern political situation. Doctor Yea was accompanied to Mount Vernon by his press attaché, Mr. Frank Tao, of Washington, D. C.

Among the guests attending were Dr. Earl Mericle, Dr. Guy A. Owsley, and Mr. James Waggener.

A business meeting was held and the following officers were elected: Dr. Joseph D. McDonald, Evansville, to succeed Dr. Noel Neifert of Tell City, as president; Dr. Gilbert Wilhelmus, Evansville, vice-president and Dr. Michael Monar, Rockport, secretary-treasurer.

The time and place of the next annual meeting was not set.

WILLIAM B. CHALLMAN, M.D., *Councilor*

Second Councilor District

The Second District Medical Society met at Vincennes on Thursday May 26 at the Elks Country Club. The meeting was well attended by 56 members from the district. Dr. Guy Owsley, President-elect of the ISMA, who was to be the guest speaker at the dinner, was unable to attend. Dr. Edwards and Dr. Phillip Fox, of Washington, and Mr. Amick, from the state office gave very interesting talks concerning the ISMA and important problems that were being presented. Dr. Phillip Fox, Washington, gave a very interesting review of Blue Shield and answered several questions that the members had concerning their activities.

Dr. Chattin, president of the society, took charge of the business meeting, at which time Washington was selected as the next meeting place. Dr. Phillip Fox of Washington, was elected president for the ensuing year and Dr. H. O. Norten was elected vice-president.

Dr. Brown of Carlisle, was re-elected as secretary and he was given a vote of thanks by the society for the number of years that he has served. Dr. Edwards of Washington was elected Counselor of the Second District for the next three years. Dr. Edwards has been very active in the Medical Society and the members present were happy to have him accept the office.

The dinner meeting was attended by the doctors and their wives, and was preceded by a very enjoyable social hour.

Several counties in the district are working to improve their hospitals.

J. H. CROWDER, M.D., *Councilor*

Third Councilor District

The past year has been a quiet one in the Third District. The Annual Meeting was held at French Lick in May, under the able chairmanship of Doctor Phil Hodgins. We heard very interesting reports from Dr. Lester Reed of Louisville regarding "What any physician should have in mind when dealing with a possible injury, either acute, or old with residual damage." Dr. Reed made an able presentation of the subject and all of us realized benefit from it.

Our second essayist, Dr. Richard Hawkins of Bedford, gave all of us many good suggestions about dealing with children—our own as well as those we see in practice. This man tempers much science with good common sense, and he is far above average in his practical approach to the specialty of pediatrics.

We are indebted to Dr. Ben Sugarman for his generous sponsorship of the social hour. By some fortuitous circumstance, this courtesy was extended throughout the afternoon.

Dr. William Challman, the councilor from the First District, who practices in Mt. Vernon, was there as our guest and had some interesting remarks to offer to those at the meeting.

The ladies auxiliary had their usual meeting and conducted their annual business affairs.

It was noted at the meeting that two hospitals have opened in the district since our last meeting, and one hospital in the district is planning to close. For the counties that have the new hospitals, the populace will benefit because their own physicians will be able to give them better care. However, Blue Cross-Blue Shield will notice a sudden increase in utilization in these areas, and this is to be expected. Bear in mind, if we can subtract one-half day of care from each hospital admission, as we go along, we will probably be able to prevent another rate increase. This is something for all of us to strive for, not only in the counties with the new hospitals, but also in those others who have had the benefit of hospital service these many years.

We, in the Third District, can again be complimented for our continued ethical and moral conduct as practicing physicians. It is with pride that I can tell you that I have not had a single complaint about any member in this district during the past year. Next year's meeting will be in Huntingburg and the date will be set sometime in the early fall.

JOHN M. PARIS, M.D., *Councilor*

Fourth Councilor District

The annual meeting of the Fourth District Medical Society was held Wednesday, May 18 at the Harrison Lake Country Club with the Bartholomew-Brown County Medical Society and Auxiliary as hosts. Dr. Robert Reed presided as president of the District and Dr. David Adler was secretary.

The delegates meeting was opened by Dr. Reed with a delegate from each county in the district present. The guests that were introduced were Dr. Guy Owsley, President-elect of ISMA; Dr. Joseph Black, Councilor; Dr. J. E. Dudding, Past-Councilor; Mr. Robert Amick, Field Representative of ISMA and Mr. L. E. Converse of Blue Shield. Dr. Owsley spoke briefly of the importance of legislative action and knowledge of medical problems and the attitude of candidates for our legislature.

Mr. Converse explained the problems of the Blues and offered his help in all the counties of the district. He also discussed the formulation of our district advisory board.

Dr. Black reported on the action of the council in regard to district and state problems, legislative action and the formulation of a new constitution and bylaws for the district.

The next district meeting will be held in Seymour with the Jackson County Society acting as host on the third Wednesday of May, 1961. The officers elected for the coming year are Dr. Harry R. Baxter, Seymour, president; Dr. Kenneth Bobb, Seymour, secretary-treasurer.

Dr. J. E. Dudding was re-elected to the Blue Shield Board for three years from the Fourth District.

Luncheon was served to approximately 100 members and wives. Dr. Guy Owsley was introduced and discussed the ISMA problems and accomplisments. Other distinguished guests and officers were introduced including Mrs. Joseph Black, immediate past-president of the Women's Auxiliary; Mrs. Joseph Dudding, chairman of the state medical care insurance committee of the Woman's Auxiliary and past-president; Mr. L. E. Converse of Blue Shield and Mr. Robert Amick, Field Representative of the ISMA; Dr. Dudding, the Blue Shield Representative for the Fourth District, and Dr. Joseph Black, Councilor for the Fourth District.

The scientific program was varied and excellent. Dr. John Campbell, chairman of the Department of Radiology, Indiana University, discussed "Radiation Hazards." Dr. Samuel Braden, Vice-President of Indiana University in charge of undergraduate development, spoke on "Economic Factors in the Education of the Future Physicians." Both men were well received and everyone appreciated their remarks.

The annual meeting ended with a social evening of dining and dancing.

This year the Fourth District worked actively in their legislative program. Many meetings were held, speakers were furnished to other groups and many letters and telegrams were sent to congressmen and congressional committees. The district legislative committee had a very successful luncheon meeting which was well attended including members of the Auxiliary.

Mr. Converse was able to formulate a Blue Shield advisory committee in the district. The councilor and the men in the district appreciate the fine cooperation of Mr. Converse in briefing them of the Blues' problems and the economic factors in the health insurance field.

The councilor expresses his thanks for the invitations to attend the various society meetings in the district.

JOSEPH M. BLACK, M.D., *Councilor*

Sixth Councilor District

Everything has been in action and every physician in the district has worked for the furtherance of the best interests of medical care of the public during this past year. Much work has been by contacting key members of each society via telephone and each in his turn has put his shoulder to the wheel and worked where and when most needed to see that all things necessary were carried out. The various officers and chairmen of key committees have each given a tremendous lift.

The annual meeting of the district, which had been agreed upon during the 1959 session was carried through on time and in good taste.

The 1960 meeting was held at the Elks City Club in Shelbyville on May 11. Free and open and frank discussion of all the various needs of the public took up much of the time during the business session. Legislative matters of local, state and national importance were further discussed and a program of action was agreed upon after a very serious meeting of minds with a unanimity of opinion that was a sight to behold plus the added thrill of seeing everyone present ready to help any officer of any association meet the challenges presented by these times and this new era.

Officers elected to serve thru 1960-1961 were all given the support of the society by being named by acclamation: John Smith, M.D., Greenfield, president; John Davis, M.D., of Flat Rock, vice-president; Miles Davis, M.D., Rushville, secretary and in charge of the program for the annual meeting to be held in Rushville on Thursday, May 11, 1961. William R. Tindall, M.D., Shelbyville, was re-elected to serve as alternate councilor. It should be noted here that William Tindall has consistently attended all Council meetings and has kept in close touch with the needs of each county in the Sixth District, in addition to keeping himself conversant with the needs of the Indiana State Medical Association.

The Sixth District has been further blessed by the help of the ladies in the Woman's Auxiliary. Not once has any member declined to do the work requested of her. Much credit is due the ladies for their relentless, untiring and ceaseless efforts in furthering better medical care by private practitioners without allowing compulsion to enter any phase of this better medical care.

HARRY PLUMMER ROSS, M.D., *Councilor*

Seventh Councilor District

The annual meeting of the Seventh District Medical Society was held in Franklin, Ind., Wednesday May 18, 1960, at the Hillview Country Club. The Johnson County Medical Society was host, and as usual, a very delightful program unfolded during the course of the day. Dr. Herbert Egbert took top honors in the golf derby. Through the efforts of the Auxiliary, the dining room and tables were very colorfully decorated with seasonal flowers. A cocktail hour preceding dinner was made available through the generosity of the local society.

Dr. Earl W. Mericle, president of ISMA was present and spoke briefly on many facets of the present problems of organized medicine.

At the business meeting that followed a sumptuous four course dinner, Dr. Malcolm Scamahorn, Pittsboro, Ind., was elected unanimously as our president-elect. Dr. Egbert was elected to succeed himself as secretary-treasurer and Dr. Glen V. Ryan was re-elected to serve another term as a member of the Blue Shield Board of Directors.

The meeting was adjourned by Dr. Ted Grisell, the incoming president.

RALPH V. EVERLY, M.D., *Councilor*

Eighth Councilor District

The past year has been a busy one as far as your Councilor is concerned. I have attended many many meetings in the interest of our Association, and have enjoyed a particularly pleasant year with our president, Dr. Mericle. The climax of the year was an excellent district meeting, held at the Country Club in Anderson, on June 8th. For many years the Council has struggled with the idea that something must be done to improve the district meetings. I feel that the Madison County group has come up with an answer to this problem, in that the entire meeting was arranged by the Auxiliary. A style show was held in the afternoon, and many of the ladies participated in golf. The usual golf tournament was held for the men.

At the business session, Dr. Stanley W. Burwell of Muncie, was elected president of the District, and Dr. Leland Brown, secretary-treasurer. Dr. Gordon Wilder succeeds me as Councilor of the district, and Dr. Irwin Hostetter was elected Alternate Councilor to replace Dr. Wilder.

The president gave a very clear account of Association problems as well as those of organized medicine in general, in his usual deft manner. A resolution was adopted at the business meeting, opposing the adoption of the Relative Value Scale, and in like manner opposing third party intervention in the practice of medicine, including any and all government services.

Dr. Fletcher McDowell reported on Blue Shield, and asked for opinions on two proposals. The first, a proposal to delete the description in the Blue Shield policy containing the statement "The Doctors' Plan," was approved. The second proposal was one to appoin an advisory committee to the District Blue Shiel Director, with representatives from each county. Thi proposal was rejected.

The industrial surgeons of the area provided th refreshments prior to a very fine dinner, and yo Councilor was privileged to introduce the speaker the evening, Senator George W. McDermott of Madis County, who discussed very ably the necessity for bu ness and professional people taking an active inter in the political arena. This discussion was one of finest your Councilor has been privileged to hear, it is strongly recommended that more presentations this type be given wherever doctors gather.

GUY A. OWSLEY, M.D., *Coun.*

Ninth Councilor District

The Ninth District Medical Society held its annual meeting in Lafayette on May 18 at the Lafayette Country Club. The Tippecanoe County Medical Society served as the host, with Dr. H. E. Klepinger, Lafayette, president and Dr. F. J. Babb, Stockwell, secretary-treasurer. The attendance at the business meeting left much to be desired. Golf, the social hour and dinner had an excellent attendance.

The business meeting was attended by Dr. Earl Mericle, president of Indiana State Medical Association, Mr. James Waggener and Mr. Howard Grindstaff. They discussed current problems and answered questions of the members.

Following the dinner hour Dr. Lloyd Harris, former Lafayette pediatrician and now a member of the Mayo Clinic staff, gave a very enjoyable talk on "The Doctor's Child."

Sporadic rumblings have been heard from component societies during the past year on insurance and professional relations, but no problems were presented at the annual meeting.

In an attempt to overcome a lack of regular communication between the Councilor and the component societies, a bi-monthly letter has been sent to each society in the past 18 months. This has included reports on Council meetings and current medical problems plus requests for information or advice from societies on specific matters. This effort has evoked little response.

The district meeting in 1961 will be in Crawfordsville on May 18 with the Montgomery County Medical Society as the host.

K. O. NEUMANN, M.D., *Councilor*

Tenth Councilor District

On Oct. 14, 1959, a meeting of the Tenth District was held at Phil Smidt's Restaurant in Whiting. It began at 4:00 p.m. with Dr. P. Q. Row, Lake County Medical Society president, presiding in the absence of the district officers. Dr. Row announced the sponsorship of the program by the Indiana Academy of General Practice and the Eli Lilly Company. He first presented Dr. Penn G. Skillern, Cleveland Clinic, who spoke and showed slides on the subject of "Status and Treatment of Goiter." Mr. George Hall, LL.B., Law Department American Medical Association, then talked on "Artificial Insemination." Mr. A. E. Crum of the Eli Lilly Company was introduced.

Following the talks there was a social hour and at 7:00 p.m. dinner was held for the 100 doctors and their wives in attendance. During the dinner, Dr. Row introduced Mr. Charles Dosch, Executive Secretary of the Indiana Academy of General Practice, and Mr. L. E. Converse, Director of Physician Relations, Indiana Blue Shield, who each briefly addressed the meeting.

Dr. Row then introduced Drs. Martin O'Neill, J. R. Frank, both of Valparaiso, who had been elected at the meeting as president and secretary, respectively, of the 10th District to serve for the year 1960. Dr. Row also introduced Dr. J. P. Vye of Gary, Councilor, and Dr. Ralph Eades of Valpariso, Alternate Councilor.

At the May 11, 1960 meeting, which was held at Indiana University, Gary Center, Gleason Park, Dr. Martin O'Neil of Valparaiso, 10th District president, presided.

In view of the fact that less than 40 members attended, it was agreed that future meetings should be scheduled in popular public restaurants.

Dr. O'Neil introduced Dr. J. P. Vye of Gary, 10th District Councilor, and Mr. Howard Grindstaff, field representative for the Indiana State Medical Association.

Dr. Harry R. Stimson, 10th District Blue Shield Board member, introduced Mr. Richard Kilbourn, Assistant Executive Vice-President of Indiana Blue Shield, who spoke on the subject of "Blue Shield in Your Future." Mr. Kilbourn discussed the trends in prepaid medical care as to costs, extent of coverage, use by patients and physicians and the interest of large industrial groups in expanding this coverage. Members asked many questions and it was agreed that organized medicine has a large stake in Blue Cross-Blue Shield as its best answer to proponents of federal medical programs and closed panel medicine.

J. P. VYE, M.D., *Councilor*

Eleventh Councilor District

The spring meeting of the Eleventh Councilor District was held May 18, 1960, at Wabash with the Wabash County Medical Society as hosts.

The meeting was called to order by Dr. Jewel. The necessary business was taken care of at this time.

Dr. Eugene S. Rifner was placed in nomination and elected as new councilor for the term beginning this fall.

Title of medical program: "Psychiatry Debunked," presenting Dr. Frank D. Hogle as moderator and consisting of:

I. "Classification of Psychiatric Syndromes Frequently Met in General Practice," by Dr. Jack G. Oatman, Davis Clinic, Marion, Indiana.
"Pointers On Recognizing Patients Need for Psychiatric Referral," by Dr. John U. Keating, Director Elkhart County Adult and Child Guidance Clinic, Elkhart, Indiana.
"Use and Misuse of Psychotropic Drugs," by Dr. John H. Wilms, Psychiatrist, Purdue University, Student Health Service, West Lafayette.
"Do's and Don'ts of Psychiatric Referral," by Dr. Frank D. Hogle, Moderator, Lafayette.

II. "Doctors, Dollars, Drugs, Drug Salesman, and Drug Houses," by Mr. John Lynn of Indianapolis, Assistant to Vice-President of Eli Lilly, Department of Corporate Development and Long Range Planning.

Wives were entertained with a coffee hour and program, presenting Miss Thelma Barnes, Charm-School Pointers.

Following a cocktail party and dinner, which was served at the Honeywell Memorial Foundation, Mr. John Tatum gave an interesting talk on "Sports and Medicine."

Grant County extended an invitation for the fall meeting on the third Wednesday in September.

M. R. ADAMS, M.D., *Councilor*

Twelfth Councilor District

The annual meeting of the Twelfth District Medical Society was held Tuesday, May 3, 1960 at Cutters Chalet in Fort Wayne. This meeting was held in conjunction with the May meeting of the Fort Wayne Medical Society, which served as host.

In the afternoon the Twelfth District Blue Shield Advisory Board met and representatives of Blue Shield presented the historical background of Blue Shield and interesting statistics covering growth of Blue Shield, utilization of Blue Shield in the counties represented, benefits derived, percentage of payments made and the various types of plans available. This meeting was open to the general membership and a valuable question and answer period took place following the formal presentation.

Following a cocktail hour and an excellent dinner, Captain Alvin S. Hyde, M.D., of the United States Air Force Medical Corps, presented a scientific program on "Medical Problems in Aerospace Flight." This was an extremely interesting program both to the physician members and to their wives.

Mr. Howard Brower of the AMA office brought greetings from the American Medical Association. The District Councilor gave a report of activities of the State Medical Association.

At the election of officers, Dr. Max M. Gitlin of Bluffton was elected president, Dr. Mahlon F. Miller, Fort Wayne, was elected vice-president and Dr. Stephen C. Michaelis, Fort Wayne, was re-elected secretary-treasurer. The invitation of the Whitley County Medical Society was accepted for the 1961 annual meeting the third Wednesday in May, 1961 at Columbia City.

MAURICE E. GLOCK, M.D., *Councilor*

Thirteenth Councilor District

Annual meeting of the Thirteenth District for 1959 was held at South Bend on November 18, 1959.

Officers elected were: Thomas Elliott, M.D., president; C. E. Muhleman, M.D., LaPorte, vice-president; James M. Wilson, M.D., South Bend, secretary-treasurer; B. E. Kintner, M.D., Elkhart, councilor and R. E. Nelson, M.D., South Bend, alternate councilor.

The evening address was given by Surgeon General L. E. Burney. This was the first in a series presented by the memorial fund bearing the name of the late Dr. Geridonna.

Mrs. James Robertson, District Councilor of the Auxiliary presided at a luncheon meeting. Speakers were Mrs. Edward Rigley, South Bend, president; Mrs. B. E. Kintner, Elkhart, President-elect; and Mrs. Otis Bowen of Bremen, Legislative Chairman of the Woman's Auxiliary to ISMA.

Throughout the year meetings of the committees were attended involving matters about Blue Shield, Osteopaths, Impartial Court Witness and Political Medicine for the Aged.

The 1960 Thirteenth District meeting is scheduled for September 28, at the Ames Pharmaceutical Company Auditorium, Elkhart, in the afternoon and in the evening at the Hotel Elkhart, where Dr. Paul Dudley White is to speak on "The Health of the Physician Himself."

BURTON E. KINTNER, M.D., *Councilor*

The Journal

It is a pleasure to report that *The Journal* is now completing another successful year. Advertising revenues have continued to offset productions costs. Printing costs have been slightly higher, but income and expenditures have balanced. The details of the finances are contained in the report of the Executive Committee.

The September 1959 issue contained a "Symposium on Rabies" consisting of papers read before the Central Indiana Veterinary Medical Association. Special reprints were made by the ISMA and mailed to members of the Indiana Veterinary Medical Association. Since then 1,750 reprints of the symposium have been made for the U. S. Public Health Service and several pharmaceutical companies.

Other special issues of *The Journal* were the annual Heart Issue in February, 1960, the annual Cancer Issue on the subject of "Malignancy in Childhood" in April, 1960, and the General Practitioner Issue in August, 1960.

During the year *The Journal* was a participant in two evaluation contests. One of these was the national contest conducted by the International Council of Industrial Editors. Out of 790 entries across the nation *The Journal* was exceeded by only 13 publications. It received a Second Award, emblematic of the highest rated publication in its category. The numerical grade of 85% exceeded by 2.15% the rating received from the same organization last year.

At the biennial Editor's Conference of the State Journal Advertising Bureau, *The Journal* was judged as one of the top category of 7 state journals. This rating was made by the same consultant who graded the state medical journals in 1957. His remarks indicated that there had been a decided technical improvement in all the journals in the two-year interval. We are proud that *The Journal* has improved sufficiently to maintain its position with the leaders.

These awards are determined by relative excellence in regard to format, typography, layout, illustrations, and cover art. They are a high compliment to our technical staff.

The editor wishes to express appreciation of the work and loyalty of *The Journal* staff, and of the many members of the Association who have given willing and active assistance.

FRANK B. RAMSEY, M.D., *Editor*

Reports of Committees

Executive

Your Executive Committee has met throughout the past year to transact the routine business of the Association, which includes reviewing the expenditures of the headquarters office, review of all bills and the budget for the Association and setting administrative policies.

Minutes of all the meetings of this Executive Committee have been published in the *Journal* during the past year and copies have been supplied to the reference committee for their study. Transactions of the Executive Committee have been previously reported to the Council.

We will review herewith some of the transactions of the Executive Committee during the past year.

October 9, 1959 Meeting

The Executive Committee met following the meeting of the Council for the purpose of organizing. At this time Dr. Don E. Wood was elected, by ballot, chairman of the Executive Committee for the year 1959-60.

November 11, 1959 Meeting

The Executive Committee approved the field secretaries' calling upon non-members of the Association and non-members of the American Medical Association, providing the county society officers approve of the calls being made upon these men.

The Executive Committee changed their bonding policy and placed all employees and all officers under a $25,000 blanket bond.

The Executive Committee reviewed the actions of the House of Delegates at its October meeting and ordered the resolutions as adopted by the House of Delegates to be introduced by the Delegates to the American Medical Association at the interim session in December of 1959.

The committee heard the reading of correspondence between the headquarters office and the Governor concerning representation at the White House Conference on Aging. As a result of this, the Commission on Public Health was advised to work very closely with the Governor's Commission on Aging and lend all assistance possible to this organization.

The Executive Committee reviewed the recent conventions of the Association and the reports of the Exhibitors Association, noting that the attendance was poor, as was participation in the exhibits. It was the belief of the committee that something should be done to try and encourage more members of the Medical Association to attend the annual convention and as a result they invited the presidents and secretaries of all the speciality groups to meet with the Commission on Convention Arrangements and the Executive Committee on Dec. 16, to discuss this problem.

The Executive Committee employed Judge Ralph Hamill as a second legal counsel for the Association to fill the vacancy created by the death of Mr. Albert Stump.

The Executive Committee then heard Dr. Richard J. Bennett and Dr. Percy E. Hopkins of the Illinois State Medical Association, who discussed the recent activities in the State of Illinois with the federal judges in establishing a Medical Witness Plan. It was explained that they were appearing before the Indiana State Medical Association at the request of two of the federal judges in the northern part of the state. The Indiana judges had been meeting with the federal judges in Illinois; these judges had requested the representatives from the Illinois State Medical Association to explain this plan to the Indiana State Medical Association in the hopes that Indiana would adopt a similar plan of cooperation with the federal courts. The Executive Committee referred this to the Committee on Legislation for study and recommendation.

December 16, 1959 Meeting

The Executive Committee approved the holding of a meeting on January 11 at which time Doctor Louis M. Orr, president of the American Medical Association, would address the business and civic leaders of the state of Indiana.

Dr. Wood, as chairman of the Commission on Legislation, informed the Executive Committee that the Commission on Legislation had discussed the establishment of the Medical Witness Plan and that Dr. Otis Bowen, a member of the commission, would appear before the Council at its next meeting for discussion of this proposal.

The Executive Committee was informed that the North Central District Blood Bank Clearing House had repaid, in full, the loan of $1,000 made to it by the Indiana State Medical Association.

The Executive Committee then adjourned to meet with the Commission on Convention Arrangements and representatives of the specialty organizations and sections of the Association. Represented at this meeting were the sections on surgery, medicine, anesthesiology, obstetrics and gynecology and radiology.

Specialty organizations represented were the Indiana Academy of General Practice, the Indiana Neuropsychiatric Association, Indiana Association of Pathologists, Indiana Chapter of the American Academy of Pediatrics, the Indiana Division of International College of Surgeons, the Indiana Trudeau Society, the Indiana Society of Internal Medicine, the Indiana Chapter of College of Surgeons and the Indiana Society of Ophthalmology and Otolaryngology.

The president, Dr. Mericle, reviewed the purpose of the meeting, pointing out that he felt there was danger facing medicine in the delusion of the parent organization by the specialty groups holding their meetings at times of the State Medical Association meeting. He pointed out he felt that the time was here for medicine to re-group and to go back to its original philosophy that all are physicians and he suggested that the groups consider the feasibility of holding their 1961 annual meetings in conjunction with the Indiana State Medical Association annual meeting. He proposed that the Association supply speakers on a 50-50 cost basis and

further offered the facilities of the new headquarters building to the specialty groups.

The general consensus of the opinion appeared to be that this was a most worthwhile suggestion and the representatives agreed to propose it to their respective organizations and to report their decisions to the headquarters office of the Indiana State Medical Association.

The committee also approved the suggestion that the Association ask the voluntary health associations to hold their annual meetings at the same time as the Indiana State Medical Association meeting in 1961.

January 9, 1960 Meeting

The Executive Committee authorized the issuance of permanent membership cards to all senior members of the Association.

The committee approved the appointment of Drs. David L. Adler, Columbus; Kenneth L. Olson, South Bend and James W. Crain, Williamsport, as members of the Advisory Hospital and Health Center Planning Council.

The Committee reviewed the correspondence between the Executive Secretary and the Joint Commission on Accreditation of Hospitals concerning the holding of staff meetings outside of the hospital and in conjunction with county medical society meetings. The committee instructed the secretary to circulate copies of this correspondence to the officers of all component county medical societies.

Dr. Glock, chairman of the Council, informed the committee that he had taken the ballot poll of the members of the Council and would be prepared to name the Building Committee at the meeting of the Council on Jan. 10, 1960.

The attorney reported on his study of the apparent conflict between the actions of the House of Delegates and the Constitution and Bylaws with respect to the building program. As a result of this a resolution to clarify this situation was prepared by the attorney and was adopted by the Executive Committee. A similar resolution was to be presented to the Council for its consideration.

The committee was informed that the first of a series of the Albert Stump Memorial Lectures to be given before the students of Indiana University School of Medicine would take place at noon on Jan. 27.

February 17, 1960 Meeting

Mrs. J. M. Black, Seymour, president of the Woman's Auxiliary to the Indiana State Medical Association, and Mrs. E. L. Rigley, South Bend, president-elect, appeared before the Committee to report on the program of the state Auxiliary and their efforts during the past year. Also reported was the expenditure of funds provided by the Association during the past year.

Following a review of the activities of the Auxiliary and the review of the Association's financial situation, the Executive Committee voted to give the Auxiliary $1,000 to assist in their program during the current year.

The committee, at the request of the Auxiliary, approved a recognition reception in honor of Mrs. Frank M. Gastineau, outgoing president of the Woman's Auxiliary to the American Medical Association, during the Miami meeting of the AMA.

The committee studied a statement prepared by the American Medical Association concerning industrial immunization programs and ordered this matter referred to the Commission on Public Health, which in turn referred it to the Council. The Council is submitting a statement concerning this proposal in its report to this House.

Noting that the printing costs of the *Journal* had increased in the last two years and we have been informed of an increase for the coming year, an increase in advertising rates for the *Journal* was approved.

March 10, 1960 Meeting

The committee complimented Dr. Woods, chairman of the Commission on Legislation, for the excellent report which he had given before the Indiana State Legislative Advisory Committee on March 8, 1960.

The committee reviewed an invitation to appoint a representative to the National Scholarship Committee of the National Foundation and this was turned down but was referred to the Council for its decision at the April meeting.

The President reported a situation which came to his attention from a member of the Board of Trustees of Indiana University and requested that the president-elect, the executive secretary and the chairman of the Council accompany him to this community to make an investigation of the apparent medical practices in that area.

April 9, 1960 Meeting

A policy was established concerning travel out-of-state for members of the Indiana State Medical Association representing the Association on official business.

A statement on tuberculin testing to become policy was presented to the committee and this was referred to the Council.

The Executive Committee referred to the Commission on Legislation the idea of introducing again legislation permitting physicians to be members of hospital boards. It was agreed that the Association would participate with the Indiana Hospital Association, Indiana Nursing Home Association and the Indiana Dental Association in formulating a Joint Council on the Health Care of the Aged.

The committee voted $500 for the Indiana Chapter of the Student AMA to help defray the expenses of sending their delegates to their national meeting in Los Angeles.

The Auxiliary requested the Executive Committee to assist them in helping them select the first recipient of the Auxiliary Health Awards Recognition. In reviewing the material with the Auxiliary, Mrs. Eck of Plymouth was selected as recipient of this first award.

Dr. Everly, chairman of the Building Committee, appeared before the Executive Committee and reported that his committee had agreed that the Association should attempt to purchase the former Governor's

mansion located on Fall Creek Boulevard adjacent to the Marott Hotel.

July 9, 1960 Meeting

The committee approved investigation by the Building Committee of borrowing $125,000 to be used for the construction of the headquarters building.

The committee established the policy that the immediate past president should serve as chairman of the annual past presidents' luncheon.

The committee recommended that Dr. Jene Bennett, South Bend, be re-appointed to the Board of Directors of the North Central District Blood Bank Clearing House as a representative of the Indiana State Medical Association.

The committee approved a recommendation made by the Commission on Medical Economics and Insurance that the Association undertake an intensive study of progressive patient-care programs.

The Executive Committee received a progress report from the Commission on Governmental Medical Services of its liaison work with the Indiana State Department of Public Welfare.

The committee was informed of the unsuccessful attempt to purchase the Governor's mansion on Fall Creek Boulevard and that they had now taken an option on the property at 3935 North Meridian Street and the Zoning Board of Indianapolis had granted the Association a variance to construct a building on this site.

The committee approved the idea presented by the Auxiliary that the Auxiliary should raise its annual dues to $5.00 per year.

The committee discussed the fast moving developments in the field of Aging and recommended to the Council that a permanent Commission or Committee on Aging should be established within the Association.

The committee also established the policy that a $3.00 charge shall be made to everyone who desires to purchase an association Roster from the *Journal*.

Respectfully submitted,
DON E. WOOD, M.D., *Chairman*
Executive Committee

Medical Defense Activities

1. *Malpractice cases.* A year ago, at the time of this report (Aug. 1, 1959) the following nine cases were pending before the committee, two of which were closed during the year, leaving seven cases still pending:

Case No. 251—Filed Sept. 25, 1942. Pending.

Case No. 285—(Closed). Filed Oct., 1952. Dismissed Nov., 1959. Expense, $3,537.05, paid Dec. 21, 1959 and $489.70, paid Nov., 1959.

Case No. 288—Filed Nov. 12, 1954. Disposed of in Superior Court in 1956; plaintiff appealed the case and won on the appeal; case may be tried over. (Expense, $270.00, paid Sept. 12, 1956, and $172.50, paid May 23, 1957.)

Case No. 296—Filed April 9, 1957. Pending. Plaintiff has died, so case will probably eventually be dismissed by the court.

Case No. 298—Filed Jan. 31, 1958. Pending.

Case No. 299—(Closed). Filed May 13, 1958. Case closed in favor of defendants based on Court's sustaining answers in abatement. Expense, $215.00, paid March, 1960.

Case No. 300—Filed June 18, 1958. Pending.

Case No. 301—Filed 1951. Pending.

Case No. 302—Filed July 30, 1957. Pending.

Since August 1, 1959, and up to August 1, 1960, no new cases have come before the committee; seven cases are therefore pending at the present time as against nine unclosed cases at the same time last year. Several threatened suits have been reported to the headquarters office but formal applications for medical defense by the Indiana State Medical Association have not been filed up to this time.

2. *Medical Defense Fund Statement from August 1, 1959 to August 1, 1960:*

Balance, August 1, 1959		$ 1,434.26
Receipts:		
Dues: 1959 members	$ 10.00	
1960 members	4,773.75	4,783.75
Interest on bonds		480.20
Matured Treasury Bills		15,000.00
		$21,698.21
Disbursements:		
Malpractice fees	$ 4,241.75	
Attorneys' salaries	2,490.00	
Travel—legal conferences	116.88	
Telegraph	1.73	6,850.36
		$14,847.85
Purchase of U. S. Treasury Bills	$11,000.00	
Less discount on U. S. Treasury Bills	145.40	10,854.60
Balance, August 1, 1960		$ 3,993.25

Membership Report

	December 31, 1959	July 31, 1959	July 31, 1960	Delinquent 1960	A.M.A. 1960
1st District					
Gibson	17	17	17	1	17
Perry	13	13	12		12
Pike	4	3	5		5
Posey	11	11	11		11
Spencer	8	8	6		5
Vanderburgh	212	211	214		206
Warrick	11	11	12		14
TOTAL	276	274	277	1	270
2nd District					
Daviess-Martin	23	23	22		21
Greene	18	18	16		8
Knox	41	41	43		41
Owen-Monroe	54	54	53	2	51
Sullivan	14	14	16		14
TOTAL	150	150	150	2	135

	December 31, 1959	July 31, 1959	July 31, 1960	Delinquent 1960	A.M.A. 1960
3rd District					
Clark	30	30	32	1	32
Dubois	22	22	22		19
Floyd	39	38	38		38
Harrison-Crawford	14	14	14		14
Lawrence	26	26	27		25
Orange	11	11	10		10
Scott	3	3	4		4
Washington	7	7	7		7
TOTAL	152	151	154	1	149
4th District					
Bartholomew-Brown	39	39	38	1	37
Dearborn-Ohio	14	14	19		18
Decatur	14	13	13		8
Jackson	19	19	20		17
Jefferson-Switzerland	29	29	24		23
Jennings	8	8	9		7
Ripley	13	13	9		6
TOTAL	136	135	132	1	116
5th District					
Clay	14	14	13		13
Parke-Vermillion	20	16	24		24
Putnam	16	16	16		16
Vigo	115	115	119		119
TOTAL	165	161	172		172
6th District					
Fayette-Franklin	20	20	19		17
Hancock	21	21	22		22
Henry	42	42	44		43
Rush	16	15	16		16
Shelby	16	15	18		18
Wayne-Union	81	81	73	5	68
TOTAL	196	194	192	5	184
7th District					
Hendricks	19	19	21		21
Johnson	32	31	30		30
Marion	1068	1067	1072		1070
Morgan	17	17	17	1	17
TOTAL	1136	1134	1140	1	1138
8th District					
Delaware-Blackford	112	110	106	5	101
Jay	18	18	16		15
Madison	108	105	105	3	98
Randolph	21	21	23		20
TOTAL	259	254	250	8	234
9th District					
Benton	8	8	9		8
Boone	20	20	20		21
Clinton	22	22	20		19
Fountain-Warren	16	16	15		15
Hamilton	23	22	24		17
Montgomery	29	29	29		29
Tippecanoe	103	103	107	1	107
Tipton	11	11	11		11
White	11	11	11		11
TOTAL	243	242	246	1	238
10th District					
Jasper-Newton	14	14	14	4	14
Lake	400	392	395		354
Porter	24	24	25		25
TOTAL	438	430	434	4	393
11th District					
Carroll	10	10	10		10
Cass	42	42	42		41
Grant	62	62	65		65
Howard	51	51	53		52
Huntington	22	21	22		21
Miami	21	21	21		19
Wabash	25	25	24		21
TOTAL	233	232	237		229
12th District					
Adams	15	15	15		14
Allen	260	256	263		262
DeKalb	21	21	20		18
LaGrange	8	8	8		8
Noble	22	22	20		18
Steuben	14	14	13		13
Wells	34	34	33		34
Whitley	17	17	17		17
TOTAL	391	387	389		384
13th District					
Elkhart	106	103	105		102
Fulton	12	12	10		10
Kosciusko	17	17	17		17
LaPorte	89	88	92		89
Marshall	22	22	23		22
Pulaski	7	7	8		7
St. Joseph	222	217	227	2	229
Starke	6	6	6		6
TOTAL	481	472	488	2	482
SUMMARY					
1st District	276	274	277	1	270
2nd District	150	150	150	2	135
3rd District	152	151	154	1	149
4th District	136	135	132	1	116
5th District	165	161	172		172
6th District	196	194	192	5	184
7th District	1136	1134	1140	1	1138
8th District	259	254	250	8	234
9th District	243	242	246	1	238
10th District	438	430	434	4	393
11th District	233	232	237		229
12th District	391	387	389		384
13th District	481	472	488	2	482
TOTAL	4256	4216	4261	26	4124

The JOURNAL

Advertising

This is a comparative report for the first six months of each year indicated.

State Journal Advertising Bureau	1957	1958	1959	1960
	$20,884.69	$29,253.57	$40,978.58	$33,314.83
Sold Direct by *Journal*	5,016.54	2,692.19	3,083.18	2,501.98
Total	$25,901.23	$31,945.76	$44,061.76	$35,816.81

NOTE: July—1958 Local ads $1,692.45.

Printing Cost

Year	Cost	No. of Pages (Inserts excluded)
1956	$38,415.57	1816
1957	46,211.34	1920
1958	50,093.16	1872
1959	63,841.30	2243
1960 (6 months)	32,719.73	1172

Year	Reading	% Reading	Adv. Pages	% Adv. Pages	Total Pages	Adv. Pages per Issue
1955	820	55	672	45	1492	124.3
1956	890	53	782	47	1672	139.3
1957	910	51	862	49	1772	147.7
1958	1055	52	969	48	2024	169
1959	1226	53	1088	47	2314	192.9

Grievance

The Grievance Committee held its meetings in October and November 1959 and in January, March and July 1960.

A plan of action has been followed for the past two years that was gradually evolved over the several preceding years. Each sincere or even plausible and appropriate grievance which is received is treated as both an opportunity to advance public relations for the medical profession and as a reminder to the physician named that the Grievance Committee is primarily interested in assisting him to satisfy the complainant if he is able to do so. A copy of every seemingly realistic grievance letter is made and promptly forwarded to the concerned physician or physicians along with a form letter from this committee encouraging the doctor to solve his problem as he deems fit if he chooses to do so.

Should this step prove unworkable, we suggest that the county medical society be contacted in the effort to reach amicable settlement locally. Only after both of these measures have failed, or been declined, does it ordinarily appear that your State Grievance Committee should act in the interest of better public and professional relations. To this end it is obviously imperative that both the complainant's evidence and the physician's evidence be objectively evaluated that mediation may be just. Inasmuch as weeks of delay in answering a complainant may aggravate the grievance, we urge prompt action as well as early notification to the State Grievance Committee of the success or failure of local mediation measures. Rarely has it been necessary to telephone a physician for a report that would enable us to reply with prompt courtesy to a complainant.

As of July 15, 1960, 19 of 20 cases considered in 1959 were closed and 13 of 19 cases thus far reviewed in 1960 were closed.

Aside from routine grievance cases the Council referred to the Grievance Committee certain aspects of the osteopathic situation. In considering the matter this committee had important help from the Council's Ad Hoc Committee, Dr. Robert K. Webster, chairman, and Drs. Neumann, Challman and Kintner who attended the January meeting. Also meeting with us on the subject were Drs. Frank H. Green and Joseph B. Davis, respectively chairman and former chairman of the Commission on Inter-Professional Relations. Our committee reports on this matter are available in the minutes of the Council meeting of January 10 and April 10, 1960.

The Council also referred for Grievance Committee study the inquiry of the Medical Disciplinary Committee of the American Medical Association. That the four key questions raised by this AMA Committee in 1959 might be answered, a number of physicians were asked to help and the chairman of the Grievance Committee met with the Indiana State Board of Medical Registration and Examination on July 12, 1960. Additional information must be obtained before October, 1960, that the subject may be ready for review by the House of Delegates of the Indiana State Medical Association as suggested by the Council.

PHILIP B. REED, M.D., *Chairman*
RAYMOND E. NELSON, *Vice-Chairman*
GEORGE L. DERHAMMER, *Secretary*
ELTON R. CLARKE, M.D.
WILLIAM H. GARNER, M.D.
LLOYD C. MARSHALL, M.D.
CLEON A. NAFE, M.D.
RUSSELL J. SPIVEY, M.D.
PAUL L. STIER, M.D.
M. C. TOPPING, M.D.

Student Loan

Following is a report on the Student Loan Fund since it was established by the House of Delegates in October, 1955, up to and including July 31, 1960:

Transfer of funds from the General Fund, as authorized by the House of Delegates:		
May 6, 1956	$10,000.00	
May 3, 1957	5,000.00	
January 16, 1959	5,000.00	$20,000.00
Payments on notes		5,381.32
Miscellaneous Income:		
Memorial donations	$ 26.00	
Donations from E. S. Jones, M.D.	217.03	
Interest on U. S. Treasury Bills	270.51	
Interest on notes	173.98	687.52
TOTAL RECEIPTS		$26,068.84
Expenditures:		
Printing of application forms, notes and checks	$ 110.25	
Loaned to students	24,088.36	
TOTAL EXPENDITURES		24,198.61
BALANCE IN FUND, JULY 31, 1960		$ 1,870.23

56 loans have been granted to 42 students;
12 students have received 2 loans each;
1 student has been granted 3 loans;
29 students have received 1 loan each.

The interest rate on loans made prior to Oct. 15, 1958, is 3½%; starting Oct. 15, 1958, the rate is 6%, as authorized by the House of Delegates. Loans do not bear interest until the student has completed his internship.

As of July 31, 1960, 10 loans, amounting to $4,820.02 in principle, have been repaid in full, plus interest of $40.28.

At the time of this report three applications for loans are pending.

Harry Plummer Ross, M.D., *Chairman*
Earl W. Mericle, M.D.
John D. Van Nuys, M.D.
Lester D. Bibler, M.D.
Okla W. Sicks, M.D.
James O. Ritchey, M.D.

Medical-Legal Review

—— no report.

NOTES

Reports of Commissions

Constitution and Bylaws

This is the annual report for 1959-1960 of the Commission on Constitution and Bylaws to the House of Delegates of the Indiana State Medical Association. Various subjects were considered and noted under the following headings:

Election in Absentia

Action was taken by the House of Delegates in October, 1959, to permit the election in absentia of an officer of the Association. Because this change does involve a constitutional amendment rather than a change in the Bylaws, further action is left to the House of Delegates to effectuate this change.

Speaker of the House of Delegates

The constitutional amendment providing for a Speaker of the House of Delegates was held up by reference committee in October, 1959, for further study regarding the duties and functions of the speaker primarily in regard to the appointment of the reference committees. Changes in the Bylaws consistent with this constitutional amendment were tabled by the reference committee in 1958, pending adoption of the Constitutional amendment. This commission decided to take no further action on the matter of a Speaker of the House, as it is now up to the House of Delegates to act on this question.

Remission of Dues

The matter of remission of dues was again brought to the attention of the commission, with respect to establishing some definition formula for determining what constitutes "good cause." After reviewing the current status since the change in the Bylaws in 1958, the commission discussed this question from many viewpoints. The views of the St. Joseph County Medical Society on the remission of dues were expressed in a letter from its president, L. C. Bixler, M.D. This letter was read and discussed at the June meeting.

The commission passed a motion to recommend a change in the Bylaws, as expressed in the following resolution:

"BE IT RESOLVED, That the fourth paragraph of Section 12 of Chapter XXV of the Bylaws, which now reads: "In the event the county society remits a member's dues for good cause, the secretary of the county medical society shall recommend in writing to the councilor of his district the remission of the state association dues of said member of the society, showing good cause why such recommendation should be granted. The councilor in turn may present the recommendation to the Council which shall have power to remit such dues."

be amended to read as follows:

"In the event the county society remits a member's dues, on account of financial hardship, the secretary of the county medical society shall recommend in writing to the councilor of his district the remission of the state association dues of said member of the society, showing why such recommendation should be granted. The councilor in turn shall present the recommendation to the Council, which shall have the power to remit such dues."

Practice, Residence and Membership

Areas of ambiguity, overlapping and borderline situations existing among the provisions of the following citations to the Bylaws were discussed:

Chapter I (Membership) Section 1 (Member);

Chapter XXV Section 4, (Judge of its Members);

Chapter XXV Section 7 (Member moves to another County);

Chapter XXV Section 8 (Living on or near a County Line).

The attitude of the commission is expressed in the following resolutions which offer changes in the Bylaws for consideration by the House of Delegates:

BE IT RESOLVED, That Section 4 of Chapter XXV of the Bylaws which now reads:

"Ch. XXV, Sec. 4. Each county society shall be judge of the qualifications of its own members, but, as such societies are the only portals to this Association and to the American Medical Association, every reputable and legally registered physician who does not practice or claim to practice, nor lend his support to, any exclusive system of medicine, shall be entitled to membership. Before a charter is issued to any county society, full and ample notice and opportunity shall be given to every physician in the county to become a member."

be amended to read as follows:

"Ch. XXV, Sec. 4. Each county society shall be judge of the qualifications of its own members, but, as such societies are the only portals to this Association and to the American Medical Association, every reputable and legally registered physician who holds a degree of Doctor of Medicine or a degree of Bachelor of Medicine, and who does not practice or claim to practice, nor lend his support to, any exclusive system of medicine, shall be entitled to membership. Before a charter is issued to any county society, full and ample notice and opportunity shall be given to every such physician in the county to become a member."

The commission voted to offer a resolution to change the Bylaws concerning transfer of membership on change of residence:

"BE IT RESOLVED, That Section 7 of Chapter XXV of the Bylaws which now reads:

"When a member in good standing in a component society moves to another county in this state his name, on request, shall be transferred without cost to the roster of the county society into whose jurisdiction he moves, provided the transfer is approved by majority vote of the membership of said society to which the membership is proposed."

be changed to read as follows:

"When a member in good standing in a component society moves to another county in this state, his name shall be transferred, without cost, to the roster of the

county society into whose jurisdiction he moves, provided the transfer is approved by majority vote of the membership of said society to which the transfer is proposed."

Model Constitution and Bylaws

The commission in regular session has considered *seriatim* the provisions of a model consitution and bylaws for a county medical society. The draft thus considered was prepared by a sub-committee of this commission, and was based primarily upon a model constitution and bylaws prepared by the Legal Department of the American Medical Association in June, 1957. The commission voted to approve this draft as changed in regular session, and to authorize its reproduction and distribution to county societies on their request. The commission has undertaken this project to assist a county medical society in bringing their constitution and bylaws up to date. It is the expressed plea of this commission that the availability of this model constitution and bylaws should not be construed that any provision is necessarily mandatory or especially urged solely by reason of the approval of this commission.

Meetings of this commission were held at Indianapolis on Oct. 9, 1959; Jan. 17, 1960; April 24, 1960 and June 19, 1960. The terms of office one or two or three years, dating from the Annual Convention of October, 1959, are indicated by the numeral placed after the name of each member.

Charles A. Jones, M.D., *Chairman, 2*
William B. Challman, M.D., *2*
Dillon Geiger, M.D., *3*
Richard H. Woolery, M.D., *3*
Gordon S. Fessler, M.D., *1*
A. W. Cavins, M.D., *3*
Howard E. Sweet, M.D., *3*
Irwin S. Hostetter, M.D., *1*
William M. Sholty, M.D., *2*
Philip J. Rosenbloom, M.D., *1*
Lowell J. Hillis, M.D., *1*
Truman E. Caylor, M.D., *2*
John B. Cleveland, M.D., *1*
G. O. Larson, M.D., *2*
Robert M. Hansell, M.D., *3*

Legislation

The Commission on Legislation had its first major meeting in January of this year and entertained representatives of various professions and organizations. This was a "Town Hall" type of meeting. Dr. Louis Orr, President of the American Medical Association, addressed this group.

The commission was quite active during the recent primaries in May of this year. Many of the candidates of both parties were interviewed and their views obtained.

As in the past, visitations were made to Washington, D. C., to contact the congressmen and senators from our state. As in the past years, this was a success.

The commission will meet again in the near future to discuss the coming Fall elections.

Don E. Wood, M.D.
Walter L. Portteus, M.D.
Co-Chairmen
Eugene F. Senseny, M.D.
P. J. V. Corcoran, M.D.
Robert O. Bethea, M.D.
Don Kerr, M.D.
Joe M. Black, M.D.
Joseph G. S. Weber, M.D.
Paul R. Tindall, M.D.
John W. Hendricks, M.D.
Paul T. Lamey, M.D.
Lee J. Maris, M.D.
J. P. Vye, M.D.
Donald K. Winter, M.D.
Otis R. Bowen, M.D.

Public Information

The purpose of the Commission on Public Information is to collect and organize for dissemination to the public all matters of public interest within the field of medicine, including the activities of other commissions in which the public interest would be involved, and including the achievements in the advancement of medicine which would be of interest to the public, to develop and maintain the relations of the medical profession with the public in such a way as to give the lay public a better knowledge and understanding of the aims, objects and value of the profession to the public.

The activities of the commission during the past year are hereby summarized.

I. Indiana State Commission on the Aging and Aged

The health care and the socio-economic needs of our senior citizens present a real challenge and our commission decided that we could best assist the Indiana State Commission on the Aging and Aged in the following manner:

A. That we publicize the objectives and activities of the Indiana State Commission on the Aging and Aged—acquaint each physician with this commission in order that he can assist and cooperate with the commission on a local level.

B. That we assist the commission on the Aging and Aged in better utilization of the facilities of the County Home, "poor farm" for our senior citizens.

C. That we consult and work with State Board of Public Health, the Nursing Home Division, in increasing the standards and quality of patient care in our nursing homes.

II. Liaison Committee with the AFL-CIO

The Council approved the reestablishment of a liaison committee between the medical profession and the AFL-CIO. Our commission accepted this responsibility. A committee of three physicians met with the AFL-CIO group on July 27, 1960, to discuss mutual problems.

III. Health Hints—Radio and T.V.

The column, "Health Hints" was distributed to approximately 200 Indiana newspapers, as in the past. The field secretaries have called numerous newspaper editors and several newspapers have been added to the list of those printing "Health Hints" on a weekly basis. These columns are all reviewed by members of the commission for corrections or additions prior to publication.

County medical societies have received lists of available radio transcripts that can be used by radio stations in their respective areas. Many of the county societies have used these programs as part of their public relations activities.

It was called to the attention of the officers and councilors of the State Medical Association the success of the television program, "Ask Your Doctor," sponsored by the Public Relations Committee of the Marion County Medical Society. This program has been on the air since the summer months. Panel discussions of common health disorders by three physicians are taped and presented on T.V. Sunday afternoon. The response has been most gratifying as determined by the numerous telephone calls and letter inquiries. It was suggested to the councilors and officers that similar programs could be conducted by our district medical officers at various television centers throughout our state.

IV. Science Fair

Continued participation in Science Fair activities including the defraying of expenses of local representatives to the National Science Fair is most desirable. The 1960 National Science Fair was held in Indianapolis and was hosted most successfully by the Marion County Medical Society.

V. State Fair Exhibits

The Commission, with the assistance of the AMA Bureau of Exhibits, is presenting exhibits that are currently in the public eye.

Members of the Woman's Auxiliary of the Marion County Medical Society will serve as attendants to these exhibits and medical students will be available to record blood pressure readings of visitors who wish such.

VI. Medical Assistants Program

Indiana University, through its extension centers, is conducting a training program for medical assistants. The program consists of a non-credit college level course consisting of six subjects of one semester each and is given one night weekly for sixteen weeks. The commission is furthering this program by giving it adequate publicity and support.

The Commission on Public Information wishes to thank Mr. Waggener and his staff for their assistance and guidance during the past year.

William G. Bannon, M.D., *Chairman*
James M. Kirtley, M.D.
Seth W. Ellis, M.D.
R. L. Kleindorfer, M.D.
Mordecai M. McDowell, M.D.
B. E. Sugarman, M.D.
Harry R. Baxter, M.D.
William R. Tindall, M.D.
Harry G. Becker, M.D.
Franklin F. Premuda, M.D.
R. M. Hummel, M.D.
Naf H. Gladstone, M.D.
Richard W. Holdeman, M.D.
T. D. Armstrong, M.D.
Albert A. Fischer, M.D.

Governmental Medical Services

The organizational meeting of the Commission on Governmental Medical Services was held Friday, Oct. 9, 1959, immediately following the adjournment of the Indiana State Medical Association, House of Delegates. At this meeting, sub-committees were appointed and a budget for the year was discussed. There have been three other meetings of the full commission during the past year with several meetings of the sub-committees on an individual basis. The activities of the commission shall be reported under the various sub-committees involved.

Civil Defense

Your Commission was represented at the Sixth Regional Civil Defense Meeting held in Chicago, Jan. 23, 1960, in conjunction with the American Medical Association. At this meeting, "Annex N" for the Indiana State Medical Services Plan, a portion of the complete Indiana Operational Plan, was discussed. An exchange of ideas and suggestions was made by representatives from Illinois, Michigan, Missouri and Wisconsin. Dr. Carter, the chairman of the sub-committee on Civil Defense, completed the course of training May 9 to 19 at Battle Creek, Mich., sponsored by the Public Health Service, entitled, "Health Services, Aspects of Health Mobilization."

The sub-committee on Civil Defense sponsored a meeting May 22, 1960, at the State Fairgrounds for Civil Defense medical services representatives from each county society, chairmen of disaster committees from each hospital, and hospital administrators. Also invited to this meeting was the Auxiliary to the Indiana State Medical Association, representatives of the Indiana State Nurses Association and other allied groups. This seminar was addressed by Gen. John McConnell, Mr. Frank Barton of the AMA, Mr. Maurice Pettit, who is the Federal Liaison Officer of O.C.D.M., and Dr. Lewis Spolyar of the Indiana State Board of Health.

Following the lecture series and the question and answer period, participants made a tour of the 200-bed Civil Defense hospital, this tour being conducted by Dr. Henry Nester of Indianapolis. It is recommended that this type meeting or seminar shall be made an annual part of the Commission on Disaster Medicine, sponsored by the Indiana State Medical Association.

The Indiana State Medical Association was represented at the annual Civil Defense meeting preceding the meeting of the AMA in Miami Beach, Fla., June 11. This meeting was conducted under the auspices of the AMA, but the program was presented by the members from the Department of the Navy. There has been much discussion during the past year concerning a shelter program; this is being discussed further, and when something definite has been decided both by the state and federal governments, further information shall be forthcoming to members of this association.

Military Manpower

There have been no meetings of the Military Manpower sub-committee during the past year since no problems have been referred to the committee.

In view of this fact, above mentioned, that there is no work requiring the attention of this committee for the past two years, and none is seen in the near future, it is suggested that the committee on Military Manpower shall be put on a standby basis till further needed.

Medicare

The sub-committee on Medicare has met several times during the past year in conjunction with the Commission on Governmental Medical Services as a whole. The reason for the existence of this sub-committee is to expedite and accelerate the processing of claims by Indiana physicians for services rendered under the Medicare contract between the ISMA and the Defense Department for the care of military dependents.

In spite of some expansion of the coverage under Medicare since Jan. 1 of this year, the number of claims received and the amount of money paid out during the first half of 1960 has decreased. At the time of this writing, figures for the first five months only are available; therefore, the first half figures presented here are the actual figures for the first five months and projection for the sixth month to obtain six months totals for comparison with last year. Last year (1959) there were 2,821 claims received during the first half against 2,636 this current year. Last year during this time there were 1,297 claims (45.9%) returned to the physician for correction or rejection against 1,115 claims (43.3%) returned this year. During the same period of time last year Indiana physicians received $223,656.17 through Medicare, compared to $185,275.28 this year.

The major reasons for returning claims to the physician are about the same as in the past, namely: absence of dates of services and absence of certification and permits; the "expected date of delivery" is frequently missing from claims for prenatal care; absence of medical authorization card and expiration date and many because the patient or accompanying parent or the claiming physician signs in the incorrect area on the claim. Only a small percentage are returned because the service is not covered by Medicare.

Veterans Medical Care Program

There has been continued interest throughout the United States concerning the increasing numbers of veterans who are being admitted to the Veterans Hospitals with non-service connected disabilities. This problem will be one of continuing study and interest, and it is felt that there shall be some discussion in Congress during the next session.

The veterans fee schedule for the state of Indiana was renewed without change for the present time.

Veterans Affairs

The Joint Liaison Committee on Veterans Affairs is composed of representative committees from each of the following: The Indiana State Medical Association, the Indiana Hospital Association, the State Dental Association and the American Legion, Indiana department.

The purpose of the Joint Liaison Committee is to attempt to secure cooperative effort and mutual support to influence legislation, particularly as it affects veterans.

Three meetings have been held since the last report: September 23, 1959; January 20, 1960 and April 20, 1960. These joint meetings were the 31st, 32nd and 33rd such meetings held in Indiana. Each representative organization takes turns in sponsoring and chairing the meeting.

Problems which have come up for consideration:

New legislation to increase veterans' pensions will cause some veterans to receive enough from their pensions to disqualify them from receiving Social Security, thus actually reducing their total income.

The Keogh-Simpson bill was favored by everyone but the American Legion Committee. They considered this class legislation.

The State Dental Association favors and asks support for HR 5984 and HR 5985, which bills would increase dental care in the Army and Air Force.

Dr. Morton Leeds, Secretary of the Commission of Aging, State of Indiana, reported on the coming Governor's Conference on Aging to take place in Indiana in September, 1960, and the White House Conference on Aging in January, 1961. Dr. Leeds implied that veterans are frequently "thrown out" of such programs.

The American Dental Association was reported as opposed to the Forand bill in its present form.

The American Legion is now advocating total treatment centers. They point out that since President Coolidge opened the Veterans Bureau hospitals to non-service connected disabilities, the V. A. hospitals have expanded to a bed capacity of 125,000 designed primarily for the care and treatment of the acutely ill. Legislation to permit a pilot study of extended or total care is to be requested of Congress. The authorization is requested to construct and maintain convalescent cottages at five veterans hospitals located one each in the Northeast, Southeast, Central, Northwest and Southwest U. S. A.

Patients would then go into V. A. hospitals under four classifications:

1. Those needing the full resources of a modern hospital—skilled nursing, laboratory, investigation, surgery, etc.

2. Those needing limited hospital facilities, essentially simple nursing care without mental supervision because of physical illness.

3. Those needing limited hospital facilities, essentially supervision and training because of their mental state.

4. Those needing no hospital facilities and retained chiefly for social reasons.

Dr. Ginsberg, State Commissioner of Mental Health, discussed mental health pertaining to veterans as follows: There are in excess of 700,000 veterans in Indiana, consisting of 1,500 Spanish American War; 71,000 World War I; 423,000 World War II and 121,000 Korean War veterans.

Three veterans hospitals in Indiana have a total capacity of 2,500, with a current load in excess of 2,400, mostly mental patients. There are 66 veterans on the waiting list at the Marion V. A. Hospital who are now in state mental institutions, 746 veterans are in the ten state mental institutions and 300 have been in such hospitals for less than one year, mostly with a diagnosis of schizophrenia. Seven hundred vets were discharged from state mental hospitals last year, mostly to their own home.

The Joint Liaison Committee is planning to sponsor a regional conference of similar organizations from Illinois, Ohio, Kentucky, West Virginia, Minnesota, Wisconsin, Iowa, Michigan, Missouri, Tennessee, Pennsylvania, Nebraska, Kansas and Arkansas. Each member organization of the Indiana Joint Commission on Veterans Affairs has agreed to contribute $100.00 toward organization expenses for this conference.

The regional conference was Sept. 17, 1960. Members of this Committee and Mr. James Waggener participated in plans and organization.

The State Hospital Association is proposing state legislation to permit hospitals to file liens against property of people who die owing the hospital a bill.

Liaison with the State Department of Public Welfare

This sub-committee has had a very active year, in that it has had several meetings with the representatives of the Indiana State Department of Public Welfare concerning various problems which have arisen concerning both groups involved. In November, 1959, the Indiana State Department of Public Welfare requested a meeting with the Indiana State Medical Association concerning a special diet program which had become rather involved, and after this meeting, representatives of the commission met the representatives of the county involved, and this was settled to the satisfaction of all. There has been a request that a study be made concerning the need for special diet programs among the recipients of welfare funds. This has been agreed to; however, we are awaiting clarification from the State Department of Public Welfare before any further activity is made in this direction.

In March, 1960, the State Department of Public Welfare contacted us regarding the matter of using a generic term on all prescriptions written for welfare patients. This had come to their attention both from the Kefauver Committee activities and from pressure from a few of the columnists writing in the Indiana papers. Considerable study was done on this subject, and several meetings were held with the representatives of the Indiana State Medical Association, Indiana Pharmaceutical Association and some of the pharmaceutical manufacturers. After material was obtained, a joint meeting was held with the State Department of Public Welfare, at which our president, Dr. Mericle, was present, as were many people throughout the state from the various county welfare agencies. It is felt that generic term alone is not adequate, nor is the use of a so-called U.S.P.H. drug safe, without knowing the source of the drug itself or its manufacturer.

If the use of generic term alone was required as a basis for saving money, there is an inherent danger of the welfare patient receiving a lower quality of medicine than those received by private patients, as even the Food and Drug Administration admits that their controls are not adequate to assure equal quality of low-cost drugs.

In reviewing the cost of welfare over the past few years, it was evident that the share of the welfare dollar being paid to physicians for their services had shown a small decrease, but there have been substantial increases in many of the other services paid for by the State Department of Welfare. One explanation for this is, of course, the inflationary times in which we are now living and also the fact that the welfare recipient is becoming more aged.

There have been various attempts made on this subject by several states throughout the United States. It has been found that most of them have been unsuccessful.

The committee feels that the required use of generic term would interfere with the practice of medicine, as we know it, in that it would not allow the physician to order for his patient, those drugs which he feels are most indicated.

After this initial meeting with the Department of Public Welfare, there were two other meetings at the request of the department, and these have been attended by representatives of your association. There is considerable discussion at these meetings concerning the cost of medical care. However, when we get the definition and an explanation, it does not mean physician's charges, as a general rule—the definition includes not only physicians' charges, but also the cost of hospitalization, nursing home services, drugs, dental care and appliances. However, there is some discussion of the fact that some physicians, although they are rare in number, who are seeing a few patients a little more than might be needed. It has been noted that some of these, however, in fact most of them—are not Doctors of Medicine.

At the last meeting of this group with the Welfare Department, the statement was made by Mr. Kelley, the Administrator of the Indiana Department of Public Welfare, that he would like to get out of the Medical

Care Program, and we feel that this is a good idea. However, it will take a considerable amount of study. It will probably take well into the next year. There are many courses open, as we see it, at the present time. These will be investigated to their fullest and reports made later on this program. The Commission on Governmental Medical Services will have a joint meeting with the Commission on Insurance, in that the problems involved in these programs will cross the activities of both groups.

This is a great challenge to the ISMA and one that your commission feels must be accepted and explored.

Miscellaneous Business

The Council referred the problem of Disability Benefits from the Social Security Department to your commission, questioning the fact that many of the examinations are done without prior explanation or questioning of the applicant. This problem was investigated, and it has been determined that if the application is processed properly, that the applicant shall be questioned as to whether or not he has adequate coverage to receive Social Security benefits. The application and the booklet given to the applicant at the time of application definitely states the requirements for receiving Social Security benefits. If this is followed and understood by the applicant there is no question as to whether or not the physical examination by the physician had anything to do with his receiving or the disallowance of said benefits.

Recommendations

1. An annual Civil Defense meeting sponsored by the ISMA each spring for the medical profession and affiliated groups involved in the State of Indiana.
2. Continuing study of the veteran admitted to the Veterans Administration hospitals with non-service connected disabilities.
3. It is recommended that each county society shall set up an active committee of liaison with their local county welfare department in review of welfare claims and welfare problems.
4. That the ISMA shall accept the challenge of the Department of Public Welfare and attempt to set up a program for caring for the medical needs of the welfare recipients of the State of Indiana.

Your commission has enjoyed working this past year for you, and wish to thank Mr. James Waggener and his office staff for their invaluable assistance during the past year.

Respectfully submitted,
Charles R. Alvey, M.D., *Chairman*
T. J. Bruegge, M.D.
George Willison, M.D.
Jack McKittrick, M.D.
Irvin E. Huckleberry, M.D.
William A. Johnson, M.D.
V. Earle Wiseman, M.D.
Glen Ward Lee, M.D.
Arvine Poppewell, M.D.
Robert E. Williams, M.D.
Harry R. Stimson, M.D.
Howard A. Stellner, M.D.
James M. Wilson, M.D.
Jean V. Carter, M.D.
Stanley W. Burwell, M.D.

Public Health

The Commission on Public Health has conducted its work during the past year in an effort to expand its activities, especially in the work of rural health and physician placement, industrial medical practices and programs, and in the consideration of the care of the aged and aging.

Meetings which have been held during the past year have seemed expedient and an effort has been made to bring into our meetings, representatives of both medical and lay groups, when the topics under consideration seem to concern them. This has been especially the case in the above named three committees.

Because of the nature of the subject, the problems of the aged and aging have been considered by the entire commission acting as a committee on the whole.

Aged and Aging

At every meeting of the commission it has met for a portion of the time as a committee of the whole to consider the problems of the aged and aging. An attempt has been made to have some member of your committee represent the medical profession in meetings, both medical and non-medical where this question was being discussed and where admission could be gained. These meetings have varied from a community to a national level in scope, and in most cases, especially where lay groups were involved, a majority of the attention was given not to the definite medical care of the Aged and Aging, but to the auxiliary aspects of it—particularly, social, economic, housing and recreation. The committee has had representation in the conferences conducted by the American Medical Association, which were primarily for information and planning by the medical profession.

The National Health Forum, in Miami, Fla., in February, 1960, was attended by several Indiana physicians, including your chairman. Sixty-three organizations were represented and a great variety of subjects discussed. There appeared to be no unanimity of opinion resolving from this meeting, which was attended predominantly by non-medical persons.

In Indiana, the committee has attempted to work closely and collaborate with the Indiana Commission on the Care of the Aged and Aging. Two Indiana doctors are now serving on that commission, and an effort has been made to have them, as well as the officers of the commission, attend our committee meetings. In turn, there has been a representative from our committee in attendance at their regional meetings over the state, and also at the planning meeting in May, 1960, at the Indiana University Medical Center.

At all these meetings there has been an attempt to organize the Indiana commission to prepare presentations for the White House Conference for the Aged and Aging to be held in Washington, in 1961. This has seemed to be somewhat of a goal for these groups, with Indiana being given an official representation of 45 delegates.

The attendance at these meetings was largely composed of representatives of social agencies and the older people in the community who have a personal interest in the subject. Again, in these meetings, the discussion was largely along housing, the cost of medical care, recreation and the legislation by which this could be secured for the older people.

Although the committee has attempted to keep active in this effort, there seem to be many unanswered questions and apparently great alarm for the care of the aged and aging. Great emphasis being put upon the poor status of living and economic hardships of our older citizens. Your committee would urge continued effort for clarification of this situation and continued efforts in publicizing the contributions made by organized medicine, individually and collectively for the benefit of our older citizens.

Industrial Health

The Committee on Industrial Health has met with the Commission on Public Health on many occasions to study the medical problems of the aged and aging.

The committee recommended approval by the House of Delegates of the Indiana State Medical Association, the American Medical Association's approved policy for immunization programs for industry.

The committee considered the ever-increasing problem of intervention of lay third party groups in "everyday" immunization programs for communicable diseases, especially poliomyelitis. They concluded that immunization programs are an integral part of the practice of medicine and as such can only be properly conducted by physicians.

The committee has communicated with the executives of several small industries in Indiana concerning the establishment of ethical industrial medical services in their plants.

The committee would recommend an expansion of liaison with economic, social and judicial groups where such seems feasible. Care must be taken in such a program to be sure there is a genuine interest in the responsibility.

RICHARD C. SWAN, M.D., *Chairman*

Conservation of Hearing and Vision

The Committee on Conservation of Hearing and Vision met in sessions of the Commission on Public Health. The problems associated with our concern were brought up and discussed.

No definitive action was required on any situation, but the members are alert to potential problems and problems in the making. The committee welcomes any inquiry or report of a specific situation coming under the committee's duties.

A. K. HARCOURT, M.D., *Chairman*

Rural Health and Physician Placement

During the past year, the Committee on Rural Health and Physician Placement has continued its efforts, meeting with various groups and attempting to answer many inquiries as to medical services in rural communities and physician placement.

Your chairman, Dr. E. S. Rifner, attended the program in Michigan for the Rural Health Forum. This forum was most inspiring and informative.

Perhaps one of the most important efforts was that of the annual Junior-Senior Day held, April 2, 1960, at the Claypool Hotel. An excellent program, with both student and graduate physicians sharing was given. Many practical questions were asked, and there seemed to be a genuine interest of the students present in organized medicine. They were also repeatedly and emphatically assured of our interest in them.

In the next year a continuation of these programs would be recommended, with an effort of expansion of the Junior-Senior Day.

E. S. RIFNER, M.D., *Chairman*

The Commission on Public Health would suggest a continuance of the program, with more attention and more detailed planning on the problem of the aged and aging, with suggestions that a better understanding may be had with these lay groups, especially the Indiana Commission for the Aged and Aging.

It is also recommended that further, careful study be made as to the community health and contagious diseases control, with a continued effort to preserve good relations with the voluntary health agencies.

Emmett B. Lamb, M.D., *Chairman*
Richard C. Swan, M.D., *Vice-Chmn.*
Howard T. Hammel, M.D., *Secretary*
Daniel Hare, M.D.
Ralph O. Smith, M.D.
Joseph E. Dudding, M.D.
Robert K. Webster, M.D.
John A. Davis, M.D.
Allan K. Harcourt, M.D.
John R. Stanley, M.D.
Forrest J. Babb, M.D.
E. S. Jones, M.D.
E. S. Rifner, M.D.
Robert M. Lohman, M.D.
John C. Richter, M.D.

Voluntary Health Agencies

In summarizing the work of the Commission on Voluntary Health Agencies for the year 1959-1960, one is immediately impressed with the activities and accomplishments of this commission for the past year.

This commission met five times during the past year and discussed all matters pertaining to its liaison function between the recognized Voluntary Health Agencies and the Indiana State Medical Association.

At the organization meeting held Oct. 9, 1959, at the Columbia Club, Indianapolis, Ind., the following assignments to the various health agencies were made as follows:

Tuberculosis: Louis Bixler, M.D. and H. O. Chattin, M.D.

Polio: Anne Nichols, M.D. and W. A. Shullenberger, M.D.

Heart: Norman Booher, M.D. and H. Glenn Gardiner, M.D.

Mental Health: Robert Reid, M.D. and Norman Booher, M.D.

Muscular Dystrophy: Wendell Ayres, M.D.
Diabetes: Kenneth H. Brown, M.D. and Charles E. Rutherford, M.D.
Cancer: Wilson L. Dalton, M.D., James Gosman, M.D. and Karl Schlademan, M.D.
Crippled Children: R. Case Hammond, M.D.
Indiana Health Foundation: James Gosman, M.D.
Multiple Sclerosis: James L. Doenges, M.D.
Cerebral Palsy: Wendell W. Ayres, M.D.

Notices of the above liaison appointments were sent out to each of the agencies concerned from the office of the Indiana State Medical Association.

The second meeting was held on Sunday, Nov. 8, 1959, at the Student Union Building, Indiana University Medical Center, Indianapolis.

At this meeting, with the suggestions in mind that Dr. Mericle made at the organizational meeting, Oct. 9, 1959, the following resolution was introduced and adopted:

WHEREAS, the Commission on Voluntary Health Agencies, in developing policy, should define its position relating to voluntary health agencies in order to guide the commission in its work, and;

WHEREAS, Voluntary Health Agencies are firmly established in the pattern of American life, and contribute much to the well-being of all citizens, and;

WHEREAS, strong medical guidance and leadership is necessary for the best efforts of all voluntary health agencies if they are to function to the best advantage of the medical profession and the people they are intended to serve, now;

THEREFORE, BE IT RESOLVED, that the Commission on Voluntary Health Agencies of the Indiana State Medical Association go on record as recognizing that while voluntary health agencies, like most other organizations are not perfect, they have a definite worthwhile value to the people in the communities they serve, and, we, therefore, in principle, approve them, and

BE IT FURTHER RESOLVED, that this commission urges the members of the Indiana State Medical Association to become affiliated and active on the state and local level in voluntary health organizations in order to give them the proper medical leadership and guidance they need to perform the greatest service to medicine and the people of the areas they serve, and

BE IT FURTHER RESOLVED, that the members of this commission who have accepted specific assignment to the various Voluntary Health Agencies make every effort to contact these agencies and become well informed in the work of these agencies.

The crowning achievement of this commission's activities culminated in the Dec. 13, 1959, meeting at Indianapolis; in which the members of this commission met with the officers of the various Voluntary Health Agencies of the state of Indiana. We, thereby, became better acquainted with these individuals and discussed briefly with them the structure of their organization and their policies, and assured them that this commission was willing to advise, if needed; and to assist them in any manner whatsoever. Also present at this meeting, as guests, were Earl Mericle, M.D., president; Guy A. Owsley, M.D., president-elect; Mr. James Waggener and Mr. Howard Grindstaff.

Questions were asked of each of the officers of the Voluntary Health Agencies represented and dealt principally with:

1. How is the agency organized?
2. How do they get their funds?
3. How do they spend their funds?
4. How can this commission help?

Many other questions, however, came to light as the meeting progressed.

The Voluntary Health Agencies represented at this meeting with their various officers present were as follows:

1. Muscular Dystrophy
2. Indiana Society for Crippled Children and Adults
3. Polio
4. Indiana Health Foundation
5. Multiple Sclerosis
6. Tuberculosis
7. Heart Association
8. Mental Health
9. Indianapolis Diabetes Association
10. Indiana Cancer Society.

It was felt that out of this meeting came a more personal relationship, a better understanding, and a closer liaison between this commission and the various voluntary health agencies represented at this particular time.

The next meeting was held on Sunday, Feb. 28, 1960, in Indianapolis. The A.M.A. booklet, "Suggested Guides to Relationships Between Medical Societies and Voluntary Health Agencies" was adopted as our official policy and was recommended to the House of Delegates for adoption. At this meeting, also the commission went on record as approving the stand of the Clay County Medical Society in cooperating with the old unit of the Cancer Society; and copies of this action were forwarded to the Clay County Medical Society and to the Indiana Division of the Cancer Society.

It was also the decision of this commission at this meeting to submit a special memorandum to the Executive Committee of the Indiana State Medical Association protesting the advertisement of the National Poliomyelitis Foundation in using the statement on its billboards that they are, "Guardians of the Nation's Health." This Commission felt that this was improper advertising and an improper statement indicating that that agency was the sole guardian of the health of the Nation, and the Commission respectfully requested the Executive Committee of the Indiana State Medical Association to authorize a letter over the signature of the Indiana State Medical Association; and direct it to the National Polio Foundation incorporating a protest of this Organization against the use of this phrase in future advertising. The Executive Committee subsequently acted favorably on this request and referred the action of this Commission to the Council with the

request that favorable action be taken on this Commission's request, and that the Association officially question the National Polio Foundation's statement, "Guarding America's Health."

The next and final meeting was held April 3, 1960, at Indianapolis. At this meeting the minutes of the Dec. 13, 1959, meeting were again discussed and it was felt that what was accomplished this year and, particularly, at the Dec. 13, 1959, meeting, was more encouraging than anything that had been done in the past several years. It was the consensus of opinion at this meeting that the mere fact that the Voluntary Health Agencies in Indiana now know what we are doing was as profitable an activity as we could possibly achieve this year.

At this meeting, it was also the feeling of this Commission that the Polio Foundation was not practicing adequate follow-up with respect to preventive treatment of poliomyelitis. This referred, in particular, to the lack of attempts to educate the public of the necessity of conducting new vaccination and re-vaccination of the susceptible groups of the population. Further, it was pointed out that the foundation was making efforts in other directions which are at least partially covered by organizations already existing and active in the voluntary health field. This commission questioned the advisability or desirability of the Polio Foundation in entering these new fields as long as the original problem remains as large as it is at the present time.

Also, at this meeting, in reply to a letter from the Indiana Tuberculosis Association concerning a statement of this commission on, "Tuberculin Testing," the following was adopted:

1. The Intradermal Test (Mantoux) is more accurate than the Vollmer (Patch) Test, and is, therefore, the procedure of choice for use in case finding programs.
2. All tuberculin testing should be done by, or with the supervision of a physician.
3. Positive tuberculin reactors and students in the schools, should be x-rayed by standard equipment rather than survey machines in order to minimize exposure to radiation.

It was also unanimously agreed at this meeting that there was no need for any further meetings of this commission this year and that the annual report would constitute the final activity of this commission.

Kenneth H. Brown, M.D., *Chairman*
Norman R. Booher, M.D., *Vice-Chmn.*
Karl R. Schlademan, M.D., *Secretary*
R. Case Hammond, M.D.
Herbert O. Chattin, M.D.
Robert M. Reid, M.D.
Anne S. Nichols, M.D.
Wilson L. Dalton, M.D.
James L. Doenges, M.D.
Charles E. Rutherford, M.D.
H. Glenn Gardiner, M.D.
Wendell Ayres, M.D.
Louis C. Bixler, M.D.
James Gosman, M.D.
Wendell A. Shullenberger, M.D.

Medical Economics and Insurance

The organizational meeting of the Commission was held in the Columbia Club, Indianapolis, Ind., at 2:00 p.m., Oct. 9, 1959.

The following officers were elected:

Chairman—John L. Langohr, M.D., Columbia City
Vice-chairman—E. T. Edwards, M.D., Vincennes
Secretary—Lowell Thomas, M.D., Indianapolis

The work of the commission was divided among four sub-committees, as follows:

Sub-Committee A—Relative Value Study: E. T. Edwards, M.D., M. E. Harden, M.D. and A. T. Jones, M.D., chairman.

Sub-Committee B—Cooperative Care of the Surgical Patient: John Langohr, M.D., Robert N. Bills, M.D., Richard P. Good, M.D., M. E. Harden, M.D. and Lowell Thomas, M.D., chairman.

Sub-Committee C—Blue Cross-Blue Shield Pathology and X-ray Transfer: Morris D. Wertenberger, M.D., John L. Arbogast, M.D., George E. Paine, M.D. and John Beeler, M.D., chairman.

Sub-Committee D—Out Patient Diagnostic Blue Shield Care: Wendell C. Stover, M.D., William Scharbrough, M.D., Hubert T. Goodman, M.D. and E. T. Edwards, M.D., chairman.

This commission has met five times during the year, and held its final meeting Sept. 18, 1960. It met jointly with the Health Insurance Council on April 24, 1960, to discuss matters of mutual interest, and four weeks later conferred at length with a representative of Blue Shield regarding past activities, present programs and a little on future planning of Blue Shield.

In anticipation of the need to explain Relative Value Study to the ISMA Membership at large, as directed in Resolution No. 6, passed by the House of Delegates, in October, 1959, this commission requested an increase of its annual budget from $1,000 to $3,000. This increase was not granted, so the members of this commission undertook to organize meetings at the county societies, each commission member being responsible for his own district. Letters, or personal calls were sent out to the various county societies, but a most indifferent response was obtained over the state. This fact is reflected in Sub-Committee A's report published below. Only in those counties where the Commission Member resided and took a personal interest in arranging specially called discussion meetings was any interest shown regarding relative value study.

Sub-Committee A: Relative Value Study

The proposed Relative Value Schedule for Indiana was printed in booklet form and presented to the House of Delegates in October, 1959. During the year, 1959-60, the members of Sub-Committee A, and the various district representatives on the commission as a whole made information and discussion available to all county societies which desired it.

This sub-committee recommends, and the commission as a whole agrees, that the Relative Value Schedule and Study, as submitted to the House of Delegates in 1959, should be rejected for the State of Indiana.

Sub-Committee B: Cooperative Care of the Surgical Patient

This sub-committee recommends that a separate schedule of fees and appropriate premiums be devised by Blue Shield to indemnify the insured who undergo procedures requiring an assistant. The assistant in the case, we feel, should render a separate statement and complete a separate Blue Shield blank.

This sub-committee offers a resolution authored by Dr. E. T. Edwards, entitled, "Blue Shield Indemnity Schedule for Surgical Assistants." The commission, as a whole, approves this resolution, which is printed under "Resolutions" and is numbered No. 5.

Knowing that such a schedule of indemnities must apply on a state-wide basis, and should not serve to increase, unduly, surgical costs in any area, this sub-committee, on May 17, 1960, petitioned the Executive Committee to consider referring this matter to the various surgical societies in Indiana, to see if a suggested schedule, acceptable to their members, might be forthcoming.

Sub-Committee C: Blue Cross-Blue Shield X-Ray and Pathology Transfer

Since the action of the House of Delegates in October, 1959, (See ISMA *Journal*, Dec., 1959, p. 2279), this sub-committee has met with representatives of the Indiana Hospital Association (Council of Professional Practice Committee on Third Party Payment), and members of Blue Cross-Blue Shield, the Indiana Roentgen Society and the Indiana Association of Pathologists.

At a meeting on April 13, 1960, it was apparent that the hospital administrators are not willing to accept the proposed transfer of funds for x-ray and pathology from Blue Cross to Blue Shield. In fact, the Indiana Hospital Association adopted a policy in October, 1959, opposing such a plan.

An explanation of the proposed plan was prepared by the Indiana Association of Pathologists and mailed, by the Radiologists and Pathologists, to all hospital administrators and to the chairmen of the boards of trustees of all Indiana hospitals. A list of questions was then prepared by the hospital administrators and presented to us at our April meeting. This sub-committee and its "consultants" are preparing replies to these questions so that a better understanding among all concerned will result. These answers will be given to the hospital group at a meeting to be held before the State Medical Meeting in October, 1960.

In short, the Radiologists and Pathologists have reaffirmed their desire for unity among the medical profession by inclusion of payment for their services under Blue Shield rather than Blue Cross. The hospital administrators have adopted a policy rejecting this. Blue Cross and Blue Shield organizations have played the role of, "spectators." This sub-committee will continue its efforts to present the viewpoint of the doctors and to work for better understanding.

Sub-Committee D: Out-Patient Blue Shield Care

"Patient-oriented" health insurance was the objective of this sub-committee's efforts this year. Most insurance programs have been directed toward hospital care, ignoring the office, the private laboratory and the out-patient hospital services. By further development of out-patient and office diagnostic provisions, especially for individual policy holders, it is believed that prepayment can reduce hospital admissions yet give the patient financial aid in meeting x-ray and laboratory bills. Since these procedures are performed by physicians, a transfer of all physician-service premiums to Blue Shield is advisable.

To present this sub-committee's recommendations to the House of Delegates, two resolutions are offered. The first is entitled, "Resolution Proposing the Transfer of X-ray and Lab Premiums from Blue Cross to Blue Shield to Provide Extended Office and Out-patient Benefits." The second is entitled, "Out-Patient Diagnostic X-ray and Pathology Benefits for Small-Group and Individual Blue Shield Policy Holders."

The Commission, as a whole, endorses these resolutions, which are published in the list of resolutions to be introduced, and are numbered Resolutions No. 6 and No. 7, respectively.

John Langohr, M.D., *Chairman*
Edward T. Edwards, M.D., *Vice-Chmn.*
Lowell I. Thomas, M.D., *Secretary*
Wendell C. Stover, M.D.
William H. Garner, Jr., M.D.
William Scharbrough, M.D.
Hubert T. Goodman, M.D.
Morris D. Wertenberger, M.D.
Albert T. Jones, M.D.
Murray E. Harden, M.D.
Robert N. Bill, M.D.
Richard P. Good, M.D.
George E. Paine, M.D.
J. L. Arbogast, M.D.
John W. Beeler, M.D.

Inter-Professional Relations

The Commission on Inter-Professional Relations has not had need for a meeting since its organizational meeting on Oct. 9, 1959.

At this meeting, Frank H. Green, M.D., was elected chairman; Robert H. Rang, M.D., was elected vice-chairman and Robert D. Howell, M.D., was elected secretary.

A budget of $450 was requested.

It has been the policy in the past that any matters which come to the state medical office, falling in the area of responsibility of this commission, be submitted for action by the commission. None have been presented except the question of osteopathic relations, and this was handled by the Executive Committee and the Council, by order of the House of Delegates.

Representative Frank Green, M.D., and Joe Davis, M.D., of the commission, attended a Grievance Committee hearing which had reference to the osteopathic-

medical relations in certain areas. This report may be found under this committee's report.

Drs. Joe Davis, C. V. Rozelle and Robert D. Howell were appointed to serve on the Joint Committee for the Improvement of Patient Care.

Dr. Nathaniel D. Ewing was asked to serve on the existing Committee of Colleges and Nursing Education. Dr. Robert H. Rang represented the commission on this committee.

Dr. Ewing was notified of the State Association's action to allow $500 for the use of this group.

Dr. Russell J. Spivey was appointed to serve on Dr. Kime's Committee for Anatomical Supply.

The Indiana Association of Pathologists and the Indiana Roentgen Society have alerted the members of this commission of their desire to ask for a change of Blue Cross policy in regard to their professional payment being changed from Blue Cross to Blue Shield. The correspondence was directed to hospital administrators and trustees.

The commission members have been given, by mail, the request of Mrs. Iva Leiferman, of the Public Health Nurses, concerning the continuity care program.

Frank H. Green, M.D., *Chairman*
Robert H. Rang, M.D., *Vice-Chmn.*
Robert D. Howell, M.D., *Secretary*
Joseph D. McDonald, M.D.
William Paynter, M.D.
Kenneth Schneider, M.D.
Paul Humphrey, M.D.
Floyd A. Boyer, M.D.
C. V. Rozelle, M.D.
Kenneth O. Neumann, M.D.
Milton B. Gevirtz, M.D.
Joseph B. Davis, M.D.
Jack L. Eisaman, M.D.
F. R. N. Carter, M.D.
Neal E. Baxter, M.D.

Medical Education and Licensure

The organization meeting for the Commission on Medical Education and Licensure was held Friday, Oct. 9, 1959, at the Columbia Club, Indianapolis. Officers elected were:

Harry L. Land, M.D., Fort Wayne, chairman

Harry E. Klepinger, M.D., Lafayette, vice chairman

Kenneth G. Kohlstaedt, M.D., Indianapolis, secretary

Ralph C. Eades, M.D., Valparaiso, chairman, Sub-Committee on Medical Education

Kemper N. Venis, M.D., Muncie, chairman, Sub-Committee on Licensure

The second meeting of the commission was held on Nov. 15, 1959, at the Student Union Building. At this meeting the commission considered the suggestions made by last year's commission:

1. It should be reported that the resolution requesting a committee of private practicing physicians of the House of Delegates of the AMA be appointed to study the problem of intern training and out-patient service was introduced at the interim session of the House of Delegates of the AMA and that this AMA committee is at present studying the problem.

2. The commission considered a mid-winter scientific meeting at French Lick impracticable in view of all the meetings already established.

3. The commission agreed on a closer liaison between the textbook division of the State Department of Health and the commission committee on Textbooks for Health Teaching in Public Schools should be continued. Dr. Elton Clarke has continued with his fine work in this field this year.

4. A publication, "Suggested School Health Policies for Indiana," was received from the State Board of Health. This had been a previous project of a subcommittee of the Commission on Education and Licensure. Dr. Jack Shields, chairman, Dr. Dallas Fickas and Dr. Robert Harris reviewed these policies and suggested that the commission recommend their acceptance to the Council of the State Medical Association. This acceptance occurred July 10, 1960. It should be pointed out that this is the culmination of some eight or 10 years work and conferences between several groups and that physicians have always been represented in the preparation of these recommended guides. It should also be understood that when these guides are published, they do not become the law as far as school health programs are concerned, but are only recommendations for the use of the school administrators in the State of Indiana.

5. The commission considered it was necessary at this time to have a Sub-Committee to study nursing education and the relationship to practicing physicians. Dr. Kohlstaedt and Dr. Harris were appointed to this committee.

6. The commission recommends that the Indiana State Medical Association establish a special commission to explore all avenues and approaches to improve and stimulate interest in medical ethics, especially re-education among the medical profession.

7. Further recommendations of last year's commission were reviewed and considered to be items already covered by other commissions or by definite AMA policy from the Council on Medical Education of the AMA.

8. Dr. Harry Klepinger was appointed chairman of a committee to have a special program on Hospital Intern Day to provide information for members of the association who were attending representing their hospital as directors of internship. It was planned that Dr. John Mahoney, Assistant Dean, would present the program, giving a survey of all recent graduates of Indiana University School of Medicine concerning educational features of their internship, as well as stipends, living conditions, etc. However, it did not take place because of inability to establish a satisfactory date.

The third meeting of the commission was held at the Student Union Building on April 3, 1960. John Van Nuys, M.D., Edward B. Smith, M.D., and John Hickam, M.D., representing the Indiana University School of Medicine, reported to the commission on present policies at the school. They reported that the movement of the first year of medicine to Indianapolis has worked out well. Indiana University is fifth in

the total enrollment in the nation. They have a full quota of interns at the University and at General Hospital. They reported that there are 51 applicants for Bloomington, but they will accept only 15.

Mr. Robert Yoho of the State Board of Health reported they would make recommendations to the State Department of Public Instruction in January, 1961, for books concerning health to be used in the next five years.

The commission approved a plan whereby an attempt would be made to cooperate with State Teachers Institutes this fall concerning health textbooks. Dr. Ralph Eades is to represent the commission in this project.

The commission considered and it was moved, and seconded, that the Indiana State Medical Association establish a fund not to exceed $500 to be available to assist a candidate, or candidates, in the preparation of a thesis concerned with the survey of health education. This fund is to be allocated to such candidates, with the understanding that this commission would act as advisor and consultant on the several areas on which a thesis might be prepared.

It was moved, seconded, and passed that the Editor of the ISMA *Journal* be requested to disseminate further information concerning school health education programs.

It was the opinion of the commission at this meeting that in the near future some recommendations concerning the relationship of the State Medical Association with the League of Nursing about nursing education should be made.

Dr. Andrew Offutt reported to the commission concerning licensed nursing homes. The commission feels that a copy of the inspection report of the individual nursing homes should be directed to the Indiana State Medical Association and a copy be directed to the secretary of the county medical society in which the home is located.

The commission also recommended that each county medical society should prepare a program to stimulate increased immunizations in their local counties.

The commission met at the Student Union Building for its fourth meeting on May 22, 1960. The meeting was held in conjunction with the State Medical Registration Board and the Committee on Osteopathy of the Indiana Medical Association. A great deal of thought-provoking and exchange of ideas occurred at this meeting.

As a result of this fourth meeting, the Commission on Education passed a resolution that the State Board of Medical Registration and Licensure be requested to re-investigate and re-evaluate the osteopathic schools and their faculties, and if they met the standards of the Indiana State Board that then the situation be reconsidered by the ISMA as to their privileges, and if the House of Delegates of the ISMA approves this action that such information be carried to the House of Delegates of the AMA by our delegates.

It was also recommended that the ISMA be asked to request the Joint Commission on Accreditation to reconsider its qualifications for accreditation of hospitals in the State of Indiana, primarily in regard to osteopathy. It was also recommended that the Council of the Indiana State Medical Association reconsider the ethical relationship of osteopaths and the M.D.'s in the State of Indiana.

The commission endorses the work of the present Board of Medical Registration and Licensure and urges continued support of the efforts of this Board by the ISMA.

The commission studied the problem of narcotic addiction in the practicing physician and since the Grievance Committee is studying the Washington State Medical Society project concerning this, it was recommended that in addition, representatives from the Commission on Education and representatives from the Indiana State Medical Registration Board be included in this study.

We are happy to report that Indiana, for the year 1959, contributed $35,620.00 to the A.M.E.F. Fund. This figure does not include contributions made directly to the A.M.E.F., nor the amount of money raised by the Auxiliary.

The Chairman wishes to thank all members of his committee for their excellent work this year and particularly sub-committee chairmen, Dr. Ralph Eades and Dr. Kemper N. Venis.

Respectfully submitted,
Francis L. Land, M.D., *Chairman*
Harry Klepinger, M.D., *Vice-Chairman*
Kenneth G. Kohlstaedt, M.D., *Secy.*
Dallas Fickas, M.D.
William C. Reed, M.D.
Robert W. Harris, M.D.
Jack E. Shields, M.D.
Basil M. Merrell, M.D.
Norman F. Richard, M.D.
William N. Wishard, Jr., M.D.
Kemper N. Venis, M.D.
Francis E. Carrel, M.D.
Ralph C. Eades, M.D.
Elton R. Clarke, M.D.
Louis E. How, M.D.

Special Activities

The commission has had only one active meeting at which time several items were discussed, as presented by the Council.

The primary interest of this commission is, and has been, American Medical Education Foundation. Since the dues assignment the state's contribution has been quite satisfactory, although the number of contributors has varied greatly.

The Auxiliary of our Association has helped greatly in this fund drive. A cooperative drive with The Indiana University Foundation has not materialized. Several joint meetings with this group, which was originally skeptical, resulted in a study with the A.M.E.F. group from the national office. However, because of a change of A.M.E.F. office leadership, this Indiana University Alumni—A.M.E.F. Fund drive has not been set up.

A second consideration has been rehabilitation and its use in full care of the sick and injured. The commission chairman met with Dr. O'Malley, of Indiana

State Board of Health and her group on this subject. A great amount of study has been made along lines of rehabilitation and its position in medical care. The commission authorized a meeting with the rehabilitation group, but a suitable date was not available. It is noted that many lay groups have entered into this field, both financially and in an advisory capacity. The medical profession does need more interest in this field and education of its members.

The only actual communication or recommendation made to the Council was in regard to a question from the Floyd County Medical Society. The component society requested a clarification by the State Association regarding approval of a "counseling service" offered in the Clark and Floyd County areas. On investigation, the "counseling service" in question was being offered primarily by an ordained minister with psychological training on a fee basis, either on referral or by "walk in." It was sponsored by a local ministerial association and also listed a few physicians as consultants. The chairman, on personal recommendation, suggested to the Council that it not make an approval at the state level. This was substantiated by the Council who so recommended.

The commission does feel that more lay groups are constantly being formed in para-medical fields and they are seeking medical organizational approval and recognition. Whether these groups be rehabilitation, counseling service or other fields, this problem must be faced by organized medicine.

Malcolm O. Scamahorn, M.D., *Chm.*
Guy B. Ingwell, M.D.
Ralph M. Steffy, M.D.
Joseph E. Coleman, M.D.
C. P. Fox, M.D.
Eli Goodman, M.D.
George A. May, M.D.
Norman M. Silverman, M.D.
H. N. Smith, M.D.
Robert M. Butterfield, M.D.
Robert H. Wiseheart, M.D.
Forrest R. LaFollette, M.D.
Earl W. Bailey, M.D.
David C. Gastineau, M.D.
E. M. Sirlin, M.D.

Resolutions

Resolution No. 1

Introduced by: LAWRENCE COUNTY MEDICAL SOCIETY

Subject: RECOMMENDATION IN REGARD TO SPECIALIZATION

WHEREAS, the number of family doctors is being depleted by specialization, and

WHEREAS, the family doctor is being replaced by chiropractors, osteopaths and cultists, and

WHEREAS, the deficiency cannot be met by more graduates from approved medical schools, inasmuch as students proceed directly into specialization, and

WHEREAS, only by having good medical doctors to refer them patients can a specialist obtain an ethical practice, and

WHEREAS, a specialist should understand the relationship of the patient in the family doctor situation; therefore be it

RESOLVED, that the Indiana State Medical Association recommend to all Specialty Boards and to the American Medical Association that all applicants have at least two years' general practice as a requirement for specialization.

Resolution No. 2

Introduced by: MARION COUNTY MEDICAL SOCIETY

Subject: RELATIVE VALUE SCHEDULES

[*The Marion County Medical Society submits the following resolution to the House of Delegates of the Indiana State Medical Association, without prejudice and with the explanation that it is submitted solely to bring its contents to a vote. The society has taken no official position on relative value schedules.*]

WHEREAS, there is diversity and inadequacy in many insurance schedules, with improper fee relationships from one procedure to another, and

WHEREAS, these schedules were originally devised by insurance companies not having special knowledge of the work involved in various medical procedures, and

WHEREAS, the doctors of Indiana are best qualified to catalogue properly the relative values of one procedure compared to another within this state, and

WHEREAS, the insurance companies and the medical profession would benefit by the doctors establishing a relative value schedule,

THEREFORE, BE IT RESOLVED, that the Indiana State Medical Association adopt and publish a relative value schedule, without a conversion factor, for the use of its members and any other agencies in the field of health for reference and guidance in the determination of value relationships of one medical, surgical, x-ray, or laboratory procedure to another.

Resolution No. 3

Introduced by: LAKE COUNTY MEDICAL SOCIETY

Subject: IMPARTIAL MEDICAL WITNESS PLAN

WHEREAS, the Impartial Medical Witness Plans in the Federal Courts of several cities, outside the State of Indiana, have been tried for periods of up to seven years and have proven to be of value to physicians in those areas, and

WHEREAS, Indiana Federal Court Justices have indicated a desire to institute similar plans in their courts, and

WHEREAS, a study made by the Lake County Medical Society has determined a need for such a program in Indiana, and

WHEREAS, the formation of the necessary panel of qualified and impartial physicians is difficult, if not impossible, on a county-wide basis; now therefore,

BE IT RESOLVED, that the Indiana State Medical Association undertake to assist in bringing about the Impartial Medical Witness Plan on a regional basis corresponding with each Federal Court, or on a statewide basis to serve all Federal Courts in Indiana.

Resolution No. 4

Introduced by: MADISON COUNTY MEDICAL SOCIETY

Subject: RESOLUTION REJECTING RELATIVE VALUE SCALE AND THIRD PARTY CONTROL OF MEDICAL SERVICES AND FEES

WHEREAS, the determination of a physician's fees is an individual matter, to be arrived at by mutual understanding between the physician and his patient, and

WHEREAS, any attempt by any other party to influence the conduct of the individual patient-physician relationship, in the matter of arriving at a satisfactory charge for service, is unjustified and endangers personal liberty, and

WHEREAS, service contracts offered by medical care plans represent an example of third party pay or interference, and

WHEREAS, the use of a relative value scale, in conjunction with a conversion factor results in creating fixed fee schedules varying by geographic and political areas and which are announced by organized physician groups serve the interests of unions, medical care plans, insurance companies and other groups, both to promote their insistence on the acceptance of a fixed set of physicians' fees and to divide those physicians unwilling to participate from their colleagues, and

WHEREAS, a relative value scale, with its conversion factor, in the face of organized group and general public pressures against justifiable fee increases, would impose unjustifiable economic restrictions, which would prove to be a financial hardship

to physicians, from which the only hope for relief would be in the direction of bargaining with representatives of labor, and insurance companies, medical care plans and others.

THEREFORE, BE IT RESOLVED that the Madison County Medical Society condemns and rejects the relative value scale, third party control of medical services, and fees, including all government medical programs, and service plan contracts as dangerous devices capable of doing great harm to patients, physicians and the medical profession, and

BE IT FURTHER RESOLVED, that a copy of this resolution be presented to the Eighth District Medical Society Meeting at Anderson, Indiana, 8 June 1960, and to the Indiana State Medical Association, House of Delegates, at the annual meeting at French Lick, Indiana, to be held in October, 1960.

Resolution No. 5

Introduced by: COMMISSION ON MEDICAL ECONOMICS AND INSURANCE, SUB-COMMITTEE B—COOPERATIVE CARE OF THE SURGICAL PATIENT

Subject: BLUE SHIELD INDEMNITY SCHEDULE FOR SURGICAL ASSISTANTS

WHEREAS, Blue Shield (Mutual Medical Insurance) was established to encourage patients to insure against medical costs by prepayment, and

WHEREAS, there is no provision for payment to surgical assistants through Blue Shield indemnities, and

WHEREAS, it is considered unethical for a surgeon to designate any portion of the presently scheduled surgical indemnity to be paid to an assistant, and

WHEREAS, an assistant is deemed necessary in a number of major surgical procedures, and should bill the patient a reasonable fee for such services,

THEREFORE, BE IT RESOLVED, that the House of Delegates request the Blue Shield Board to establish an additional indemnity schedule for surgical assistants, requiring separate claim forms to be submitted by the assistant, and

BE IT FURTHER RESOLVED, that the indemnity schedule for surgical assistants be established at $20 for the first hour, and $10 for each succeeding hour, or portion thereof, not to exceed a total of three hours, or $40, and

BE IT FURTHER RESOLVED, that minor surgical cases, suc has T and A's, D and C's, and other procedures not requiring an assistant by good surgical principles (see definitions by College of Surgeons and Accreditation Commission) be *not* included in the schedule, and

BE IT FURTHER RESOLVED, that interns and residents, or others being trained in a hospital training program, be *not* awarded the assistant's indemnity.

Resolution No. 6

Introduced by: COMMISSION ON MEDICAL ECONOMICS AND INSURANCE, SUB-COMMITTEE D, OUT-PATIENT BLUE SHIELD CARE

Subject: RESOLUTION PROPOSING THE TRANSFER OF X-RAY AND LAB PREMIUMS FROM BLUE CROSS TO BLUE SHIELD TO PROVIDE EXTENDED OFFICE AND OUT-PATIENT BENEFITS

WHEREAS, health insurance programs should enable the public to insure against large expenses resulting from illness, and

WHEREAS, in 1946, when Blue Shield was formed, Blue Cross agreed to transfer premium earnings to pay radiologist and pathologist fees to Blue Shield when the latter was financially solvent, and

WHEREAS, such transfer of funds requires a relatively small administrative cost, and

WHEREAS, this is now being done in Indiana in the payment of fees for x-ray therapy and in other Blue plans for diagnostic procedures, and

WHEREAS, it is *not* necessary to change the radiologist's or pathologist's personal contract with his hospital to provide such changes between the two insurance companies, and

WHEREAS, such a change will reduce hospital admission of ambulatory patients who could receive expensive x-ray and lab studies as office or out-patients,

THEREFORE, BE IT RESOLVED, that the House of Delegates of the Indiana State Medical Association, at its annual meeting, October, 1960, recommend to the Boards of Blue Cross and Blue Shield that the appropriate amounts of the Blue Cross premiums representing x-ray and lab benefits be transferred to Blue Shield.

Resolution No. 7

Introduced by: COMMISSION ON MEDICAL ECONOMICS AND INSURANCE, SUB-COMMITTEE D, OUT-PATIENT BLUE SHIELD CARE

Subject: OUT-PATIENT DIAGNOSTIC X-RAY AND PATHOLOGY BENEFITS FOR SMALL-GROUP AND INDIVIDUAL BLUE SHIELD POLICY HOLDERS

WHEREAS, an increasing number of hospital admissions of ambulatory patients has increased the cost of medical care, and

WHEREAS, changing social and economic factors have removed much of the patient's desire to stay out of the hospital, and

WHEREAS, the emphasis on hospital-oriented insurance programs has reduced the public understanding that quality medical care can be obtained in an office,

on an ambulatory basis, by well qualified—often the same—physicians as in a hospital,

THEREFORE, BE IT RESOLVED, that the House of Delegates at its annual meeting in October, 1960, recommend to the Blue Shield Board that a policy be provided for individual and/or small groups which would include payment of office and/or hospital out-patient x-ray and laboratory fees to qualified physicians as designated by local medical societies on the basis of their training, experience and capabilities, and

BE IT FURTHER RESOLVED, that these payments not exceed 80% of the hospital in-patient fee for the same procedure in that community, with a maximum of $100 per year per contract, and with the usual restrictions used in the present riders for such benefits.

Scientific Exhibits

ROBERT O. ZINK, M.D., *Madison, Chairman*

NURSING RESOURCES

Exhibitor: Indiana League for Nursing, Indianapolis

PROGRESSIVE MUSCULAR DYSTROPHY

Exhibitor: Muscular Dystrophy Association of America, Inc., New York, N. Y.

THE SERVICE PROGRAM OF THE AMERICAN CANCER SOCIETY, Exhibit A

Exhibitor: American Cancer Society, Indiana Division, Indianapolis.

HEMOPHILIA

Exhibitor: Midwest Chapter of the National Hemophilia Foundation, Chicago, Ill.

INDIANA OCCUPATIONAL THERAPY ASSOCIATION

Exhibitor: Indiana Occupational Therapy Association, Indianapolis.

REHABILITATION FROM BIRTH THROUGH RETIREMENT

Exhibitor: American Physical Therapy Association, Indiana Chapter, Indianapolis.

PROPIONYL ERTHROMYCIN—LABORATORY AND CLINICAL CONSIDERATIONS

Exhibitor: R. S. Griffith, M.D., Marion County General Hospital, Indianapolis.

A NEW ULTRA SHORT ACTING BARBITURATE—METHOHEXITAL SODIUM FOR INTRAVENOUS ANESTHESIA

Exhibitor: V. K. Stoelting, M.D., Indiana University Medical Center, Indianapolis.

PHARMACY AND MEDICINE

Exhibitor: Indiana Pharmaceutical Association, Indianapolis.

HEART-IN-ACTION

Exhibitor: J. B. Roerig & Co., New York, N. Y.

GOOD MENTAL HEALTH DEPENDS ON YOU

Exhibitor: Indiana Association for Mental Health, Indianapolis.

Co-Exhibitor: Orange County Association for Mental Health.

RESISTANT URINARY TRACT INFECTIONS

Exhibitor: Robert Lich, Jr., M.D., Louisville, Ky.

Co-Exhibitors: Lonnie W. Howerton, M.D.; Lawrence A. Davis, M.D.; Joseph E. Maurer, M.D.; University of Louisville School of Medicine and Children's Hospital.

IMMEDIATE CHOLANGIOGRAPHY or (OPERATIVE CHOLANGIOGRAPHY)

Exhibitor: Caylor-Nickel Clinic, Bluffton, Ind.

Co-Exhibitors: Harold D. Caylor, M.D.; Pierre C. Talbert, M.D.; Robert R. Bishop, M.D.; Donald W. Meier, M.D., Clinic Hospital, Bluffton, Ind.

CONSULT YOUR PATHOLOGIST

Exhibitor: Indiana Association of Pathologists, Terre Haute, Ind.

Co-Exhibitors: Jack G. Weinbaum, M.D., Terre Haute; Paul Evans, M.D.; Methodist Hospital, Indianapolis; Thomas A. Stump, M.D., I. U. Medical Center, Indianapolis; Harold C. Thornton, M.D., Indianapolis; Charles E. Geckler, M.D., Muncie.

MANAGEMENT OF DEPRESSION IN GENERAL MEDICINE

Exhibitor: Hans Tauber, M.D., New York, N. Y.

Co-Exhibitors: Joseph L. Bell, M.D., and Albert C. Santy, M.D., New York, N. Y. Frank Pulito, M.D., Freeport, Long Island, N. Y.

DIAGNOSIS OF XANTHOMATOSIS

Exhibitor: Richard M. Caplan, M.D., University of Michigan Hospital, Ann Arbor, Mich.

Co-Exhibitors: Paul Winder, M.D.; Richard M. Caplan, M.D.; Walter Block, Ph.D.; Arthur C. Curtis, M.D., University of Michigan Medical Center.

WHO HAS V. D.?

Exhibitor: Indiana State Board of Health, Indianapolis.

Co-Exhibitor: United States Public Health Service, Communicable Disease Center.

MICHIGAN'S PROGRAM IN POSTGRADUATE MEDICINE

Exhibitor: The Department of Postgraduate Medicine, University of Michigan Medical Center, Ann Arbor, Mich.

Co-Exhibitors: John M. Sheldon, M.D., Director, Department of Postgraduate Medicine; Harry A. Towsley, M.D., Associate Director, Department of Postgraduate Medicine; Park W. Willis, III, M.D.; George H. Lowery, M.D.; Thomas Flotte, M.D.; Samuel J. Behrman, M.D., The University of Michigan, Medical Center, University Hospital, Ann Arbor, Mich.

DEVELOPMENT OF COMPREHENSIVE REHABILITATION SERVICES FOR SEVERELY HANDICAPPED YOUNG PEOPLE

Exhibitor: James A. Carter, Administrative Assistant, Indiana Society for Crippled Children and Adults, Inc., Indianapolis.

DOUBLE-BLIND EVALUATION OF A NEW AGENT IN MUSCULO-SKELETAL DISORDERS

Exhibitor: C. David Cooper, M.D., Washington, D. C.

Co-Exhibitors: Charles S. Wise, M.D., Charles R. Peterson, M.D., Jerome Epstein, M.D., George Washington University School of Medicine, Washington, D. C.

DOES ECG CONTRAINDICATE ECT?

Exhibitors: Melvin Shalowitz, M.D., Charles Pfister, M.D., R. G. Novick, M.D., The Forest Hospital, Des Plaines, Illinois.

NOTES

Technical Exhibits

Booth **Company and Products**

38 **ABBOTT LABORATORIES,**
North Chicago,
Abbott Laboratories invites you to visit our exhibit. Our representatives will be happy to answer any questions you may have concerning our leading products and new developments.

28 **AKRON SURGICAL HOUSE, INC.,**
Indianapolis 4
Clarence Lippott, Ed Hallyburton
Akron Surgical House, Inc., is pleased to announce its exhibit at the annual convention of the Indiana State Medical Association on Oct. 3, 4 and 5, 1960.

Clarence Lippott and Ed Hallyburton will be on hand in our booth to answer any questions about the items of instruments and equipment to be on display.

32 **AMES COMPANY, INC.,**
Elkhart, Ind.
William E. Furrow, David Kishline
Ames Company, Inc. will feature Decholin with Belladonna and its effectiveness in pregnancy and Combistix, the "dip-and-read" reagent strip for protein, glucose and the determination of pH.

The Ames representatives will be pleased to discuss the use of Clinitest and Acetest in the detection and management of the diabetic patient.

26 **BLACK & SKAGGS ASSOCIATES,**
Fort Wayne-Indianapolis
Harold L. Neff, Paul D. Evans, John B. Hogan, Allison E. Skaggs
John Hogan of Battle Creek, Harold Neff of Fort Wayne and Paul Evans of Indianapolis will welcome Indiana physicians at Booth 26.

PM clients are urged to bring in their friends who want to discuss their problems relating to the business side of medicine.

16 **THE BORDEN COMPANY,**
New York, N. Y.
Featuring Bordens new pediatric creme Methakote for the treatment of diaper rash in all degrees of severity. Eliminates B ammoniagenes, the causative factor and prevents staph and other secondary invaders. The added sulphur bearing amino acids accelerate wound healing at site of lesion. Information on Methakote and our infant formulas, Bremil and Mull-Soy, is available through our courteous representatives.

3 **GEORGE A. BREON & COMPANY,**
New York 18, N. Y.

23 **THE CENTRAL PHARMACAL COMPANY,**
Seymour, Ind.
Norman Kolbe
Central's exhibit will feature Cenasert Improved, an effective new weapon for treating Trichomonal, monilial and bacterial vaginitis. Medical service members of our staff will be in attendance at our booth to discuss this specialty and others that will be on display.

15 **THE CHLORASEPTIC COMPANY,**
Washington 1, D. C.
Dr. Robert I. Schattner, Elsa Glass
Chloraseptic is specifically designed to destroy infectious bacteria while relieving soreness and pain.

Clinical tests by nose and throat specialists, oral surgeons and by a medical school on hospital patients, proved Chloraseptic to be a non-toxic and efficient aid in the healing process. According to laboratory findings Chloraseptic destroys infectious bacteria in 15 seconds.

Booth **Company and Products**

4 **CIBA PHARMACEUTICAL PRODUCTS INC.,**
Summit, N. J.
Ismelin is a new Ciba antihypertensive indicated in advancing hypertension. Alone, or in combination, it has lowered blood pressure effectively in 80 to 90% of patients.

Ismelin affords a new way to control hypertension: Since Ismelin acts at the site of arteriolar blood pressure regulation—that is, the nerve-arteriole junction—it has no central or parasympathetic effects. Ciba representatives will be glad to discuss this and other Ciba products.

108 **THE COCA-COLA COMPANY,**
Atlanta 1, Ga.
Ice-cold Coca-Cola served through the courtesy and cooperation of the Coca-Cola Bottling Company Inc., of Jasper and The Coca-Cola Company.

40 **CURTIS AND FRENCH, INC.,**
Indianapolis 2
Jack Curtis, Mac McCain
Curtis and French, Inc. again extends to all their many friends a hearty welcome to visit Jack Curtis and Mac McCain at Booth 40. We expect to show as many new items as we think you will be interested in.

114 **DePUY MANUFACTURING COMPANY, INC.,**
Warsaw
Tip Welker, Mrs. C. L. Welker, J. Keaton Landis
Tip Welker will be showing the latest in splints, orthopedic appliances and fracture equipment.

Besides the newest innovations for the orthopedic surgeon, a full line of those products for the doctor in general practice is also on display.

31 **DESITIN CHEMICAL COMPANY,**
Providence, R. I.
Mr. Ames Fennell
Desitin Ointment, for treatment of burns, ulcers, diaper rash, abrasions, etc.; Desitin Powder, relieves chafing, sunburn, diaper rash, etc.; Desitin Suppositories and Rectal Ointment, relieve pain and itching in uncomplicated hemorrhoids, fissures; Desitin Baby Lotion, protective, antiseptic; Desitin Acne Cream, a non-staining, flesh-tinted "Medicream" for the treatment of acne vulgaris; Desitin Cosmetic and Nursery Soap, supermild; Desitin Suppositories with Hydrocortisone, prompt response to inflammatory conditions in proctitis, severe pruitus, edema.

17 **DICTAPHONE CORPORATION,**
New York, N. Y.
G. I. Colombel, Ray West, Ron Forrest
For Busy Doctors—Dictaphone time-master dictating equipment, featuring the famous Dictabelt record, saves time and trouble in maintaining case histories, files and correspondence. For busy clinics and hospitals—Dictaphone Corporation presents the telecord system of network dictation by phone, which extends dictating facilities to any number of remotely-located areas, with recording and transcription centralized.

Try, too, the new portable, battery-powered Dictet recorder for out-of-the-office use.

10 **THE DIETENE COMPANY,**
Minneapolis, Minn.
Earl Rohe
Meritene is the good-tasting protein-vitamin-mineral food supplement prescribed to provide concentrated nutrition for patients with poor appetite or tolerance for ordinary food. Let us serve you a cool, refreshing Meritene nourishment.

While there, review also our Dietene Reducing Plan, designed to get better cooperation from over-weight patients. The Dietene Plan provides optimum nutrition and maximum satiety without drugs.

Booth	Company and Products

121 THE DOHO CHEMICAL CORPORATION, New York, N. Y.

Karl Coleman

Doho Chemical Corporation is pleased to exhibit Auraigan for Ottis Media and removal of cerumen, Otosmosan, fungicidal and bactericidal in the suppurative and aural dermatomycotic ears, Rhinalgan, nasal decongestant, and Laryigan, throat spray and gargle.

From Mallon Chemical Corporation, Division of DOHO, we will exhibit Rectalgan, for relief of pain and discomfiture in hemorrhoids, pruritus and perineal suturing, and Dermoplast, an aerosol spray for surface pain, burns and abrasions.

102 EATON LABORATORIES, Norwich, N. Y.

R. M. O'Hanlon, A. E. Bower

Furacin®, brand of nitrofurazone, Cream aids cervical and vaginal tissue toward a rapid return to a healthy, normal state in the postpartum period; safely controls cervicovaginal infection in the puerperium, prevents chronicity; averts infection and delayed healing of cervix and episiotomy wound; reduces discharge, irritation and malodor; increases postpartum comfort.

110 ENCYCLOPEDIA BRITANNICA. Indianapolis

Robert Vaughn, James F. Bruce

Now Available—Direct from the Publisher—The brand new 1960 edition of Encyclopedia Britannica. During your visit to the Indiana State Medical Association Convention in French Lick, Oct. 2nd thru 5th, be sure to drop by our booth 110 and say hello.

115 MARSHALL ERDMAN & ASSOCIATES, INC., Madison, Wis.

Erdman Prefabricated Medical Buildings are the result of years of experience in the field of design, manufacturing and construction. No other company has had as extensive experience in this field. Over 300 doctors are now practicing in Erdman-built Medical Buildings. Experienced Architects, Engineers and Construction Superintendents of the Erdman Company will design, manufacture and build your Medical Building from the land-planning stage until you open the door into your own office.

104 THE FOREST HOSPITAL, Des Plaines, Ill.

Morris B. Squire, Brenda Handforth

The exhibit will introduce Forest Hospital to Indiana physicians. Forest Hospital is a 90-bed private psychiatric hospital, one of only 53 hospitals fully approved by the American Psychiatric Association. Forest Hospital is also approved by the Joint Commission on Accreditation of Hospitals and by the Blue Cross-Blue Shield Commission.

35 GREAT BOOKS OF THE WESTERN WORLD, Chicago, Ill.

Armin Eastman, Lorraine Eastman, Hal Sloane

The Great Ideas Program featuring the master-key to the Great Books . . . the Syntopicon.

A new advancement in liberal education, is built around the revolutionary Syntopicon. This master-key "Idea-Indexes" all the Great Books, making it possible to find what the great writers and thinkers said about any ideas in minutes. The program will help business and professional people, students, graduates—or anyone interested in exploring the fascinating world of great ideas.

Booth	Company and Products

1 J. E. HANGER, INC., Indianapolis 2

A warm welcome awaits you at Hanger's prosthetics display. Discuss with the trained personnel in attendance your patients' prosthetic needs. Also see models of the newly developed Patella Tendon Bearing legs for below knee amputations, quad muscle contoured sockets for the above knee amputee and all new developments of research by the University of California, New York University and Northwestern University.

112 H. J. HEINZ COMPANY, Pittsburgh, Pa.

20 INDIANA NATIONAL BANK, Indianapolis

George W. Eggleston, Cornelius O. Alig, Jr., Merle H. Miller, Jr.

The Indiana National Bank booth will be staffed by officers from the bank's Trust Department who are specialists in the investment management and trust fields.

These men are well qualified to discuss agency accounts, living trusts and estate management.

19 LEDERLE LABORATORIES, Pearl River, New York, N. Y.

You are cordially invited to visit the Lederle booth where our medical representatives will be anxious to discuss the latest products applicable to your practice.

Featured will be Declomycin® Demethylchlortetracycline, the most recent contribution to broad-spectrum antibiotic therapy, Aristocort® Triamcinolone, the highly effective, well tolerated corticosteroid, and other Lederle products.

41 ELI LILLY AND COMPANY, Indianapolis 6

Harley Chastain, Jack W. Hill, E. C. Horst

You are cordially invited to visit the Lilly exhibit located in space 41. The Lilly sales people in attendance welcome your questions about Lillly products and recent therapeutic developments.

105 J. B. LIPPINCOTT COMPANY, Philadelphia, Pa.

J. W. Colen

7 LOUISON'S PHARMACEUTICALS, Evansville

Bert Bonnell, Norman McKean, Lowell Eastham

Louison's pharmaceuticals of Evansville is a first-time exhibitor this year. They distribute a quality line of prescription specialty items which will be of interest to every doctor at the meeting.

You are cordially invited to drop in at booth seven on the main floor for a "get acquainted" chat with Louison's representatives, Mr. Norman McKean and Mr. Bert Bonnell.

113 MALTBIE LABORATORIES, DIVISION WALLACE & TIERNAN, INC., Belleville, N. J.

Maltbie Laboratories announces an entirely new chemical entity, Dornwal, a non-sedative tranquilizer that works for greater therapeutic effect. Also featured are: Caldecort, an antifungal, antibacterial, anti-inflammatory dermatologic ointment; Desenex, for athlete's foot; Nesacaine, a safe, potent and rapid-acting local anesthetic; Cholans, for hepato-biliary dysfunction; and Caldesene Medicated Powder for diaper rash.

119 THE S. E. MASSENGILL COMPANY, Bristol, Tenn.

Ed Manson, Bill Axsom

Booth	Company and Products
39	**MEAD JOHNSON & COMPANY, Evansville** Oscar L. Miller, in charge; John Floren, John F. Steen The Mead Johnson exhibit has been arranged to give you the optimum in quick service and product information. To make your visit productive, specially trained representatives will be on duty to tell you about their products.
107	**MEDCO PRODUCTS COMPANY, Tulsa, Okla.**
48	**THE MEDICAL PROTECTIVE COMPANY, Fort Wayne** Kenneth W. Moeller, A. Russell Quilhot As the Number One Malpractice Insurer, The Medical Protective Company offers unexcelled coverage. With exceptional proficiency in defense, so essential to the doctor's protection today, its experience in successfully handling 80,000 claims and suits during 61 years of professional protection exclusively is unparalleled in the professional liability field.
46	**MERRILL LYNCH, PIERCE, FENNER & SMITH, INC. Indianapolis 4** Robert T. Shumaker, Fredric Massena
106	**MILEX-ALPHA PRODUCTS, Morton Grove, Ill.**
122	**MILLER SURGICAL COMPANY, Chicago 39, Ill.** William E. Mettler See the Miller Electro-scalpel, Mark C Model, Miller Radiotherm and Surgidyne (Tube and Spark Gap Unit). These cutting, coagulating and desiccating units are calibrated to do the most delicate work as well as light major surgery. Accessories such as snares, coagulator w/smoke ejector, suction tubes and grasping forceps also available. Also diagnostic equipment: illuminated otoscopes, ophthalmoscopes, eyespud with magnet, transillumination lamps, headlites, vaginal speculum with smoke ejector and Gorsch designed stainless steel protoscopes and operating scopes, all sizes with magnification. See the variable wall rayostat which converts battery operated equipment to electric.
118	**V. MUELLER & CO., Chicago, Ill.**
42	**MUTUAL MEDICAL INSURANCE, INC., (The Blue Shield Plan), Indianapolis** R. S. Saylor, L. E. Converse, R. C. Kilbourn Mutual Medical Insurance, Inc. (Blue Shield Plan) will have its exhibit in Booth 42. Representatives of the Plan will be on hand at all times to answer questions and be helpful in any way possible. Special materials will be distributed explaining the operation of the Plan, the benefits it affords the physician and the public.
18	**NATIONAL DRUG COMPANY, Philadelphia, Pa.**
120	**ORTHO PHARMACEUTICAL CORPORATION, Raritan, N. J.** Erick G Tysklind, in charge; David D. L. Johnson, Ronald P. Flynn, Richard L. Johnston, Walter R. Phillips At booth 120, Ortho is featuring a new monilicidal vaginal cream, Sporostacin. This emollient white cream contains the unique chemical chlordantoin which, because of its structure, has the unusual ability to penetrate the monilial membrane. Clinically proved, Sporostacin Chlordantoin Cream is the treatment of choice in monilial vaginitis.
37	**PARKE, DAVIS & COMPANY, Detroit 32, Mich.** B. S. Pearce, L. F. Limoges Medical Service members of our staff will be in attendance at our booth to discuss important Parke-Davis specialties which will be on display.
49	**PFIZER LABORATORIES, Brooklyn, N. Y.** The Pfizer Laboratories' display has been specifically arranged for your convenience and to give you the maximum in quick service and product information. To make your visit worthwhile, technically trained medical service representatives will be on hand to discuss with you the latest developments in Pfizer research.
45	**PITMAN-MOORE COMPANY, Indianapolis 6, Ind.** You are cordially invited to attend Pitman-Moore's booth where the newest Pitman-Moore specialty is displayed, and where experienced representatives will be in attendance.
2	**REX BUSINESS MACHINES CO., Indianapolis 4** Curt Benner The Rex Business Machines Co. will have on display a complete line of office machines for the doctor's office, including typewriters, adding machines, dictation machines, check protectors. Rex is exclusive dealer for the Stenorette dictation machines and Olympia typewriters. A 10% discount will be given on any equipment purchased during the convention, with the exception of Stenorette dictation machines.
6	**R. J. REYNOLDS TOBACCO COMPANY, Winston-Salem, N. C.** C. A. Burgess, B. H. Crawford Welcome to the R. J. Reynolds Tobacco Company Exhibit! You are cordially invited to receive a cigarette case (monogrammed with your initials) containing your choice of Camel, Winston Filter, Menthol Fresh Salem or Cavalier King Size Cigarettes.
24	**RICKRICH SURGICAL SUPPLIES, INC., Evansville 10** I. J. Rickrich, George F. Carter, John J. Stephens All physicians are cordially invited to visit our display in Booth 24. The most modern of sterilizing, physical therapy and EKG equipment will be shown, as well as many other items.
12	**A. H. ROBINS COMPANY, INC. Richmond, Va.** Don Rasico, Bob Fortune, D. W. Otoupal For the relief of pain due to or associated with skeletal muscle spasm Robins presents Robaxisal (Robaxin with aspirin) and the new Robaxisal-PH (Robaxin with Phenaphen). Also shown at this meeting: Adabee and Adabee-M, Robins therapeutic multivitamin without B_{12} or folic acid; Dimetane Expectorant; and the comprehensive analgesics Phenaphen and Phenaphen with Codeine.
25	**ROCHE LABORATORIES, Nutley, N. J.** John Hansen Librium—completely new therapeutic agent for superior, safer, faster control of anxiety, tension, common emotional disturbances without dulling effect or depressant action of tranquilizers. Madribon—completely different, low-dosage sulfonamide of value in treatment of bacterial infections, especially respiratory. Tigan—specific antiemetic agent effective prophylactically and therapeutically against most clinically significant type of nausea and vomiting.

Booth	Company and Products

33 **J. B. ROERIG AND COMPANY,**
New York, N. Y.

30 **ROSS LABORATORIES,**
Columbus, Ohio

William Bolling, Don Turner

Ross Laboratories, manufacturer of Similac, features Similac With Iron, a new prepared infant formula supplying 12 mg of ferrous iron per quart of formula.

Similac With Iron is designed for use at the time exogenous iron is indicated in infancy to support the usual diet and to provide prophylaxis against iron deficiency during the period of greatest incidence, from 6 to 18 months of life.

117 **SANBORN COMPANY,**
Waltham 54, Mass.

14 **SANDOZ PHARMACEUTICALS,**
Hanover, N. J.

47 **W. B. SAUNDERS COMPANY,**
Philadelphia, Pennsylvania

Among the new Saunders books published since last year's Meeting these clinical titles are especially noteworthy: Williamson: Office Diagnosis, Bakwin & Bakwin: Behavior Disorders in Children, Mulholland, et al.: Surgical Management II, Schaffer: Diseases of the Newborn, Greenhill: Obstetrics and Garrison's History of Medicine.

123 **SCHERING CORPORATION,**
Bloomfield, N. J.

Carl Sievert, Edwin Leinhos

Schering Corporation welcomes the members of the Indiana State Medical Association. Schering products to be featured will include: Fulvicin, the first oral antifungal antibiotic for ringworm; Rela, a new muscle relaxant-analgesic that eases sprains, strains and low back pains; Alpen, the new synthesized oral penicillin; Naqua, effective new oral diuretic—and antihypertensive.

21 **JULIUS SCHMID, INC.**
New York

36 **CLAYTON L. SCROGGINS ASSOCIATES,**
Cincinnati 19, Ohio

This professional business management firm has rendered a complete and comprehensive service to physicians exclusively since 1945.

A few moments at this booth may be the most important moments you could devote.

Tax returns—Bookkeeping—Office Layouts—Individually Typed Letters to Delinquent Accounts (No Commission)—Personnel Selection and Instruction—Fees—Partnerships—Investments.

109 **SEALY MATTRESS COMPANY,**
Louisville, Ky.

William A. Edie

Have thirty seconds? That's all the time needed to accurately measure your exact bedding requirements with the new scientific Sealy Conform-a-graph. In just ½ minute the Conform-a-graph will show you: 1. Degree of firm sleeping support you require. 2. Correct bedding length to fit your height. 3. Visual graph of your own individual weight distribution.

See for yourself. And at the same time comfort test Sealy's famous Posturepedic, designed with the help of leading orthopedic surgeons.

Booth	Company and Products

29 **G. D. SEARLE & CO.,**
Chicago 80, Ill.

Ed Rinderknecht, George Standley

You are cordially invited to visit the Searle booth where our representatives will be happy to answer any questions regarding Searle Products of Research.

Featured will be our new Aldosterone-Blocking Agent for edema or ascites, Aldactone.

100 **SEVEN-UP BOTTLING COMPANY, INC.**
Indianapolis

13 **E. R. SQUIBB AND SONS,**
New York, N. Y.

44 **STERILMASTER COMPANY,**
Los Angeles 25, Calif.

James Bowden

Sterilize with Sterilmaster Autoclave—completely automatic, two efficient portable sizes. The very minimum of moving parts—only two solenoid valves—makes it trouble free. The stainless steel jacket and gray hammertone base lets it blend nicely with other equipment.

9 **STORCK PHARMACEUTICALS,**
St. Louis, Mo.

Storck will feature: (1) Tetrasule, the pioneer protracted PETN, suggesting three ways to get better results with any angina pectoris regimen; (2) Quinette Insert, the 12-day therapy for tenacious trichomonas and mixed vaginal infections; (3) Watr-Wax, the insert base which assures rectal absorption equal to oral in combatting migraine and nauseas.

5 **THE STUART COMPANY,**
Pasadena, California

John W. Nichol, Jr., Hugh Wallace, Patrick Fellinger

11 **THERMO-FAX SALES, INCORPORATED,**
Indianapolis 2

Dale Bond, John Starkey

There are more Thermo-Fax Copying Machines at work in more offices than any other make. Here's Why: Its the fastest—four second speed! Its the cleanest—no chemicals—all electric, its the easiest one-step operation.

Thermo-Fax Copying Machines are manufactured by Minnesota Mining & Manufacturing Company. Five different models are available.

101 **S. J. TUTAG & COMPANY,**
Detroit 34, Mich.

Frank Duesterbeck, Shelby Crouch, Edward Pabst, Stanley Tutag, Richard Teagan, Bill Wilber

Introducing Kelatrate, hematinic that is "Non-Ferruginous" in character containing not only chelated iron but chelated minerals as well. These are supported by the B-Complex Vitamins.

Also introducing a new antiobesity agent for prompt and emphatic hunger control—with little or no central nervous system stimulation. Cydril, new chemical compound that possesses anorectic action with low toxicity, is available in two forms: Tablet and the sustained-release Tutag Granucap (T. M. Reg. U.S. Pat. Off.).

43 **U. S. STANDARD PRODUCTS CO.,**
Mount Prospect, Ill.

William H. Snider, William K. Base

Featuring Americaine topical anesthesia for effective and prolonged relief of surface pain and itching, in ointment and aerosol form.

Also Isoclor, new antihistamine-decongestant for oral relief of nasal, sinus, and chest congestion. Extends range in decongestant therapy from relief of simple nasal congestion to include chest discomfort; to permit free breathing and inhibit excessive mucosal discharge, postnastal drip, and resulting night cough.

Booth	Company and Products
27	**U. S. VITAMIN & PHARMACEUTICAL CORPORATION, New York 17, N. Y.** D B I—new "full-range" oral hypoglycemic agent. D B I, brand of phenformin (N^1-B-phenethylbiguanide HCl) is distinctly different in chemical structure and physiologic action from the oral hypoglycemic sulfonylureas. Effectively lowers blood sugar and eliminates glycosuria in mild, moderate and severe diabetes. D B I, in combination with insulin, improves regulation of "brittle" adult and juvenile diabetes.
111	**WARNER-CHILCOTT LABORATORIES, Morris Plains, N. J.** Jack Goodrich, in charge; James Kleinhelter, H. Wayne Cumbee Nardil—safe, new, rapidly effective treatment for true (endogenous) depression, restores depressed and despondent patients to reality, no toxic effect on blood, liver or kidneys. Gelusil—the physician's antacid—for the relief of gastric hyperacidity and management of peptic ulcer. Provides two protective coating gels for prompt, prolonged relief of pain. Peritrate—long-acting coronary vasodilator for patients with coronary artery disease—whether angina pectoris or coronary occlusion. Peritrate improves coronary blood flow, thereby increasing collateral circulation, with no significant change in blood pressure or pulse rate. Smooth onset of action virtually eliminates nitrate headache.

Booth	Company and Products
34	**THE WARREN-TEED PRODUCTS CO. Columbus, Ohio** William Haydock, John L. Cron The Warren-Teed Products Company representatives cordially welcome all registrants to visit their display booth featuring four pharmaceutical specialties. Chymolase—aqueous sterile solution of chymotrypsin for relief of local inflammation and/or edema. Ilopan—injectable d-pantothenyl alcohol for treatment of flatulent gastrointestinal distention. Kaon—extremely palatable oral potassium. Modane—nutritional deconstipant.
22	**WINTHROP LABORATORIES, New York, N. Y.** pHisoAc, a new therapeutic topical cream for acne and related skin blemishes, contains colloidal sulful 6%, resorcinol 1.5%, and hexachlorophene 0.3%, in a fat-free, quick-drying, flesh-toned base. It is virtually odorless, spreads smoothly and evenly and can readily be washed off with water. pHisoAc Cream is keratolytic also removes excess oil and helps dry and degerm the skin, unblock clogged pores, and remove blackheads.

CONVENTION SECTION

Table of Contents

CONVENTION ISSUE (begins) **1725**

OFFICIAL CALL TO THE HOUSE OF DELEGATES **1726**

HOUSE OF DELEGATES **1727**

1959-60 ISMA OFFICERS **1730**

- **Councilors** **1730**
- **Past Presidents** **1730**
- **Delegates to AMA** **1730**
- **50-Year Club, 1960** **1731**

REFERENCE COMMITTEES **1731**

OFFICERS OF THE ISMA **1732**

- **The Journal** **1734**
- **Section Officers** **1735**

PROGRAM FOR THE 111th ANNUAL ISMA CONVENTION **1738**

CONVENTION ARRANGEMENTS COMMITTEES **1744**

INSTRUCTIONAL COURSES—Schedule and Application Blank **1742**

ENTERTAINMENT FEATURE **1743**

ART AND HOBBY SHOW **1745**

WOMEN'S PROGRAM **1746**

HOTEL ADVANCE RESERVATION FORM **1744**

AMENDMENTS TO THE CONSTITUTION AND BYLAWS **1748**

OFFICERS' REPORTS

- **Executive Secretary** **1751**
- **Treasurer** **1751**
- **Chairman of the Council** **1754**
- **District Councilors**
  - First Councilor District **1756**
  - Second Councilor District **1756**
  - Third Councilor District **1757**
  - Fourth Councilor District **1757**
  - Sixth Councilor District **1758**
  - Seventh Councilor District **1758**
  - Eighth Councilor District **1758**
  - Ninth Councilor District **1759**
  - Tenth Councilor District **1759**
  - Eleventh Councilor District **1759**
  - Twelfth Councilor District **1760**
  - Thirteenth Councilor District **1760**
- **Editor of the JOURNAL** **1760**

REPORTS OF COMMITTEES

- **Executive** **1761**
  - Medical Defense **1763**
  - Membership Report **1763**
  - The Journal Advertising **1764**
- **Grievance** **1765**
- **Student Loan** **1765**
- **Medical-Legal Review** (no report)

REPORTS OF COMMISSIONS

- **Constitution and Bylaws** **1767**
- **Legislation** **1768**
- **Public Information** **1768**
  - Indiana State Commission on the Aging and Aged **1768**
  - Liaison Committee with AFL-CIO **1768**
  - Health Hints **1769**
  - Science Fair **1769**
  - State Fair Exhibits **1769**
  - Medical Assistants Program **1769**
- **Governmental Medical Services** **1769**
  - Civil Defense **1769**

Table of Contents—Continued

Military Manpower 1770

Medicare 1770

Veterans' Medical Care Program..... 1770

Veterans' Affairs 1770

Liaison with the State Department of Public Welfare 1771

Miscellaneous Business 1772

Recommendations 1772

Public Health 1772

Aged and Aging 1772

Industrial Health 1773

Conservation of Hearing and Vision..... 1773

Rural Health and Physician Placement..... 1773

Voluntary Health Agencies 1773

Medical Economics and Insurance..... 1775

Sub-Committee A: Relative Value Study.... 1775

Sub-Committee B: Cooperative Care of the Surgical Patient 1776

Sub-Committee C: Blue Cross-Blue Shield X-Ray and Pathology Transfer..... 1776

Sub-Committee D: Out-Patient Blue Shield Care 1776

Inter-Professional Relations 1776

Medical Education and Licensure..... 1777

Special Activities 1778

RESOLUTIONS 1780

SCIENTIFIC EXHIBITS 1783

TECHNICAL EXHIBITS 1785

NOTES

ADVERTISERS INDEX ON PAGE 1724

one businessman has epilepsy... even his colleagues need not know—if his seizures are adequately controlled

With proper medication, epileptics may achieve success in a wide variety of professions.[1]

for improved seizure control

DILANTIN® **SODIUM KAPSEALS®** ... *outstandingly effective in* ***grand mal and psychomotor seizures:*** *"*DILANTIN *is an effective anticonvulsant which is useful in controlling epileptic attacks of any type with the exception of idiopathic petit mal."*[2] *"It* [DILANTIN] *is one of the few useful anticonvulsants in which oversedation is not a common problem when full therapeutic doses are employed."*[3] DILANTIN Sodium *(diphenylhydantoin sodium, Parke-Davis) is available in several forms, including Kapseals of 0.03 Gm. and of 0.1 Gm., in bottles of 100 and 1,000.*

other members of THE PARKE-DAVIS FAMILY OF ANTICONVULSANTS

for grand mal and psychomotor seizures: PHELANTIN® Kapseals *(Dilantin 100 mg., phenobarbital 30 mg., desoxyephedrine hydrochloride 2.5 mg.), bottles of 100.* ***for the petit mal triad:*** MILONTIN® Kapseals *(phensuximide, Parke-Davis) 0.5 Gm., bottles of 100 and 1,000; Suspension, 250 mg. per 4 cc., 16-ounce bottles* • CELONTIN® Kapseals *(methsuximide, Parke-Davis) 0.3 Gm., bottles of 100.*

LITERATURE SUPPLYING DETAILS OF DOSAGE AND ADMINISTRATION AVAILABLE ON REQUEST.

(1) Abraham, W., in Green, J. R., & Steelman, H. F.: Epileptic Seizures, Baltimore, Williams & Wilkins Company, 1956, p. 132. (2) Crawley, J. W.: M. Clin. North America 42:317 *(March) 1958. (3) Bray, P. F.:* Pediatrics 23:151, *1959.*

PARKE-DAVIS

PARKE, DAVIS & COMPANY
Detroit 32, Michigan 27660



The Journal

October 1960

of the INDIANA STATE MEDICAL ASSOCIATION

Office of Publication:
1019 Hume Mansur Building, Indianapolis, Indiana

$1.00 per copy
except Yearbook
$5.00 per year

Contents

SCIENTIFIC

Sickle Cell Anemia: Case Report and Review, Arthur S. Morse, Jr., M.D., Muncie 1857
Gout, John H. Oyer, M.D., Fort Wayne 1863
Meckel's Diverticulum Presenting as a Pelvic Tumor, John P. Baxter, M.D., Dennis S. Megenhardt, M.D., Kenneth Thornburg, M.D., Indianapolis 1867
Sex and Chromosomes, Keith Hammond, M.D., Muncie 1870
The Adrenal Cortex and Reproductive Failure, Richard W. Stander, M.D., Indianapolis 1873
Treatment of Poisonous Snakebites: Present Status of Incision and Excision, Henry M. Parrish, M.D., Indianapolis 1879
The Case of the Bloated Bartender, Arnold Lieberman, M.D., New York, N.Y. 1884
Electrocardiogram of the Month: Atrial Fibrillation, Atrial Tachycardia with Block, and Ventricular Tachycardia, Due to Digitalis Intoxication, Charles Fisch, M.D., Indianapolis 1889

EDITORIALS

Most Aged Don't Want Federal Help 1896
Diabetes Week 1896
Editorial Notes 1897
Nation Fights No-Vote-Itis (Guest Editorial) 1898
Rabies Trends, 1960 (Guest Editorial) 1899
Democracy is NOT a Spectator Sport (Guest Editorial) 1900

SPECIAL FEATURES

Schizophrenia in Children, Gordon T. Brown, M.D., Indianapolis 1906
Analysis, Review and Evaluation of Clinical Practice in the Hospital, from the Bulletin of the Joint Commission of Accreditation of Hospitals 1918
On the 1960 Election Scene:
Physicians Gear for Political Action as New Hoosier Group Forms 1923
Health and Medical Platform Summaries, 1960 1925
State Legislation Roundup, From The Citation, American Medical Assn. 1927
This Office Will be Closed (notice for display in doctor's office 1931
Guy A. Owsley, M.D., President, Indiana State Medical Association, 1960-61 1934

REGULAR FEATURES

Month in Washington 1808
Fourth Estate 1814
Abstracts, Book Reviews 1844
More About the Federal Employee Blue Shield and Blue Cross Programs (One of a series) 1852
Letters to the Editor 1854
Journal Medical Essay Contest 1893
President's Page 1902
Woman's Auxiliary Reports to ISMA 1904
Board of Health Report 1943
Wanted: Physicians, Locations 1948
News Notes 1936
New Medical Supplement Appears in Current Magazine 1936
Indiana Flying Physicians Honored 1936
I.U. Researchers Study Arterioles' Regulating Ability 1941
Future Meetings, Seminars, Courses 1944
Deaths 1949

BUSINESS

County Society News 1950
Association News: Executive Committee, August 12, 1960 1951

EDITORIAL AND ADVERTISING INFORMATION

All articles must be typewritten, double-spaced with margins of one inch.

Photographs should be printed on glossy paper. Negatives cannot be used.

Illustrations are desirable. Selection of illustrations submitted at discretion of editor and editorial board members. Cost of color illustrations must be shared by the author.

Contributors are responsible for all statements made in their articles. The editors and editorial board members may not be in agreement with all views expressed by authors, but it is desired to give all authors as great latitude as possible. However, the right is reserved to reduce in length or reject any article.

Articles are accepted for publication with the understanding that they are submitted for exclusive publication in THE JOURNAL of the Indiana State Medical Association.

Communications dealing with editorial matter should be sent to Frank B. Ramsey, M.D., Editor, 1802 North Illinois Street, Indianapolis 2, Indiana. All other communications should be sent to THE JOURNAL of the Indiana State Medical Association, 1019 Hume Mansur Building, Indianapolis 4, Indiana.

Advertising rates will be furnished on request. Copy must be received by the 5th of the month preceding month of issue. (Scientific manuscripts must be received at least two weeks earlier if geared for a specific issue.)

Entered as second class matter January 25, 1933, at the Postoffice at Indianapolis, Indiana. Copyright, 1960, by the Indiana State Medical Association. Published monthly at 1019 Hume Mansur Bldg., Indianapolis 4, Indiana.



To the relief of musculoskeletal pain, new MEDAPRIN* adds restoration of function

Analgesics offer temporary relief of musculoskeletal pain, but they merely *mask* pain rather than getting at its *cause*. New Medaprin, in addition to bringing about prompt subjective improvement, promotes the *restoration of normal function* by suppressing the inflammation that *causes* the pain.

Medaprin, Upjohn's new analgesic-steroid combination, contains aspirin plus Medrol,** the corticosteroid with *the best therapeutic ratio in the steroid field.*† Instead of suffering recurrent discomfort because of the "wearing off" of analgesics, the patient on Medaprin experiences a smooth, *extended* relief and more normal mobility.

Indications: Medaprin is indicated in mild-to-moderate rheumatic and musculoskeletal conditions, including rheumatoid arthritis, deltoid bursitis, low back pain, neuralgia, synovitis, fibromyositis, osteoarthritis, low back sprain, traumatic wrist, sciatica, and "tennis elbow."

Dosage: The recommended dosage is 1 tablet q.i.d. The usual cautions and contraindications of corticotherapy should be observed.

Supplied: In bottles of 100 and 500.

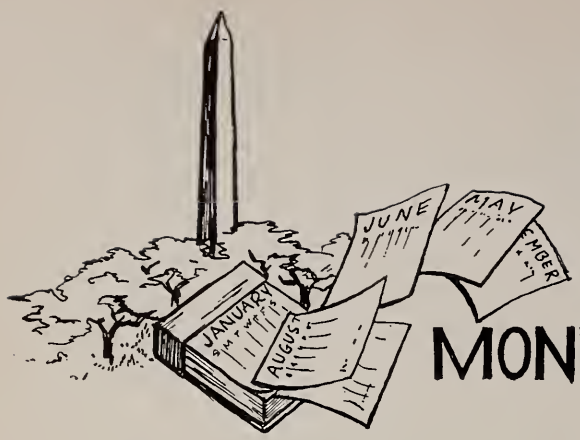
Formula: Each Medaprin tablet contains

- 300 mg. acetylsalicylic acid, for prompt relief of pain
- 1 mg. Medrol, to suppress the causative inflammation
- 200 mg. calcium carbonate, as buffer

*TRADEMARK **TRADEMARK, REG. U. S. PAT. OFF.—METHYLPREDNISOLONE, UPJOHN
†RATIO OF DESIRED EFFECTS TO UNDESIRED EFFECTS

The Upjohn Company, Kalamazoo, Michigan

Upjohn



This summary of what is happening in Washington is prepared by A.M.A.'s Capital office and airmailed to *The Journal* on the ninth of each month preceding month of issue.

MONTH IN WASHINGTON

Washingon, D. C.—The federal government is offering states liberal matching funds to provide health care for needy and near-needy persons 65 years of age and older.

The program, which Congress approved in the bob-tailed post-convention session, is supported by the American Medical Association and allied health groups.

Congressional approval of the federal-state program marked a victory for the medical profession and a defeat for Democratic Presidential Nominee John F. Kennedy, the AFL-CIO and other advocates of the Social Security approach to the problem.

In a key vote on the issue, the Senate rejected by a 51-44 vote a Kennedy proposal that would have provided hospitalization and medical care for the aged under the Social Security system. The Kennedy plan would have required an increase in payroll taxes.

Republicans and Southern Democrats joined in the Senate to defeat the Social Security approach which was opposed vigorously by the medical profession.

After voting down the Kennedy plan and a separate proposal of the Eisenhower Administration, the Senate passed a modified version of a House-approved program. The modifications, sponsored by Sen. Robert S. Kerr (D., Okla.) and others, provided for increases in the percentage of federal matching funds and for administrative changes designed to facilitate state participation.

Under the legislation as signed into law by President Eisenhower, (1) substantial increases are authorized in federal grants to states to help with health care expenses of the 2.4 million persons on old age assistance rolls, and

(2) Federal matching funds are offered the states to finance a new program of health care for an estimated 10 million aged persons who are not on relief but whose incomes may be inadequate to take care of all their health costs.

Start of the program was authorized for Oct. 1 for those states where new state legislation is not required.

ADMINISTERED ENTIRELY BY STATES

Administration of the program rests entirely with the states subject to Federal approval in broad terms. It is up to each individual state

Continued on page 1812

Clinical results with Trancopal®[2]

	Excellent	Good	Fair	Poor	Total
LOW BACK SYNDROMES					
Acute low back strain	25	19	8	6	58
Chronic low back strain	11	5	1	1	18
"Porters' syndrome"*	21	5	1	1	28
Pelvic fractures	2	1	—	—	3
NECK SYNDROMES					
Whiplash injuries	12	6	2	1	21
Torticollis, chronic	6	2	3	2	13
OTHER MUSCLE SPASM					
Spasm related to trauma	15	6	1	—	22
Rheumatoid arthritis	—	18	2	1	21
Bursitis	2	6	1	—	9
TENSION STATES	18	2	4	3	27
TOTALS	112 (51%)	70 (32%)	23 (10%)	15 (7%)	220 (100%)

*Over-reaching in lifting heavy bags resulting in sprain of upper, middle, and lower back muscles.

Dosage: **Adults, 200 or 100 mg. orally three or four times daily.**
Relief of symptoms occurs in from fifteen to thirty minutes and lasts from four to six hours.

How Supplied: Trancopal Caplets®
200 mg. (green colored, scored), bottles of 100.
100 mg. (peach colored, scored), bottles of 100.

Winthrop LABORATORIES, New York 18, N. Y.

Continued from page 1808

whether it participates. Eligibility standards for beneficiaries and what health care services are provided are matters for the states to decide.

If a state so chooses, it can take care of all the health needs of an eligible beneficiary. The law authorized inpatient hospital services; skilled nursing home services; physician's services; outpatient or clinic services; home care services; private duty nursing services; physical therapy and related services; dental services; laboratory and x-ray services; prescribed drugs, eyeglasses, dentures and prosthetic devices; diagnostic screening and preventive services, and any other medical care or remedial care recognized under state law.

For medical expenses of persons on old age assistance rolls, the federal government will contribute 50 to 80%—with states with low per capita income getting the larger percentages of federal aid—of an amount equal to $12 multiplied by the number of old age assistance recipients in a particular state.

The matching formula will be the same for financing the health care of the near-needy but there is no $12 limitation figure.

Health, Education and Welfare officials estimated first-year costs of the program at $262 million—$202 million federal and $60 million state. Annual costs are estimated to rise by the end of the fifth year to $340 million federal and $180 million state. However, these estimates admittedly are no more than educated guesstimates because so much depends upon state action.

INDIANA CONTRIBUTION ESTIMATED

It was estimated that maximum participation and a state contribution of $3 million would bring Indiana $3.6 million in federal matching funds in the first year of the program.

The medical-care-for-the-aged legislation was included in an omnibus measure titled Social Security Amendments of 1960. It also eliminated the age 50 requirement for eligibility for disability insurance benefits.

The Senate knocked out of the House bill a provision that would have brought physicians under Social Security coverage.

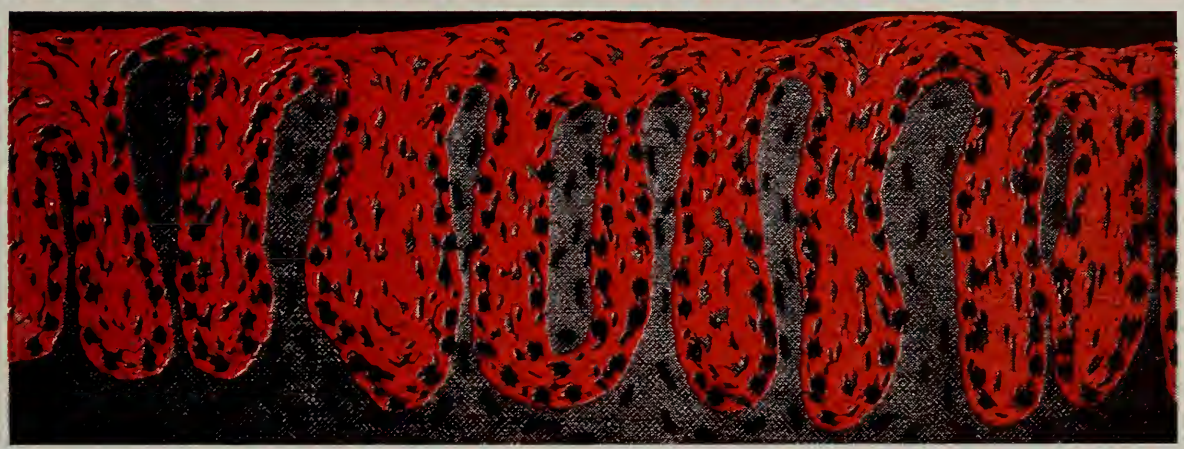
On other legislation of interest to the medical profession:

Congress passed bills authorizing expenditure of $10 million of counter-part funds abroad to stimulate international research; authorizing up to 15% of National Institutes of Health research grants for non-governmental medical research; directing a broad study of air pollution problems; requiring informative labeling on packages of hazardous substances for household use, and giving the government power to establish a tolerance on the amount of color additives that may be used in various products.

The Senate failed to act upon House-approved legislation that would have given physicians and other self-employed persons a tax break on income put into private pension plans. ◄

a promise fulfilled







All corticosteroids provide symptomatic control in rheumatoid arthritis, inflammatory dermatoses, and bronchial asthma. They *differ* in the frequency and severity of side effects. Introduced in 1958, ARISTOCORT Triamcinolone bore the promise of high efficacy and relative safety. Physicians today recognize that the promise has been fulfilled . . . as evidenced by the high rate of refilled ARISTOCORT prescriptions.

Aristocort® Triamcinolone LEDERLE

Lederle LEDERLE LABORATORIES, A Division of AMERICAN CYANAMID COMPANY, Pearl River, N.Y.



LOOKS AT MEDICINE

This section of THE JOURNAL is devoted to the presentation of opinions which appear on the editorial pages of the public press, and which are of interest to the medical profession. Its function is to review comments which may be favorable or unfavorable to medicine. Members are invited to submit editorial clippings for this column.

Wall Street, U. S. A.

Drug Industry's Economic Growth

By JOHN E. McKEEN

Everyone agrees that economic growth is good for the country. But what is the formula that insures a healthy growth rate? W. Allen Wallis, special assistant to President Eisenhower, has suggested a three-part combination—an abundant flow of new ideas, a willingness to take risks and the speedy adoption of successful new ideas. This is a combination that underlies the success of almost every major company in the ethical pharmaceutical industry.

In the drug field, new ideas have been plentiful and scientific research has turned them into the most effective drugs the world has ever known. Thanks to research, a whole range of once deadly and crippling diseases has been wiped out as major hazards, with an incalculable saving in life.

According to the United States Public Health Service, deaths from diseases against which antibiotics are effective have been slashed 19 to 92% since 1945. Deaths from typhoid, for example, are down 67%, diphtheria, 92%; dysentery, 85%. Tuberculosis, the sixth leading cause of death back in 1945, is no longer among the ten top killer diseases today.

It is estimated that, in treating the major infectious diseases, such new drugs as the antibiotics will help save the lives of more than 100,000 Americans this year. In hospitals, modern drugs have cut in half the required time for treating ear, nose and throat infections and that means a lower hospital bill.

No Easy Success

The firms that discover and develop these effective drugs are the ones which prosper—but not automatically. An idea is one thing, a useful drug is quite another, and more often than not a difficult journey lies between the two. This brings up the second point of the growth formula—willingness to take risks.

No company gets ahead in the pharmaceutical industry unless it is willing to stake a sizable amount of money in research with little assurance of success either in the laboratory or in the market place. Products can be outdated in a matter of months. By the time a company brings a new product to market, its research men are usually hard at work on improvements and so are the company's competitors.

This works to the benefit of the public, but the risks inherent in such a system are both large and unpredictable. Everyone remembers the crash program to produce vaccine when Asian influenza threatened a few years ago. Then the danger vanished and, with it, the investment in vaccine stocked in warehouses.

The third point in the growth formula—speedy adoption of new methods—has been part and parcel of the drug industry in recent years.

Develop New Tools

Pharmaceutical manufacturers have developed almost revolutionary tools for solving problems in fermentation, synthetic chemistry, extraction and purification and mass production. Less dramatic than the discovery of a new drug, production developments are in the long run almost as important, for unless an adequate supply can be

Continued on page 1818

REMEMBER THIS: SO DOES ENARAX

Think of your patient with peptic ulcer—or with gastrointestinal dysfunction—on a typical day.

Think of the anxieties, the tensions.

Think, too, of the night: the state of his stomach emptied of food.

Disturbing?

Then think of ENARAX. For ENARAX was formulated to help you control precisely this clinical picture. ENARAX provides oxyphencyclimine, the inherently long-acting anticholinergic (up to 9 hours of actual achlorhydria[1]) . . . plus Atarax, the tranquilizer that doesn't stimulate gastric secretion.

Thus, with b.i.d. dosage, you provide continuous antisecretory/antispasmodic action and safely alleviate anxiety . . . with these results: ENARAX has been proved effective in 92% of G.I. patients.[2-4]

When ulcerogenic factors seem to work against you, let ENARAX work for you.

ENARAX® B.I.D.



(10 MG. OXYPHENCYCLIMINE PLUS 25 MG. ATARAX®†) A SENTRY FOR THE G.I. TRACT

dosage: Begin with one-half tablet b.i.d. — preferably in the morning and before retiring. Increase dosage to one tablet b.i.d. if necessary, and adjust maintenance dose according to therapeutic response. Use with caution in patients with prostatic hypertrophy and only with ophthalmological supervision in glaucoma.

supplied: In bottles of 60 black-and-white scored tablets. Prescription only.

References: 1. Steigmann, F., **et al.:** Am. J. Gastroenterol. **33**:109 (Jan.) 1960. 2. Hock, C. W.: to be published. 3. Leming, B. H., Jr.: Clin. Med. **6**:423 (Mar.) 1959. 4. Data in Roerig Medical Department Files.

†brand of hydroxyzine

FOR HEMATOPOIETIC STIMULATION
WHERE OCCULT BLEEDING IS PRESENT
HEPTUNA® PLUS
THE COMPLETE ANEMIA THERAPY

ROERIG Rx

New York 17, N. Y.
Division, Chas. Pfizer & Co., Inc.
Science for the World's Well-Being™

Continued from page 1814

promptly produced, clinical research and widespread use of the drug are seriously delayed.

This was the problem which so severely limited the clinical testing of penicillin in the early days of World War II. It is the same problem a Soviet scientist recently complained of, in noting the Russian drug industry's inability to mass-produce certain drugs.

In the area of quality controls, the experienced, reputable pharmaceutical firms have made some remarkable strides to insure that consumers get safe, high quality medicines. Last year, for example, two Pfizer scientists perfected an automatic electronic computer system for quality control in testing the potency of antibiotics and other drugs.

Ends Human Error

One of the most important features of the system is that it virtually eliminates human error.

This is the kind of developmental research that is constantly being carried out by the leading pharmaceutical companies, in addition to the discovery of new drugs. All of this research is expensive, but it is money well spent.

anorectic-ataractic ®
BAMADEX
meprobamate 400 mg., with d-amphetamine sulfate 5 mg., Tablets

FOR THERAPY
OF OVERWEIGHT PATIENTS

- d-amphetamine depresses appetite and elevates mood
- meprobamate eases tensions of dieting (yet without overstimulation, insomnia or barbiturate hangover).

Dosage: One tablet one-half to one hour before each meal.

A LOGICAL COMBINATION
IN
APPETITE CONTROL

Lederle

The industry's modern research facilities and scientific manpower are helping to make possible the screening of some 40,000 chemicals a year in the search for cancer drugs, and playing an important role in the National Cancer Chemotherapy Screening Program. Lacking such highly developed resources, the nation's health effort would be seriously crippled.

The combination of new ideas, risk-taking and prompt action in the pharmaceutical industry has led to unparalleled growth and progress. Yet inherent in this growth is the swift pace of drug obsolescence and it may well be that in the years to come, many of today's wonder drugs will end up as tomorrow's discards.

The industry's level of income therefore must be geared to provide adequate incentives and resources to enable drug companies to compete successfully. There is no better way to assure the nation's future in the search for new drugs to combat disease and illness.

New York Herald Tribune
Aug. 3, 1960

Medical Care for the Elderly

After the Eisenhower Administration unveiled its sweeping voluntary medical care program for the elderly yesterday a leading Democrat commented:

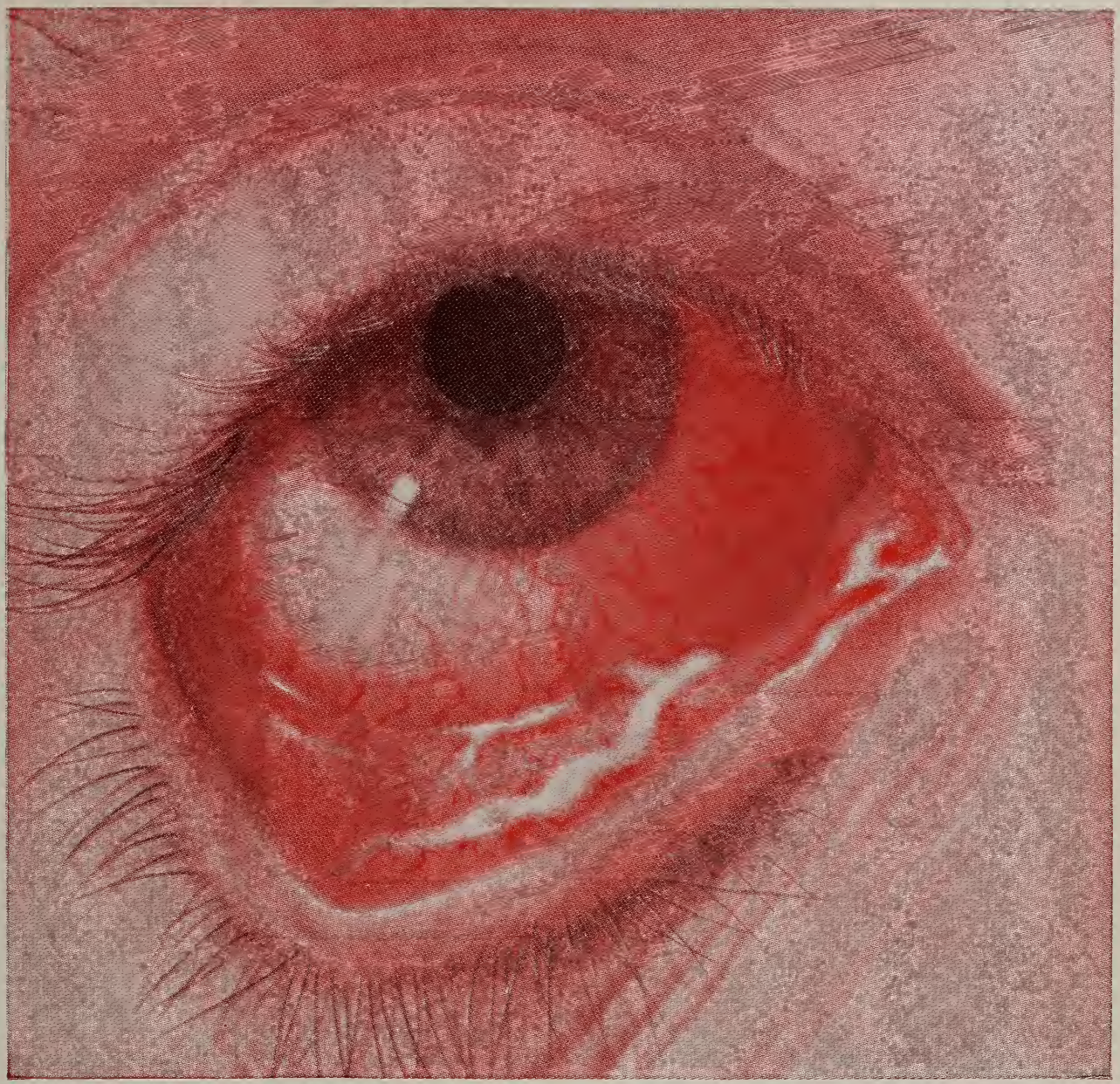
"The Administration has 'outfinessed us' in election-year maneuvering."

That comment tells the story of what is going on in Washington concerning medical care for persons over 65.

Democratic presidential hopefuls are trumpeting for the Forand bill or some variation of it—a program which would incorporate medical care for the elderly in the social security system.

The Republicans, with a tough election battle ahead, felt this was an issue they could not afford to ignore. Welfare Secretary Arthur Flemming was given a rush job of coming up with a plan to which party orators could point with pride but which still would meet limitations imposed by President Eisenhower.

Flemming's plan is better than the Forand bill. It would help provide medical care for the elderly who are not covered by social security; it would be voluntary; in essence it would provide government help only for major illness since persons joining would have to pay the first $250 of hospital-medical costs and 20%



no irritating crystals[1] · uniform concentration in each drop[2]

STERILE OPHTHALMIC SOLUTION

NEO-HYDELTRASOL®

PREDNISOLONE 21-PHOSPHATE-NEOMYCIN SULFATE

2,000 TIMES MORE SOLUBLE THAN PREDNISOLONE OR HYDROCORTISONE

"The solution of prednisolone has the advantage over the suspension in that no crystalline residue is left in the patient's cul-de-sac or in his lashes . . . . The other advantage is that the patient does not have to shake the drops and is therefore sure of receiving a consistent dosage in each drop."[2]

1. Lippmann, O.: Arch. Ophth. **57**:339, March 1957.
2. Gordon, D.M.: Am. J. Ophth. **46**:740, November 1958.

supplied: 0.5% Sterile Ophthalmic Solution NEO-HYDELTRASOL (with neomycin sulfate) and 0.5% Sterile Ophthalmic Solution HYDELTRASOL®. In 5 cc. and 2.5 cc. dropper vials. Also available as 0.25% Ophthalmic Ointment NEO-HYDELTRASOL (with neomycin sulfate) and 0.25% Ophthalmic Ointment HYDELTRASOL. In 3.5 Gm. tubes.

HYDELTRASOL and NEO-HYDELTRASOL are trademarks of Merck & Co., Inc.

MSD MERCK SHARP & DOHME Division of Merck & Co., Inc., Philadelphia 1, Pa.

of remaining costs until benefits were exhausted.

But the Administration's plan, by Secretary Flemming's estimate, would cost $1.2 billion a year when going full tilt, with the states to pay half of this. This money would come out of Federal and state treasuries, requiring more taxes in most instances or, if provided by deficit financing, increasing inflationary pressures.

The Forand plan on the other hand would be financed by higher Social Security taxes.

The problem of providing medical care for the elderly with low incomes is most important. But it also is most complex.

It is too important and too complex to be dealt with by an election-minded Congress in a rush job just before Congress is to quit for the national party conventions.

In every state of the union, commissions have been gathering data on the problems of the aged for submission and discussion at the White House Conference on Aging scheduled for January.

ANNUAL
CLINICAL CONFERENCE

CHICAGO MEDICAL SOCIETY

February 28, March 1, 2 and 3, 1961

Palmer House, Chicago

Lectures *Teaching Demonstrations*

Medical Color Telecasts

Instructional Courses

The CHICAGO MEDICAL SOCIETY ANNUAL CLINICAL CONFERENCE should be a MUST on the calendar of every physician. Plan now to attend and make your reservation at the Palmer House.

Congress should wait until it sees what the experts have to say.

On a matter this important and this expensive, Congress owes it to the country to take plenty of time and study so we'll all know where we're going and what's involved.

Indianapolis Times
May 5, 1960

Americans Pay for Health

Five years ago the typical American family spent 42% less money on health services. Now that same family spends $294 a year, with more than half of the increase accounted for by greater use of health services. Higher charges took care of less than half of the nearly $150 hike in the family's annual bill for health.

Another interesting fact is that children and older members of the family have increased their use of medical services by about 45% during the five years from 1953 to 1958. This additional use may have been in the form of special treatment, early attention to ward off disease or more complicated forms of medication.

More people than ever are now protected by some form of health insurance. This is particularly true among the people over 65.

These facts seem to lead to the conclusion that Americans are willing to spend more for personal health, and that they are capable of paying the bill through individual, voluntary means. Certainly there is no comfort here for those who want to open the sidedoor to a government health program through the Social Security system.

Indianapolis Star
Feb. 24, 1960

Power Mower Dangers

Each year more people learn the hard way that the power mower can be a dangerous weapon, especially in the hands of a novice.

While there is no present way of estimating the number of power mower accidents that occur each year throughout the nation, the National Safety Council made a study which showed that (a) permanent disability results from one in each group of seven accidents; (b) the injury or disability most frequently involves toes or feet; and (c) the injured person is usually the operator of the mower (70%) but may be an ob-

Continued on page 1824

of clinical use...

Proven

in more than 750 published clinical studies

Effective

for relief of anxiety and tension

Outstandingly Safe

1. simple dosage schedule produces rapid, reliable tranquilization without unpredictable excitation
2. no cumulative effects, thus no need for difficult dosage readjustments
3. does not produce ataxia, change in appetite or libido
4. does not produce depression, Parkinson-like symptoms, jaundice or agranulocytosis
5. does not impair mental efficiency or normal behavior

Miltown®

meprobamate (Wallace)

Usual dosage: One or two 400 mg. tablets t.i.d.
Supplied: 400 mg. scored tablets, 200 mg. sugar-coated tablets; or as MEPROTABS*—400 mg. *unmarked,* coated tablets.

WALLACE LABORATORIES / *Cranbury, N. J.*

*TRADE-MARK

CM-2533

Continued from page 1820

server or a passer-by who is struck by some object thrown by the mower (blade or piece of metal that happens to be on the lawn).

The council concludes its report with recommendations both for the manufacturers of the 12 million mowers in use in the U.S.A. and for operators.

Briefly stated these include:

1. Covering revolving parts with built-in guards.
2. Completely enclosing sides.
3. Securely mounting front and rear guards.
4. Increasing the length of the handle so that the operator cannot pull the mower back onto his feet.
5. Installing a ground wire.
6. Clearing the area to be mown of sticks, stones, wire and metal objects before starting the operation.
7. Limiting mowing to daylight hours when the grass is neither wet nor slippery.
8. Forbidding children younger than teens to handle the mower.
9. Forbidding persons or pets to hang around while the mowing operation is in progress.
10. Starting the motor only when the feet are firmly planted on a safe and level area.
11. Cutting sideways on hills and banks.
12. Refueling out-of-doors after stalling the motor.
13. Learning to disengage clutch quickly in any emergency.

How about checking your mower and your technic against this list?

Kokomo Tribune
Aug. 1, 1960

Turning First to Washington

Our letters column today is devoted to answers to some recent remarks of ours on the Forand and other measures before Congress to make the federal government responsible for medical care of the aged.

The letters show that the problem is on the minds of many of our readers, as well as close to their hearts. They recognize, as we are sure most of us do, that responsibility for helping the aged and the helpless must rest not solely on the shoulders of the afflicted, but elsewhere in our society.

Continued

Tested . . . and proved . . .

ORAL therapy in diaper rash!



Convenient . . . simply open a capsule and add the contents to the baby's daily formula, or to fruit juice or water. No lotions . . . no rinses . . . no ointments . . . just oral therapy.

Send for samples and literature.

S. F. DURST & CO., INC.
Philadelphia 20, Pa.

Effective therapy! Thousands of pediatricians and general practitioners prescribe Pedameth for ammonia dermatitis—and they continue to prescribe it. Clinical tests have proved its effectiveness. Pedameth is safe because it contains only dl-methionine (0.2 Gm.) one of the essential amino acids. When Pedameth is administered, the pH of the urine is lowered and an as-yet-unknown antibacterial agent appears in the urine. Pedameth works . . . it's the safe, effective, convenient answer to ammoniacal diaper rash.

Prescribe

PEDAMETH®

(dl-methionine DURST)

in common Gram-positive infections due to susceptible organisms

YOU CAN COUNT ON

TAO®*

(triacetyloleandomycin)

even in many resistant Staph*



1,928 published cases in the two years since TAO was released for general use show:

94.3% effectiveness in respiratory infections (617 cases including tonsillitis, staphylococcal and streptococcal pharyngitis, bronchitis, infectious asthma, broncho-pneumonia, lobar pneumonia, bronchiectasis, lung abscess, otitis.) **You can count on TAO.**

92% effectiveness in skin and soft tissue infections (900 cases including pyoderma, impetigo, acne, infected skin disorders, wounds, incisions and burns, furunculosis, abscess, cellulitis, chronic ulcer, adenitis.) **You can count on TAO.**

87.1% effectiveness in genitourinary infections (349 cases including urethritis, cystitis, pyelitis, pyelonephritis, orchitis, pelvic inflammation, acute gonococcal urethritis, lymphogranuloma venereum.) **You can count on TAO.**

75.8% effectiveness in diverse infections (62 cases including fever of undetermined origin, peritoneal abscess, osteitis, periarthritis, septic arthritis, staphylococcal enterocolitis, gastroenteritis, carriers of staphylococci.) **You can count on TAO.**

95.6% of 1,928 cases free of side effects—in the remaining 4.4%, reactions were chiefly mild gastrointestinal disturbances which seldom necessitated discontinuance of therapy.

*In 884 of 1,928 cases the causative organisms were mostly staphylococci. The majority of clinical isolates were found to be resistant to at least one of the commonly used antibiotics and many patients had failed to respond to previous therapy with one or more antibiotics. **TAO proved 93.4% effective in these 884 cases.**

Complete bibliography available on request.

DOSAGE: varies according to severity of infection. Usual adult dose—250 to 500 mg. q.i.d. Usual pediatric dose: 3-5 mg./lb. body weight every 6 hours.

NOTE: In some children, when TAO was administered at considerably higher than therapeutic levels for extended periods, transient-jaundice and other indications of liver dysfunction have been noted. A rapid and complete return to normal occurred when TAO was withdrawn.

SUPPLY: TAO CAPSULES—250 mg. and 125 mg., bottles of 60. TAO ORAL SUSPENSION—125 mg. per 5 cc. when reconstituted, palatable cherry flavor, 60 cc. bottles. TAO PEDIATRIC DROPS—100 mg. per cc. when reconstituted, flavorful; special calibrated dropper, 10 cc. bottles. INTRAMUSCULAR or INTRAVENOUS—10 cc. vials, as oleandomycin phosphate.

OTHER TAO FORMULATIONS ALSO AVAILABLE: TAO®-AC (Tao, analgesic, antihistaminic compound) capsules, bottles of 36. TAOMID® (Tao with Triple Sulfas)—tablets, bottles of 60. Oral Suspension—60 cc. bottles.

For nutritional support VITERRA® Vitamins and Minerals
Formulated from Pfizer's line of fine pharmaceutical products.

New York 17, N. Y.
Division, Chas. Pfizer & Co., Inc.
Science for the World's Well-Being™

FOURTH ESTATE

Continued

Mr. James M. Tyler of Seattle, Wash., for example, notes that unless some sort of federal plan is created, the burden of caring for the aged will fall mostly upon the middle-income group, inasmuch as the rich can take care of their hospital and doctor bills while the poor generally are taken care of anyway. He finds contradictions in our argument that while responsibility lies first with the sons and daughters of the aged, that responsibility should not be carried out through federal taxes. We argue, he says, "against the cause of thrift ambition and sound financial management" so far as middle-income people are concerned when we question turning this responsibility over to the federal government.

The federal government, of course, could play a most important role in a solution. Congress could, for example, make all medical and hospital bills paid by anyone deductible not just from income, but deductible from income tax, if it were so minded. Or it could reduce much wasteful spending on unnecessary domestic projects and then reduce the taxes everybody pays.

It could even enforce thrift and sound financial management on the government so that the dollar will cease to be eroded. Thus the aged who, as Mr. Carson of Syracuse, N. Y., says "have for a lifetime practiced the American virtue of thrift" will feel the medical demands of old age less heavily. Those are ways the federal government can help not only the aged but the aging.

But will it really help the nation for the federal government to create another vast bureaucracy, with its manifold powers, its tendency to proliferate, its ingrained thriftlessness, its red tape and the increased burden of taxes to support it that has never failed to follow? It is just such a burgeoning of bureaucracy that, through its incessant appetite, has prevented so many of the aged from putting aside enough for their old age.

Another federal encroachment on individual responsibility ought to be considered only as a last resort when all else has failed. For the cause of individual thrift, ambition and sound financial management are never served by turning first to Washington.

Wall Street Journal
May 9, 1960



PRESENTING: *modern, easy to use aerosol*

PANTHO-FOAM

hydrocortisone . . . 0.2%
pantothenylol 2%

the dramatic inflammatory-suppressive, antipruritic, antiallergic efficacy of hydrocortisone

plus the soothing, antipruritic, healing influence of pantothenylol

Doctor Says Educational System at Fault

Is Your Child Having Trouble?

Patricia McCormack

NEW YORK (UPI)—Benjamin Franklin failed in "arithmetik" when he was 11. He dropped out of school.

Later achievements proved Franklin wasn't stupid. But when he left school, his records showed that he wasn't bright enough to keep up with other students.

"Apparently his mind at that age could not reason out or solve problems given in early texts," Dr. John R. Frank of Valparaiso, Ind., said—in defense of modern boys and girls who are having trouble in school.

"Because we cling to the traditional methods of instruction, today we see boys in the first two grades of high school dropping out of school for the same reason Franklin left," Dr. Frank said.

The trouble with traditional methods of education is that they disregard the activities and functions of the developing human brain. That point is the theme of a report by Dr. Frank to the Indiana State Medical Association. (*JISMA* 52:10, Oct. 1959, pp. 1741-1745.)

He cited these "disharmonies in education"—

"We teach arithmetic before the child has any need for it or any interest in the subject;

"We teach mathematics, subjects that require reason and abstract thought, in high school before the human mind can reason well;

"We fail to teach languages when the child is young, when memory is the best and the mind is in the imitative state."

Dr. Frank said the failure to teach foreign languages early results in unnecessary difficulty in learning them in high school and college.

Arithmetic, which almost universally is begun in the first grade, should be omitted until the third grade or until the child is eight and the brain is more mature.

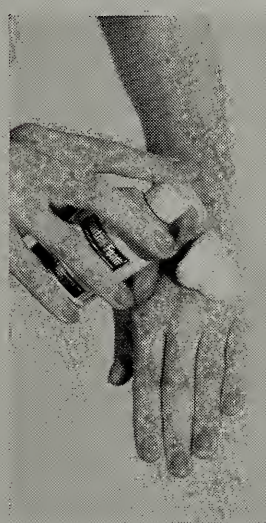
In general, Dr. Frank suggests that subjects that require reasoning and abstract thought should be taught after puberty and memory subjects should be taught before puberty.

"An average child of four to eight years of age shows little interest in arithmetic," he said. "Also, subjects like algebra and geometry—requiring reasoning—should not be taught until the body and the brain are fairly mature and the mind can reason."

Continued

push-button control in

skin inflammation, itching, allergy



PANTHO-FOAM

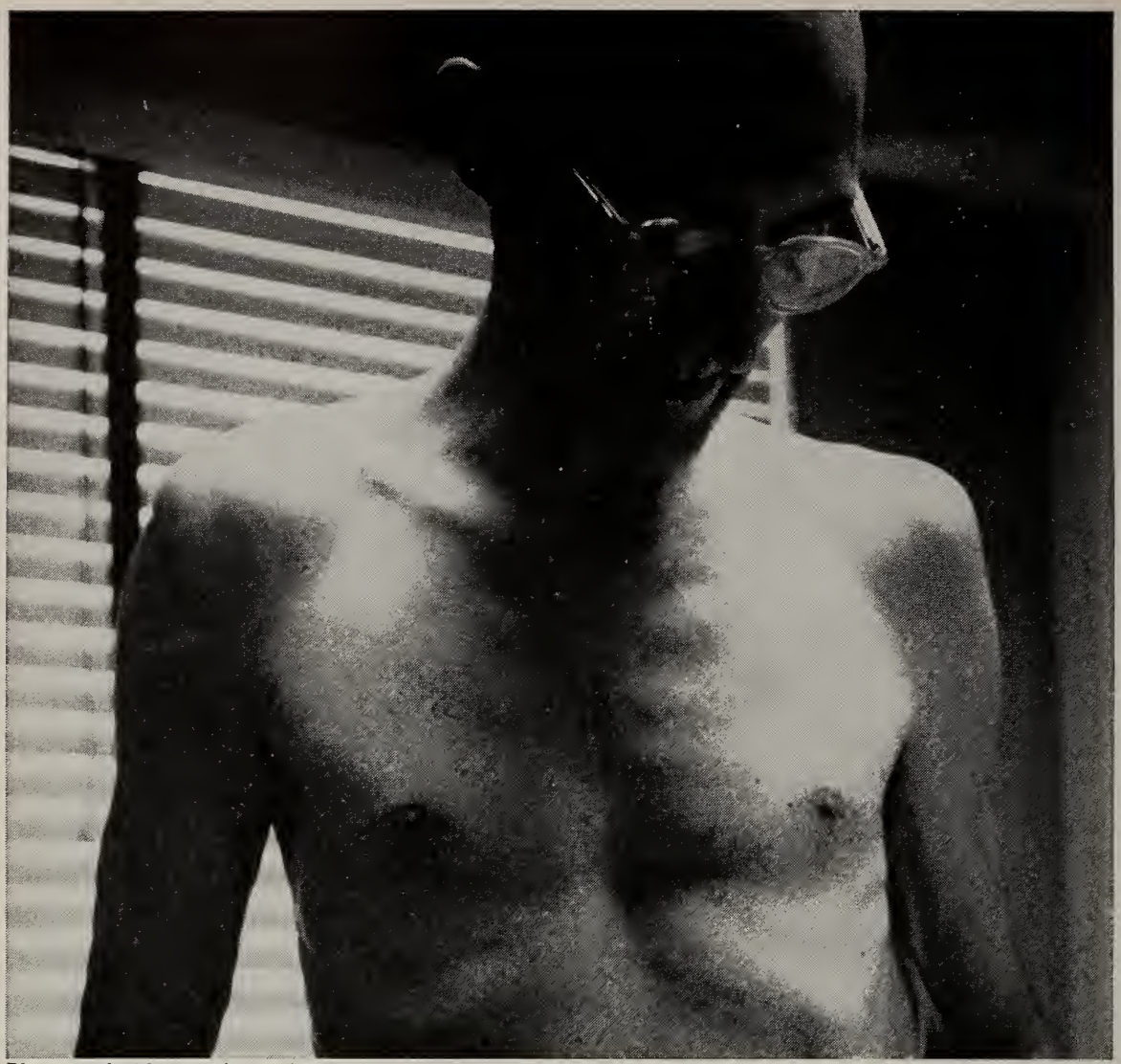
This non-occlusive foam lets the skin "breathe" as it "puts out the fire" of inflammation — unlike ordinary ointments.

Applied directly on affected area, **pantho-Foam** is today's non-traumatizing way to provide prompt relief and healing in . . .

burns
eczemas (infantile, lichenified, etc.)
dermatitis (atopic, contact, eczematoid)
neurodermatitis
pruritus ani et vulvae
stasis dermatitis

supplied: aerosol container of 2 oz.

u.s. vitamin & pharmaceutical corp.
Arlington-Funk Laboratories, division • 250 East 43rd Street, New York 17, N.Y.

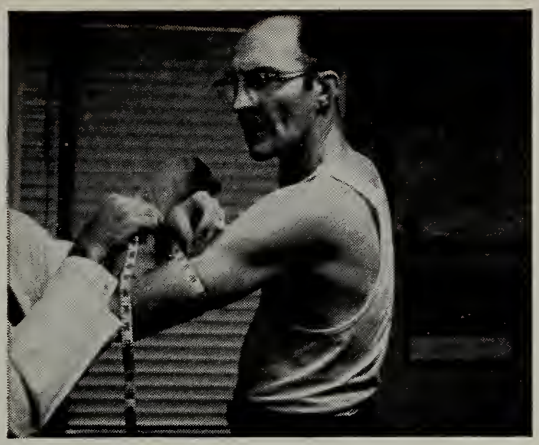


Photos used with patient's permission.

How new **Dianabol** rebuilt muscle tissue in this underweight, debilitated patient

Patient was weak and emaciated before Dianabol. R. C., age 51, weighed 160 pounds following surgery to close a perforated duodenal ulcer. His convalescence was slow and stormy, complicated by pneumonia of both lower lobes. Weak and washed out, he was considered a poor risk for further necessary surgery (cholecystectomy). Because a conventional low-fat diet and multiple-vitamin therapy failed to build up R. C. sufficiently, his physician prescribed Dianabol 5 mg. b.i.d.

Patient regains strength on Dianabol. In just two weeks R. C.'s appetite increased substantially; he had gained 9½ pounds of lean weight. His muscle tone was improved, he felt much stronger. After 4 weeks, he weighed 176 pounds. Biceps measurement increased from 10" to 11½". For the first time since onset of postoperative pneumonia, his chest was clear. Mr. C.'s physician reports: "He tolerated cholecystectomy very well and one week postop felt better than he has in the past 2 years."



Dianabol: new, low-cost anabolic agent

By promoting protein anabolism, Dianabol builds lean tissue and restores vigor in underweight, debilitated, and dispirited patients. In patients with osteoporosis Dianabol often relieves pain and increases mobility.

As an anabolic agent, Dianabol has been proved 10 times as effective as methyltestosterone. Yet it has far less androgenicity than testosterone propionate, methyltestosterone, or norethandrolone.

Because Dianabol is an oral preparation, it spares patients the inconvenience and discomfort of parenteral drugs.

And because Dianabol is low in cost, it is particularly suitable for the aged or chronically ill patient who may require long-term anabolic therapy.

Supplied: *Tablets,* 5 mg. (pink, scored); bottles of 100.

Complete information sent on request.

Dianabol®
(methandrostenolone CIBA)

converts protein to working weight in wasting or debilitated patients

CIBA
SUMMIT, NEW JERSEY

2/2829MD

Continued

Since girls mature about three years sooner than boys Dr. Frank believes they may be taught mathematics sooner.

"Practically, however," he said, "the girls should wait until 15 to 16 and take those subjects along with the boys."

The expert said the brain is most receptive to learning physical activities—dancing, piano playing, typing—early in life. He defined "early" as the period between age eight and 16.

Chicago, Ill., *Herald American*
Feb. 28, 1960

Who Can Afford Sickness?

One of the most inane arguments advanced by those who want government to direct medical care for elderly citizens is one based on the theme, "It costs too much to get sick. Old folks can't afford to be sick any more."

The medical aid proponents clearly indicate that they will reverse this condition, and by getting Federal money for elderly persons, they will meet the costs of illness. The argument then runs, "If we have Federal aid, you can pay the costs of being sick. Old folks can afford to be sick, then, without having to worry."

This line of reasoning is foolish. No one can ever afford to be sick.

An infant has no problem regarding the cost of medical care since the child must depend upon its parents for treatment when illness strikes. But can a child really afford to be sick just because he doesn't face some economic charge for treatment and care? Even in its childlike state, the human body is not going to make a deliberate choice of illness simply because there is the certainty that money is of no concern.

For that matter, can a very rich man afford to be sick? When a person comments that he can afford to act in a certain way or buy a certain article, the element of deliberate desire is involved. Many wealthy men have been ill. Riches provide no immunity to disease and aging, and often the pressures of extreme wealth brings ills which do not beset those who have less money. Does wealth really make sickness something to be afforded?

Who, honestly, can afford to be sick?

Continued

FOURTH ESTATE

Continued

Americans need to strip away the ingenious camouflage which has been wrapped around proposals to bring Federal interference into the personal lives of millions. The fact is that this country cannot afford the continual expansion of Federal control.

Indianapolis Star
April 16, 1960

You Keep Only Half

A study of what happens to wages, made in Milwaukee, turned up the startling fact that the average wage earner in that city actually is allowed to spend only about half of what he earns.

Here is the way it figures out:

The average annual earnings in Milwaukee were calculated at $6,712. This amount includes $1,414 worth of fringe benefits, which is money spent by the employer on behalf of the worker rather than being paid out to him in wages. That leaves $5,298 paid directly in average wages. Using national average figures for taxes of all kinds—income, property, excise and so on—it was calculated that $1,851 of this average pay goes for taxes. That leaves $3,447, or a bit over 51% of the $6,712 total. This the worker actually can spend as he pleases.

On an hourly basis, the average wage in Milwaukee is calculated at $3.22½. Of this 68 cents is in fringe benefits, leaving $2.54½ as the wage paid directly. Taxes take 85 cents of that, leaving $1.65½ an hour for the worker to spend. A total of $1.57 of his hourly wage is spent for him, either by the employer or by government.

It seems very fine to have employers taking care of such things as insurance, hospitalization, vacations, sick leave, recreation facilities, retirement and coffee breaks. It seems fine to have government providing for the exigencies of unemployment, sickness or injury, old age, dependent relatives, traffic jams, the hunt for a parking place, commuter fare increases, crowded golf courses, overproduction on the farm, mortgaging the house, bad television programs, city slums, high rents and weekends in the country.

But all such things cost money. The money to do them on behalf of society is subtracted from the individual's pay, in one way or another.

Do you really prefer to have done for you all the things that are done for everyone—whether you benefit or not—by your employer and by the various levels of government? Are all these things together really worth half of your pay?

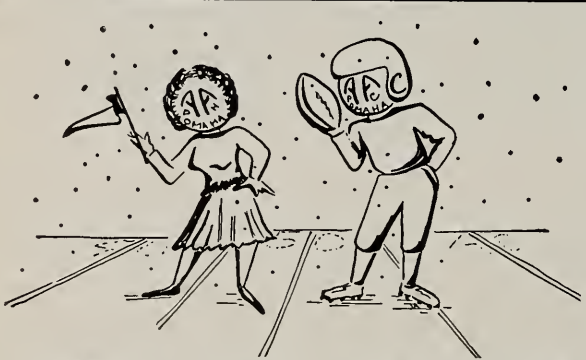
Indianapolis Star
April 17, 1960

Legislation Without Thought

When the Senators were voting the other day on various proposals for giving medical care aid to old people, they lined up very largely along party lines.

This, to be sure, surprised nobody. The only reason Congress is in session at all is because Sen. Johnson, who is both the majority leader in the Senate and a candidate for Vice President, thought such a session would be a good political forum for the campaign, and the Senate is also the habitat of both the Democratic and Republican candidate for President.

Continued



PROTECTION AGAINST LOSS OF INCOME FROM ACCIDENT & SICKNESS AS WELL AS HOSPITAL EXPENSE BENEFITS FOR YOU AND ALL YOUR ELIGIBLE DEPENDENTS

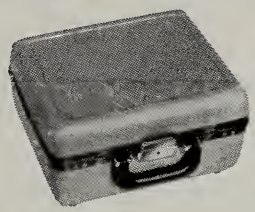
ALL PREMIUMS COME FROM

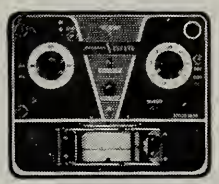
PHYSICIANS SURGEONS DENTISTS

ALL BENEFITS GO TO

PHYSICIANS CASUALTY & HEALTH ASSOCIATIONS
OMAHA 31, NEBRASKA
Since 1902
Handsome Professional Appointment Book Sent to you FREE upon request.

18 pounds,  instrument and accessories

Brief-case size 

Simple, straightforward  operation

Lightweight, unequalled portability 

Complete diagnostic accuracy

MODEL 300

VISETTE

ONE OF THREE PRECISION
ELECTROCARDIOGRAPHS MADE BY SANBORN

Ask your local Sanborn Branch Office
or Service Agency man (42 cities throughout the country),
for a demonstration or descriptive literature

SANBORN COMPANY
MEDICAL DIVISION
175 WYMAN ST., WALTHAM 54, MASS.



MODEL 300
VISETTE
$625 delivered,
continental
U. S. A.

INDIANAPOLIS *Resident Representative* 1635 North Gent Ave., Melrose 2-3768

FOURTH ESTATE

Continued

But our thought here is not just to comment on the cheaply partisan aspects of the day's doings, already rather widely commented upon, but rather to draw attention to the fact that nobody seems to know what the day's doings did.

On the day the Senate acted on medical care, for example, it had before it three separate and distinct proposals, each of considerable complexity, and several other amendments of uncertain import. Yet in the debate the supporters of none of these proposals seemed able to offer any clear explanation of their practical effect; they fell back largely upon rhetoric about their general intent—and, naturally, about the wickedness of the intent of others.

As for the final Senate version, it would take someone more calculating than a Philadelphia lawyer to figure out what it will actually mean to the country in terms of who will be affected, what will be provided for them and how much it will cost. Neither its supporters nor its critics can offer anything more than general guesses.

So for this reason, if for none other, the two lonely men who voted "no" on the final version, Sen. Thurmond and Sen. Goldwater, were right.

For even if you pass over all questions about the wisdom or necessity of plunging the federal government into a medical care program, it is a highly dubious business for the Congress to act under the inevitable pressures of a national political campaign. Granted the best will in the world, political leaders cannot be immune to both the pressures of "buying votes" or the pressures to see that the other party doesn't get "credit" for doing whatever is done.

But the partisan nature of the vote is only a part of the trouble. Perhaps the worst part is the sheer pressure of speed. Granted that some Senators might withstand the pressures of partisanship, there remains the immense problem of taking a vast and complicated subject, understanding it and trying to make some sense out of it.

As a major policy consideration for the Congress, old-age medical care is only a few months old. It was not even seriously considered at all until this year's session was well under way; and haste has marked its whole history since then. Neither the Administration with its proposal, nor the committees of the two Houses with theirs, have been able to hold adequate hearings or consider deeply all the various possibilities and consequences.

Politics or no politics, this is simply not the way for the Congress to enact legislation that will make such a revolutionary change in the shape of our society. The nation's old people are not going to be rendered destitute by a few months more time to consider carefully what is to be done so that, if we adopt such a program, what is done will be wisely conceived.

We don't know who has won the political skirmishing in Washington so far. But we are pretty sure that when the Congress charges into this kind of unconsidered action the whole country is the loser.

Wall Street Journal
Aug. 26, 1960

Continued

A persistent salesman refused to leave when the secretary told him the boss was out. An hour passed, then two. Finally, weary of being a prisoner in his own office, the boss admitted the salesman.

"My secretary told you I was out," exclaimed the puzzled boss. "How'd you know I was in?"

"Easy," explained the salesman. "Your secretary was working."

—Quote, June 19, 1960.



WABASH VALLEY SANITARIUM—HOSPITAL

Lafayette, Indiana
Telephone Riverside 3-1679

A hospital for the treatment of neuro-psychiatric disorders.

Custodial cases are accepted in limited numbers.

— OPEN STAFF —

DONALD R. KINZER
Manager

ALL OVER AMERICA!

KENT with the MICRONITE FILTER IS SMOKED BY MORE SCIENTISTS and EDUCATORS

than any other cigarette!*



KING-SIZE, REGULAR-SIZE OR CRUSH-PROOF BOX

THIS does not constitute a professional endorsement of Kent. But these men, like millions of other Kent smokers, smoke for pleasure, and choose their cigarette accordingly.

The rich pleasure of smoking Kent comes from the flavor of the world's finest natural tobaccos, and the free and easy draw of Kent's famous Micronite Filter.

If you would like the booklet, "The Story of Kent", for your own use, write to: P. Lorillard Company—Research Department, 200 East 42nd Street, New York 17, New York.

For good smoking taste, it makes good sense to smoke KENT

*Results of a continuing study of cigarette preferences, conducted by O'Brien-Sherwood Associates, N.Y., N.Y.

A PRODUCT OF P. LORILLARD COMPANY · FIRST WITH THE FINEST CIGARETTES · THROUGH LORILLARD RESEARCH

© 1960, P. LORILLARD CO.

Continued

Medicinal or Political?

Politically no one gained much in the Senate's "great debate" over medical care for the aged. What we wonder is whether financially or security-wise anyone gained much either.

It wasn't surprising when the solid Democratic majority, backed by five Republicans, turned down the plan Vice President Richard Nixon favored, a plan which would have let the needy aged choose one of three forms of health insurance, providing a minor amount of the financing themselves.

It was somewhat more surprising—though not a complete upset—when Sen. John Kennedy, Nixon's Democratic opponent for the presidency, and Kennedy's running mate, Senate Majority Leader Lyndon Johnson, failed to hold enough Democrats together to push through their plan. It would have linked financing of medical care directly to Social Security.

With both presidential candidates smarting, what came out was a plan, already largely approved by the House, for caring for "medically indigent" oldsters. This is to be financed by both federal and state funds. That means it can't be effective until a number of state legislatures have acted. That means there will be no medical assistance for the aged—other than that already available—until after the election.

It would seem, therefore, that it would have been more statesmanlike, whether or not politically wiser, to have waited until after the election to have made a decision on so complex an issue. Why point with pride at a decision when those it is intended to benefit will have no results at which to point?

We called attention the other day to a survey of the problem by two Emory University professors which showed that most of the aged contacted preferred government medical help only as a last resort. We still see much merit in those findings.

Medical care for the aged, of course, will be a big issue in the current campaign, though the principal candidates will now be more in the position of complaining than crowing.

We would hope, therefore, that this whole problem can be faced more realistically when a new administration and a new Congress can view it with the election results behind, possibly as a partial guide rather than in front, obscuring the scenery.

Gary Post Tribune
Aug. 26, 1960

The Medical Care Issue

The tumult in Washington over medical care for the aged has subsided for the present, and it's become more apparent as to what has been going on. The problem is not so much care of the aged but who is going to develop a campaign issue, phony or otherwise, in the presidential year.

It was strange how the furor over medical care suddenly boiled up in Washington. At one time we got the impression that everyone over 65 must be participating in a barrage of demands that Congress act. "The old people are on the march," was the word.

What was the fact about this march? Well, apparently that it never took place, and that the flood of entreaties to Capitol Hill was a contrived affair.

Rep. Thomas B. Curtis (R-Mo), a member of the House Ways and Means Committee, had a good bit to say about it in the House the other day.

There hadn't been any plans for the committee to consider social security legislation this year, Curtis said. Then COPE, the lobbying arm of the AFL-CIO, decided to make the Forand medical care bill its 1960 issue. COPE had decided to keep hands off the Labor Reform Act, according to Curtis, because Jimmy Hoffa of the Teamsters was going to work on it, and COPE needed something else to shout about.

So the barrage of mail on medical care began. But according to Curtis, practically none of it came from older people who presumably were in such great need of aid.

"It consisted almost entirely of mass printed postcards requiring the sender only to add his name and address," Curtis said. "Most of the cards were 'sticker-addressed' to the congressman. An analysis of my mail and the mail of the congressmen I checked with at random demonstrated that almost all of it was COPE inspired."

Continued

Squibb Announces Chemipen

Squibb Alpha-Phenoxyethyl Penicillin Potassium

new chemically improved penicillin which provides the highest blood levels that are obtainable with oral penicillin therapy



As a pioneer and leader in penicillin therapy for more than a decade, Squibb is pleased to make Chemipen, a new chemically improved oral penicillin, available for clinical use.

With Chemipen it becomes possible as well as convenient for the physician to achieve and maintain higher blood levels—with greater speed—than those produced with comparable therapeutic doses of potassium penicillin V. In fact, Chemipen is shown to have a 2:1 superiority in producing peak blood levels over potassium penicillin V.*

Extreme solubility may contribute to the higher blood levels that are so notable with Chemipen.* Equally notable is the remarkable resistance to acid decomposition (Chemipen is stable at 37°C. at pH 2 to pH 3), which in turn makes possible the convenience of oral treatment.

And the economy for your patients will be of particular interest—Chemipen costs no more than comparable penicillin V preparations.

Dosage: Doses of 125 mg. (200,000 u.) or 250 mg. (400,000 u.), t.i.d., depending on the severity of the infection. The usual precautions must be carefully observed with Chemipen, as with all penicillins. Detailed information is available on request from the Professional Service Department.

Supply: Chemipen Tablets of 125 mg. (200,000 u.) and 250 mg. (400,000 u.), bottles of 24 tablets. Chemipen Syrup (cherry-mint flavored, nonalcoholic), 125 mg. per 5 cc., 60 cc. bottles.

*Knudsen, E. T., and Rolinson, G. N.: Lancet 2:1105 (Dec. 19) 1959.

'CHEMIPEN' IS A SQUIBB TRADEMARK.

SQUIBB

Squibb Quality—the Priceless Ingredient

FOURTH ESTATE

Continued

After the Forand bill and the Boggs bill, a watered-down alternative, were voted down by the Ways and Means Committee, Curtis reported, the mail dwindled away to a trickle "and at the present time it is practically nothing."

So much for the march on Washington. It apparently was not a bonafide demand by the aged for action in their behalf.

Curtis points out why. The most needy aged group—those on relief and not receiving social security—would have gained nothing from the Forand bill. The second group, persons on social security, are more interested in relaxing the $1,200 limit on their supplemental earnings. If they can earn more without losing their social security, they don't need federal aid. For the others who are aged, private health insurance is easily available.

(Insurance statistics show almost half those over 65 now have some form of private health insurance, with the percentage rapidly increasing.)

Curtis does admit catastrophic health insurance is needed for the aged. But he points out that the Forand bill offers just the reverse; its hospital benefits would stop after the first 60 days.

Unfortunately, the contrived postcard barrage on Congress did have an effect, even after the Forand and Boggs bills were sidetracked. President Eisenhower was induced to let Secretary Arthur Flemming go to the Capitol with a hastily drafted substitute and the issue is stirring again.

The Forand bill would pay for medical care through social security. It would cost about $1.1 billion a year and would mean an extra quarter percent payroll tax on both employes and employers. The two-fold administration plan would cost perhaps more, but with states and federal government sharing the bill. It is planned more to handle catastrophic illness, but it is a cumbersome affair.

Neither Forand nor Flemming proposal should be attractive to either the aged or the taxpayers generally. There is a problem to be faced, but these are not good answers. Nor is the answer likely to be found during the welter of partisan debate in a campaign year.

Gary Post-Tribune
May 19, 1960

OVER 80 YEARS' SPECIALIZED EXPERIENCE IN THE RESTORATIVE TREATMENT OF

"THE PROBLEM DRINKER"

At The Keeley Institute your patients are assured of receiving:

- the most modern, coordinated, comprehensive, rehabilitative regimen
- in addition to medical, nutritional and physiotherapeutic treatment, we also offer psychiatric diagnosis and psychotherapy
- full cooperation throughout with the referring physician
- in addition to the care of the alcoholic we also treat narcotic and drug addiction
- surprisingly low cost—to cover all medical care, medicines, laboratory work, room and excellent cuisine

You can obtain more detailed information by writing us direct.

WE WELCOME YOUR REFERRALS...

THE KEELEY INSTITUTE
DWIGHT, ILLINOIS

Member American Hospital Association, Member Illinois Hospital Association. Licensed by the Department of Public Health, State of Illinois.

What Do the Aged Want?

Did anyone ever ask the nation's aged whether they want, or need, all things given to them and done for them? Or has the care-for-the-aged become a handy football for politicians to grab up and carry as election time rolls around?

It seems there is much evidence the aged themselves don't like being placed in the category of being either indigent or childlike, and that they want government aid as a last, not first, resort.

Professors James W. Wiggins and Helmut Schoeck of Emory University in Atlanta, Ga., are social scientists. They have been studying the problem and their preliminary report on a study of the bulk of citizens over 65 and not in institutions is enlightening.

In the sampling 90% said they were in good or fair health; two-thirds declared they were in good health and only 10% said they were in poor health. Final survey remarks written by interviewers give a profile of the aging that shows

Continued

when she's not like herself anymore

Metalex® basic in the care of the aging



when body tone, mental and sensory faculties begin to fade—*she's irritable, confused, forgetful, apathetic*

when voices begin to fade—*in loss of auditory acuity, in tinnitus*

when vision begins to dim—*in loss of visual acuity, in loss of peripheral vision*

℞ Metalex® *cerebral stimulant / vasodilator*

The stimulant—pentylenetetrazol—facilitates cerebral and reflex nerve activity.

The vasodilator—nicotinic acid—augments blood and oxygen supply to vital areas—

Thus, METALEX increases body tone and aids mental and sensory faculties.

Composition: Each teaspoonful (5 ml.) of the Elixir and each Tablet contains: Pentylenetetrazol 100 mg., Nicotinic Acid 50 mg.

Dosage: One or two teaspoonfuls of the Elixir or one or two Tablets four times a day—one-half hour before meals and before bedtime.

Available: Elixir: Pint and Gallon bottles. Tablets: Bottles of 100 and 1000.

References: 1. Goodman, L. S. and Gilman, A.: The Pharmacological Basis of Therapeutics, 2nd Ed., New York, Macmillan Company, 1955. 2. O'Reilly, P. O., Demay, M. and Kotlowski, K.: Cholesteremia and Nicotinic Acid. A.M.A. Arch. Int. Med. 100:797-801 (Nov.) 1957.

STORCK Pharmaceuticals, Inc.,
2326 Hampton Blvd., St. Louis 10, Mo.

them to be in good health and cheerful mood and they appear self-reliant and disdainful of efforts to single them out for special consideration.

The picture is clear. Most aging respondents placed their cash-equivalent assets over liabilities to be in excess of $10,000 and this does not include life insurance benefits due at death. Many reported they had no debts, did not believe in credit buying. This reinforces medical data which shows 92% said they had no medical needs not now being taken care of and 68% said they would take care of unexpectedly large medical bills by cash, by mortgaging homes or would use the cash value of insurance or sell stocks and bonds.

The lack of enthusiasm for governmental help stands out in the response to a question concerning housing if the individual could not finance it himself. Almost half preferred housing under church auspices and less than one fourth chose government housing, even in case of great need. The mere suggestion of governmental housing brought a fright-reaction from some.

Social workers and other interest groups often insist that our modern way of life has become so complicated that our senior citizens need someone to tell them how to take care of themselves. The survey does not bear this out. Many find problems much easier for them than they were for their parents and grandparents.

The care for the aged program, like so many other projects, is off to a runaway development before the primary question has been properly considered and answered. Certainly there are many thing that can be done for the aged and the list is without limit. But, first, do the aged really need all these things and, second, do they really want them? A great many would be surprised to know the aged are much like so many of us—they resent being treated as incapable of thinking and doing things for themselves.

The conclusion of the report is worth thinking about. It warns there should be concern that through studying the aged the social scientists may make them objects rather than persons and in so doing produce problems where none have existed.

There is one thing certain: Concepts of the aged should be re-examined. The politicians are too quick to find ways to spend money, particularly if they think votes can be won. Ways that are not needed to spend money are of much greater interest.

The Gary Post-Tribune
Aug. 22, 1960

A LOGICAL ADJUNCT TO THE WEIGHT-REDUCING REGIMEN

meprobamate **plus** d-amphetamine... reduces appetite...elevates mood...eases tensions of dieting...**without** overstimulation, insomnia or barbiturate hangover.

Dosage: One tablet one-half to one hour before each meal.

anorectic-ataractic

BAMADEX®

meprobamate 400 mg., with d-amphetamine sulfate 5 mg., Tablets

Lederle

And Not So Pressing After All

Now it seems the shirt-tail meeting of Congress, arranged by the Democrats to take care of various "pressing" bills, may end ahead of schedule with several "liberal" measures either defeated or shelved.

There were the usual cynics, of course, who suggested from the beginning that the extra meeting might be a political gimmick designed to put the Republicans on record against government-distributed goodies. In theory the Democrats couldn't lose. If their high-spending plans were approved, they could claim credit. If their bills were vetoed, the Republicans would suffer



IN COLDS AND SINUSITIS— THE RIGHT AMOUNT OF "INNER SPACE" RIGHT AWAY

Neo-Synephrine hydrochloride relieves the boggy feeling of colds immediately and safely, without causing systemic toxicity or chemical harm to nasal membranes. Turbinates shrink, sinus ostia open, ventilation and drainage resume, and mouth-breathing is no longer necessary.

Gentle Neo-Synephrine shrinks nasal membranes for from two to three hours without stinging or harming delicate respiratory tissues. Post-therapeutic turgescence is minimal. Neo-Synephrine does not lose its effectiveness with repeated applications nor does it cause central nervous stimulation, jitters, insomnia or tachycardia.

Neo-Synephrine solutions and sprays produce shrinkage of tissue without interfering with ciliary activity or the protective mucous blanket.

For wide latitude of effective and safe treatment, Neo-Synephrine hydrochloride is available in nasal sprays for adults and children; in solutions from ⅛% to 1%; and in aromatic solution and water soluble jelly.

Winthrop LABORATORIES
New York 18, N. Y.

NEO-SYNEPHRINE®
(Brand of phenylephrine hydrochloride)
hydrochloride
NASAL SOLUTIONS AND SPRAYS

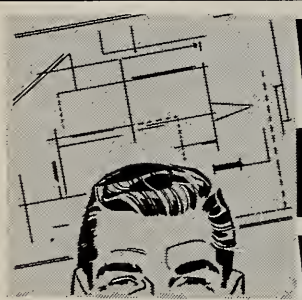
for it at the polls. The scheme seemed airtight because in a Presidential election year—so the lofty liberal theory goes—the voter is only an outstretched hand.

Unfortunately for Messrs. Johnson and Kennedy, the best laid plans of politicians sometimes go awry. In this case, it was the Republicans who sponsored a civil rights bill which the Democrats decided to reject. Then the Republicans and conservative Democrats teamed up to knock down a plan to put old-age medical benefits under Social Security. And other measures, such as Federal aid to the housing industry and Federal aid to education, have thus far not made it to the floor.

So now Sen. Kennedy has declared that he's for cutting the session short and going home just as fast as possible.

And perhaps, as if it were needed, this is the final evidence that all those "pressing" bills are not really very pressing after all.

Wall Street Journal
Aug. 26, 1960



VISION REQUIRES VISION

Vision for planning man's future largely originates in the mind's eye — but it must be translated to the visual medium for understanding by those who follow the lead. White-Haines follows the professional man's lead in augmenting or correcting visual defects through fine quality ophthalmic craftsmanship, and has been a dependable source for more than half a century.

THE White-Haines OPTICAL COMPANY
34 Modern Laboratories
OHIO • PENNSYLVANIA • MARYLAND
KENTUCKY • W. VIRGINIA • INDIANA
MICHIGAN • ILLINOIS

Safe Used Cars and Drunken Driver Penalties

Anything constructive that will help improve highway safety is worth trying. This is true of a proposal by the Governor's Traffic Safety Study Commission to require used car dealers to certify that all vehicles sold by them have passed a rigid safety test.

It is doubtless true, as State Sen. Eugene Bainbridge of Munster says, that some used cars sold to the public are in terrible condition. This is not the case of all used cars, for most dealers are conscientious and make special efforts to see that their cars are safe and in good operating order before they deliver them.

But if the Governor's commission has evidence that a large number of used cars are not in proper condition when sold, it has reason to make its recommendation for new legislation.

The commission is also thinking of recommending a change in the law covering drunk driving. It has under consideration a proposal to junk the present one-year mandatory prison sentence for drunk drivers convicted of inflicting bodily injury and would leave the sentencing up to the judge. But the sentence for first convictions, in cases of injury, would range from one to five years and $5,000 fines. In addition, a violator could lose his driver's license for a year.

Drivers caught while driving under the influence of alcohol would be subject to five days in jail on the first offense and their licenses could be suspended from two to six months, if the proposed changes are made.

The problem of the drinking driver is such a serious one that any revisions of the law should not weaken the power of the state to deal with it. The present mandatory penalty of one year for drunk drivers who injure other persons has a good deal of merit because it is mandatory. If the proposed change removes the mandatory feature, and leaves the matter of sentencing to judges, we do not believe it will be effective. If, however, the one-to-five-year sentence would mean that the one-year minimum would still be mandatory, the change would be in order. It would be a good change if it added weight to the fight to drive the drinking motorist off the highways.

Kokomo Tribune
July 4, 1960
◄

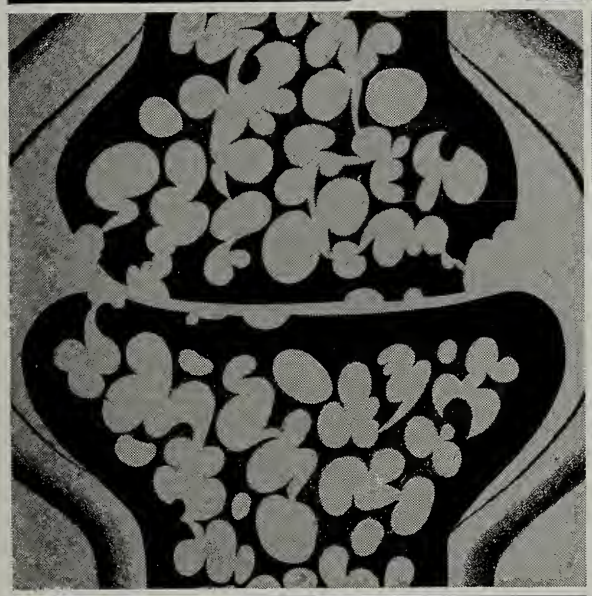
in rheumatic disorders

whenever aspirin proves inadequate



Sterazolidin®

brand of prednisone-phenylbutazone



Even in the more transient rheumatic disorders, an anti-inflammatory effect more potent than that provided by aspirin is often desirable to hasten recovery and get the patient back to work.
By combining the anti-inflammatory action of prednisone and phenylbutazone, Sterazolidin brings about exceptionally rapid resolution of inflammation with relief of symptoms and restoration of function.
Since Sterazolidin is effective in low dosage, the possibility of significant hypercortisonism, even in long-term therapy, is substantially reduced.

Availability: Each Sterazolidin® capsule contains prednisone 1.25 mg.; Butazolidin®, brand of phenylbutazone, 50 mg.; dried aluminum hydroxide gel 100 mg.; magnesium trisilicate 150 mg.; and homatropine methylbromide 1.25 mg. Bottles of 100 capsules.

Geigy, Ardsley, New York

Geigy

165-60

ABSTRACTS

BOOK REVIEWS

COLLEGE CAMPUS PSYCHIATRY

By H. G. Whittington, *J. of Kansas Med. Soc.* 61:327-329, 1960.

This common-sense article comes from the director of the Mental Health Clinic of the Student Health Service of the University of Kansas, in which clinic almost four percent of the total enrollment of the school is seen each year, with a variety of emotional problems, covering the entire range of psychiatric illness except those diseases confined to old age.

The article appeals fundamentally to family physicians for recognition of psychiatric illness at these ages, the need for which is supported by the fact that only one of 500 students seen in the last two-year period had been referred by a local physician. It is suggested that doctors are simply insensitive to the emotional problems of adolescents although alert to similar problems in adults, forgetting, "all the exquisite self-torture, confusion, and doubt of our young patients."

It is also suggested that the family physician take a practical approach to the problem of poor scholastic work, remembering that "the most frequent cause of poor academic achievement is low academic ability" and that "motivation for further education is often lacking."

COOK COUNTY
GRADUATE SCHOOL OF MEDICINE
INTENSIVE POSTGRADUATE COURSES
STARTING DATES — FALL, 1960

Surgical Technic, Two Weeks, November 7, December 5
Blood Vessel Surgery, One Week, November 28
Surgery of Colon & Rectum, One Week, November 28
Gallbladder Surgery, Three Days, October 17
Surgery of Hernia, Three Days, October 20
General Pediatrics, Two Weeks, October 3
Electrocardiography & Heart Disease, Two Weeks, October 3
Internal Medicine, Two Weeks, October 17
Hematology, One Week, October 10
Diagnostic Radiology, Two Weeks, October 17
Board of Surgery Review, Part I, Two Weeks, November 7
Gynecology, Office & Operative, Two Weeks, October 31
Vaginal Approach to Pelvic Surgery, One Week, November 28
Obstetrics, General & Surgical, Two Weeks, October 3
Fractures & Traumatic Surgery, Two Weeks, October 24

TEACHING FACULTY—ATTENDING STAFF OF COOK COUNTY HOSPITAL

Address:
REGISTRAR, 707 South Wood Street, Chicago 12, Illinois

The author feels that there is nothing unusual in a college student making one or more false starts before ending up in the right career. Contrasted to this is the factor of chronic personality disorder expressed in long-standing academic difficulty or some acute disturbance shown in a sudden falling off of achievement after previous good accomplishment.

The author believes that the family doctor is capable of resolving most of these adolescent emotional disturbances if he will make himself available as a friend and listener to these young people and their parents. The author closes by decrying the use of ataraxic medication in this age group as a substitute for sympathetic understanding on the part of the family physician.

Stephen L. Johnson, M.D.
Evansville

IMPOTENCE AND DIABETES MELLITUS

By Leonard Tushnet, *J. of Med. Soc. of N.J.* 57:256-257, 1960.

This article sounds a timely warning against explaining all functional type complaints on a psychologic basis. From what the author calls his general family practice, he cites five case reports of impotence developing in men with previously normal sexual patterns. In three of the patients it had been assumed to be the result of a guilt complex.

Prior to the diagnosis of the diabetes mellitus one patient had psychotherapy, one psychoanalytic therapy over a period of two years, one treatment by a "psychologist," and one, rather than admit his complaints locally, had been seen by three out-of-town psychiatrists and had one course of injection treatments. Four of the five regained normal sexual activity following control of their diabetes mellitus.

Stephen L. Johnson, M.D.
Evansville

CARCINOGENESIS—Mechanisms of Action

By G. E. Wolstenholme, O.B.E., M.B., B.Ch., and Maeve O'Connor, B.A., Editors for the Ciba Foundation. 336 pp., 48 illustrations. $9.50. Little, Brown & Company, Boston, Mass., 1959.

This book is a collection of original papers by an international group of authors whose approaches to the problem are as varied as their interests. The agents discussed are viruses, radiation, hormones, amines and metals. The immunologic aspects are reviewed, and the two-stage concept of skin carcinogenesis is presented with new implications. The final chapter on the problems of testing preparations for carcinogenic properties in the chemical industry broadly hints at its tremendous scope. Each paper is followed by a list of selected references and unedited discussion by the symposium participants. The summary is pertinent: There is no one basic mechanism of carcinogenesis. The book is technical, theoretical and in some areas, not readily understandable. It is a timely publication for researchers, but the busy practitioner will find little information of clinical value.

N. D. Sisson, M.D.
South Bend Medical Foundation, Inc.

Continued



Use of pHisoHex for washing the skin augments any other therapy for acne — brings better results. Now, pHisoAc Cream, a new acne remedy for topical application, suppresses and masks lesions — dries, peels and degerms the skin. Together, pHisoHex and pHisoAc provide **basic** complementary topical therapy for acne.

pHisoHex, antibacterial detergent with 3 per cent hexachlorophene, removes soil and oil better than soap — provides **continuous** degerming action when used often. pHisoHex is nonalkaline, nonirritating and hypoallergenic.

When pHisoAc Cream is used with pHisoHex washings, it unplugs follicles, helps prevent development of comedones, pustules and scarring. New pHisoAc Cream is flesh-toned, not greasy. It contains colloidal sulfur 6 per cent, resorcinol 1.5 per cent, and hexachlorophene 0.3 per cent in a specially prepared base. pHisoAc is pleasant to use.

A new "self-help" booklet, **Teen-aged? Have acne? Feel lonely?,** gives important **psychologic first aid** for patients with acne and describes the proper use of pHisoHex and pHisoAc. Ask your Winthrop representative for copies.

pHisoAc is available in 1½ oz. tubes and pHisoHex is available in 5 oz. plastic squeeze bottles and in bottles of 16 oz.

pHisoHex® and pHisoAc for acne

trademark

Winthrop
LABORATORIES
New York 18, N. Y.

IN SEARCH OF COMPLICATIONS

Memoirs of Eugene de Savitsch, M.D., 352 pages; Andre Deutsch, Soho Square, London W. 1, 1958, 21 shillings.

After the mawkish meanderings and plaintiff pulings of one Russian best seller—*Dr. Zhivago*—it is refreshing indeed to turn to the autobiography of a real life ex-Russian nobleman, Baron Eugene de Savitsch. While still in his teens, this individual born to luxury went through the fiery crucible of the losing side of the Russian Revolution. Cast upon American shores with just the shabby clothes on his back, he had the additional misfortune of coming down with tuberculosis. Had he merely wrung his hands and railed at his fate, he would have been just another faceless victim of circumstance.

The tale, however, is of a completely different sort. A real life Horatio Alger story emerges as de Savitsch sallies forth from the sanatorium, struggles as a medical student, fails, tries again, takes a post as a surgeon in the Congo, and (eventually) evolves into THE surgeon to the diplomatic corps and the famous names of Washington, D. C., London and all points of the compass East and West.

Without being afflicted with undue modesty, Dr. de Savitsch escapes having the inflated ego that bores. His running comments on the passing scene are pungent, probe with the keenest of scalpels exposing both the good and the sham, and, much more often than not, are original and most thought-provoking.

All persons of good will and ALL doctors in particular are urged to scan especially the chapter on "The Dachau of the U.S." I met Dr. de Savitsch at the University of Chicago where we worked side by side as students of "Ajax"—the great physiologist, A. J. Carlson. I accept this chapter as having its facts straight. The shocking facts as given should be pondered as we discuss narcotics and what to do about them. Only when petty bureaucrats acquire unlimited, uninvestigated absolute power over some of their less fortunate fellow citizens can such truly horrifying abuses occur—even in this great Land of Freedom.

Dr. de Savitsch wrote this splendid volume while recuperating in London from a coronary occlusion. It is a tragedy that a second attack was fatal in the spring of 1960. I would have so wanted to ask the author for several items to be inserted in this unpretentious book. Maybe, the executor could put into the next reprinting a couple photographs of the author as he was during the halcyon pre-Revolutionary days as a student at Tsarskoye Selo and another photograph as he was in his prime. It is a pity that Dr. de Savitsch had not put down on paper his reflections on the present Russian regime. As far as I know, he was the first one in this country to mention Khrushchev's name after Stalin's death, "Watch the durable peasant!"

Also, Dr. de Savitsch was very careful to omit the personal chitchat on the historical personages that had come to him for surgery. He carried to the grave much that could have enlivened these memoirs and also have shed light on current events.

This reviewer *can,* however, make a personal plea with his wife to arrange for an American reprinting of these fascinating memoirs. America was the land of his adoption; this is the least that should be done. I do believe that he would have welcomed the thought.

Arnold Lieberman, M.D.
New York, N. Y.

DR. ZHIVAGO

Translated from the Russian of Boris Pasternack.

The enormous reputation acquired by Boris Pasternack lies very firmly in his splendid poesy (totally garbled when translated) and in his translation of Shakespeare into Russian. "Dr. Zhivago" is my first contact with this author. Maybe, even the translation of a prose work suffered butchery in the process; maybe, I just expected too much. Frankly, I cannot explain its stay on the top of the best seller list except as a consequence of the enormous furor generated by the ban placed upon its publication within Russia itself. It is my opinion that the Kremlin blundered egregiously when it made this book a political issue. Without such gratuitous publicity, it is to be doubted that many people in this country would have heard of it.

"Zhivago" itself is a play on words: *gentlemanly rake* comes fairly close—an individual who had lived to the hilt and seen all there is to life. The name sets the theme; the canvas is vast; the characters are numerous (and confusing); much is said and more is implied—

The Norbury Sanatorium

Established 1901 — Incorporated
Licensed — Jacksonville, Illinois

FRANK GARM NORBURY, A.M., M.D., Medical Director
HENRY A. DOLLEAR, M.D., Superintendent
FRANK B. NORBURY, M.D., Physician

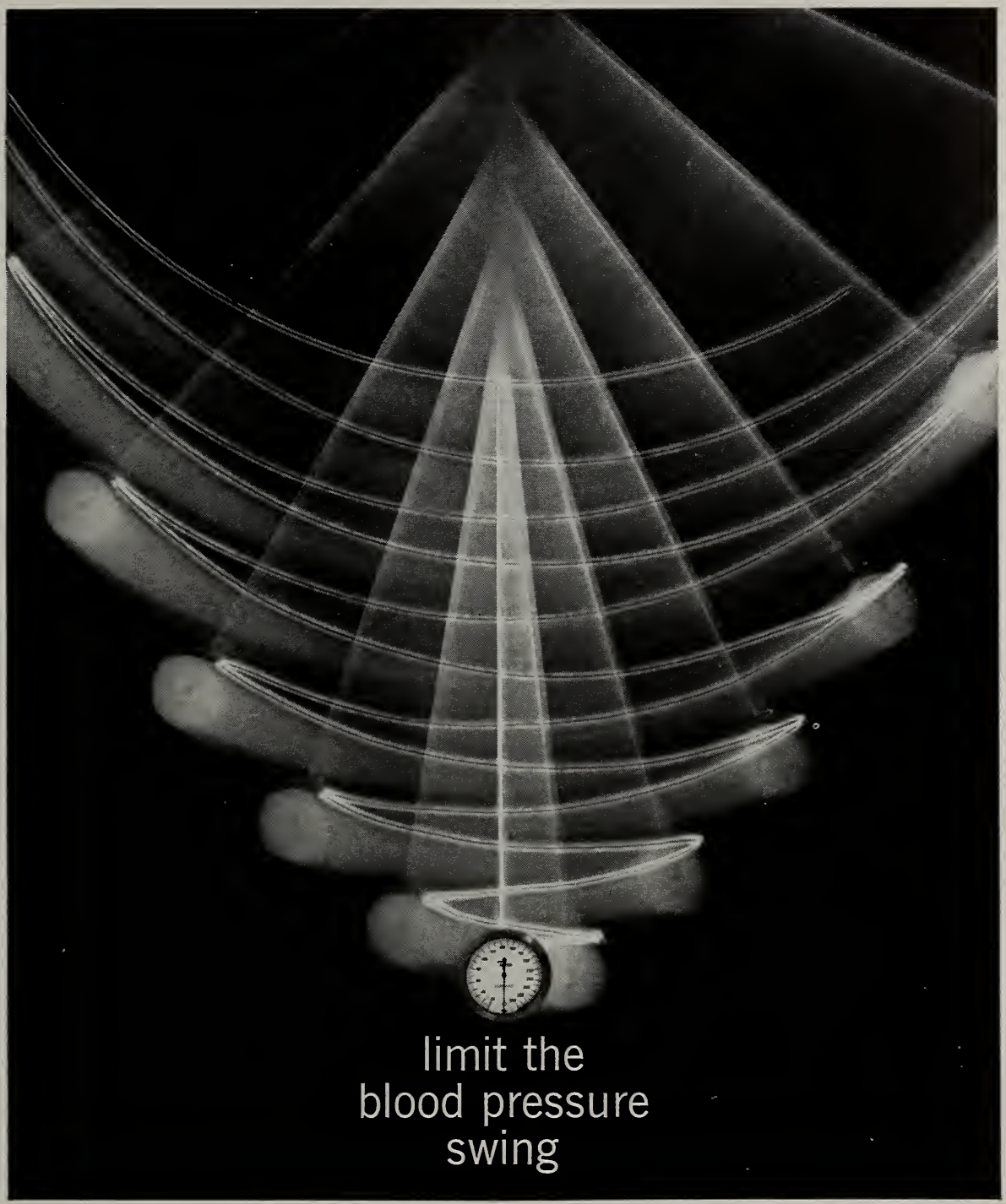
Operating

Maplecrest—

Restful, congenial, homelike surroundings are combined with the most modern diagnostic and therapeutic equipment.

Maplewood—

Most comfortable home for individuals requiring rest, scientific diagnosis and treatment. Fireproof construction.



Rautrax-N lowers high blood pressure gently, gradually . . . protects against sharp fluctuations in the normal pressure swing. Rautrax-N combines Raudixin, the cornerstone of antihypertensive therapy, with Naturetin, the new, safer diuretic-antihypertensive agent. The complementary action of the components permits a lower dose of each thus reducing the incidence of side effects. The result: Maximum effectiveness, minimal dosage, enhanced safety. Rautrax-N also contains potassium chloride — for added protection against possible potassium depletion during maintenance therapy.

Supply: Rautrax-N — capsule-shaped tablets — 50 mg. Raudixin, 4 mg. Naturetin, and 400 mg. potassium chloride. Rautrax-N Modified — capsule-shaped tablets — 50 mg. Raudixin, 2 mg. Naturetin, and 400 mg. potassium chloride. For complete information write Squibb, 745 Fifth Avenue, New York 22, N. Y.

new **Rautrax-N***

Squibb Standardized Whole Root Rauwolfia Serpentina (Raudixin) and Benzydroflumethiazide (*Naturetin) with Potassium Chloride

Squibb Quality—The Priceless Ingredient

SQUIBB

RAUDIXIN,® RAUTRAX,® AND NATURETIN® ARE SQUIBB TRADEMARKS.

to that extent the comparison with Tolstoy's *War and Peace* might be valid. But the fatal flaw lies in the fact that it deals with the self-imposed frustrations of a totally impractical member of the Russian intelligentsia circa 1900, i.e., Pasternack's own milieu.

In many ways, Pasternack is describing himself. But, good a writer as he is, he lacks the insight of a Dostoyevsky or the scalpel of a Balzac. Had "Dr. Zhivago" had himself psychoanalyzed, the book would certainly have been the gainer. The hero is a member of the upper classes; he reproaches himself for being so comfortable while the mouzhiks are in want. With a monotonous continuity, the good doctor goes through various masochistic performances. Various persons (mostly female) perpetually feel sorry for his (self-inflicted) plight; they rescue our bedraggled hero who (most unheroically) welcomes the escape hatch.

Dr. Zhivago has no self control or back-bone; he will not resist himself no matter how wrong he knows his impulses of the moment to be. He is unfaithful to his wife and family; he flees his adult responsibilities even as he realizes the enormity of his derelictions—it is that he simply will not control either his ego or his id!! Most exasperatingly, just at the climax, precisely at the point where Dostoyevsky or Balzac would have gone into exhaustive analytical detail—just there, Pasternack calmly leaves Zhivago in mid-air, stops abruptly and goes on the next situation. Apparently, Boris Pasternack does not trust himself to REALLY dissect the hero—himself, that is. Or does he lack the analytical touch?



"It was nothing really . . . cut myself shaving! Now are you ready for that delicate operation?"

Curiously enough, Zhivago is hostile to the idea of being Jewish; he is not anti-Semitic in the vulgar, Nazi sense of the word. However, we should remember that Boris Pasternack was a Jew converted to Christianity so that he is an intellectual kinsman of such converts of a century ago as Heinrich Heine and Felix Mendelssohn. Pasternack does have Zhivago express many Tolstoyan concepts; the hero also mouths a number of confused ideas that are neither flesh nor fowl nor even good red herring. It may be that the key to Boris Pasternack himself may lie in a dispassionate dissection of his flight from the rationalities of Judaism. Some day, a perceptive biographer may pierce the murky envelope veiling both "Dr. Zhivago" and his creator from the public gaze.

All in all, by his very failure, Pasternack succeeds in presenting to the world the clinical portrait of the pre-Bolshevik, Russian intellectual: the blundering ineptness, the hopelessly muddled thinking; the weak-kneed yielding to desires no matter how wrong, the anguished pose of martyrdom—all are there.

Had Khruschchev had the wit to give Zhivago the Lenin prize, few Westerners would have read it. *Dr. Zhivago* makes comprehensible Lenin's success: there were just too many Zhivagos around. On that basis, it merits a niche as recommended reading for all social inactionists.

Arnold Lieberman, M.D.
New York, N. Y.

®
BAMADEX
meprobamate 400 mg., with d-amphetamine sulfate 5 mg., Tablets
anorectic-ataractic
A logical combination for appetite suppression
meprobamate **plus** d-amphetamine...suppresses appetite...elevates mood... reduces tension...**without** insomnia, overstimulation or barbiturate hangover.
Dosage: One tablet one-half to one hour before each meal.
Lederle

as it calms anxiety!

Smooth, balanced action lifts depression as it calms anxiety... rapidly and safely

Balances the mood — no "seesaw" effect of amphetamine-barbiturates and energizers. While amphetamines and energizers may stimulate the patient *—they often aggravate anxiety and tension.*

And although amphetamine-barbiturate combinations may counteract excessive stimulation—*they often deepen depression.*

In contrast to such "seesaw" effects, Deprol's smooth, *balanced* action lifts depression as it calms anxiety—both at the same time.

Acts swiftly — the patient often feels better, sleeps better, within a few days. Unlike the delayed action of most other antidepressant drugs, which may take two to six weeks to bring results, Deprol relieves the patient quickly — often within a few days. Thus, the expense to the patient of long-term drug therapy can be avoided.

Acts safely — no danger of liver damage. Deprol does not produce liver damage, hypotension, psychotic reactions or changes in sexual function—frequently reported with other antidepressant drugs.

Bibliography *(13 clinical studies, 858 patients)*: **1.** Alexander, L. (35 patients): Chemotherapy of depression — Use of meprobamate combined with benactyzine (2-diethylaminoethyl benzilate) hydrochloride. J.A.M.A. *166*:1019, March 1, 1958. **2.** Bateman, J. C. and Carltan, H. N. (50 patients): Meprobamate and benactyzine hydrochloride (Deprol) as adjunctive therapy for patients with advanced cancer. Antibiotic Med. & Clin. Therapy 6:648, Nov. 1959. **3.** Beerman, H. M. (44 patients): The treatment of depressian with meprobamate and benactyzine hydrochloride. Western Med. *1*:10, March 1960. **4.** Bell, J. L., Tauber, H., Santy, A. and Pulito, F. (77 patients): Treatment of depressive states in office practice. Dis. Nerv. System 20:263, June 1959. **5.** Breitner, C. (31 patients): On mental depressions. Dis. Nerv. System 20:142, (Section Twa), May 1959. **6.** Gordon, P. E. (50 patients): Deprol in the treatment of depression. Dis. Nerv. System 21:215, April 1960. **7.** Landman, M. E. (50 patients): Clinical trial of a new antidepressive agent. J. M. Soc. New Jersey. In press, 1960. **8.** McClure, C. W., Papas, P. N., Speare, G. S., Palmer, E., Slattery, J. J., Konefal, S. H., Henken, B. S., Wood, C. A. and Ceresia, G. B. (128 patients): Treatment of depression — New technics and therapy. Am. Pract. & Digest Treat. *10*:1525, Sept. 1959. **9.** Pennington, V. M. (135 patients): Meprobamate-benactyzine (Deprol) in the treatment of chronic brain syndrome, schizophrenia and senility. J. Am. Geriatrics Soc. *7*:656, Aug. 1959. **10.** Rickels, K. and Ewing, J. H. (35 patients): Depral in depressive conditions. Dis. Nerv. System 20:364, (Section One), Aug. 1959. **11.** Ruchwarger, A. (87 patients): Use of Deprol (meprabamate cambined with benactyzine hydrochloride) in the office treatment of depression. M. Ann. District of Columbia 28:438, Aug. 1959. **12.** Settel, E. (52 patients): Treatment of depression in the elderly with a meprobamate-benactyzine hydrochloride cambination. Antibiotic Med. & Clin. Therapy *7*:28, Jan. 1960. **13.** Splitter, S. R. (84 patients): Treatment of the anxious patient in general practice. J. Clin. & Exper. Psychopath. In press, April-June 1960.

Dosage: Usual starting dose is 1 tablet q.i.d. When necessary, this dose may be gradually increased up to 3 tablets q.i.d.

Composition: 1 mg. 2-diethylaminoethyl benzilate hydrochloride (benactyzine HCl) and 400 mg. meprobamate. **Supplied:** Bottles of 50 light-pink, scored tablets. Write for literature and samples.

Deprol®

WALLACE LABORATORIES / *Cranbury, N. J.*

CD-2843

More About the Federal Employee Blue Shield And Blue Cross Programs

(One of a series prepared by Blue Cross—Blue Shield)

Blue Cross—Blue Shield led all other organizations in the enrollment of Federal workers when they chose a health program in June. Nationally, more than 55% of the estimated 1,695,000 employees chose Blue Cross—Blue Shield. In Indiana, preliminary reports reveal that based on the national average of enrollment, acceptance of Blue Cross—Blue Shield here was higher than the national average. Some 32,000 Federal employees living in Indiana were eligible for protection.

Basic Benefits

This program includes Basic Benefits, handled by Indiana Blue Shield and Supplemental Benefits, provided through Health Service, Inc. and Medical Indemnity of America, Inc., on a national basis.

Basic Benefits for surgical and medical expense include a High Option and a Low Option. In Indiana the Low Option approximates our Standard Schedule and the High Option approximates our Preferred Schedule. For these Basic Benefits the doctor should complete a regular Indiana Blue Shield claim form, and mail it to the Blue Shield office in the usual manner.

Most Federal employees now have their Federal employee Identification Cards, but if such a member does not have his new card, ask him to obtain his identification number and enrollment code numbers from his employer. Be sure to include these numbers on the claim form submitted to Indiana Blue Shield.

Supplemental Benefits add to the Basic Benefits in amount and kind. Between the Basic Benefits and the Supplemental Benefits there is a deductible to be paid by the Federal employee member. After such a deductible is paid, Supplemental Benefits provide payment for the major portion of most covered expense over the deductible.

The "Deductible" and Co-Insurance

The Deductible is the amount the member pays for services and supplies included under Supplemental Benefits before Health Service, Inc., starts paying any Supplemental Benefits. The deductible is $100 under High Option and $200 under Low Option.

There is a separate Deductible for each covered member of the member's family for each Benefit Period. However, if two or more covered members of the same family are injured in the same accident, the member pays only one Deductible for those members.

Supplemental Benefits

When a patient exhausts his Basic Benefits, he will be entitled to Supplemental Benefits. Also, while a patient is receiving Basic Benefits, he will be entitled to receive *concurrently* certain benefits that are provided *only* under Supplemental Benefits.

To claim Supplemental Benefits, the Federal employee member must file a completed Major Medical Claim Form, together with itemized bills and receipts connected with the claim. This material is sent by the member to Blue Cross—Blue Shield, 14th and L Streets NW, Washington 5, D. C. The doctor does not complete a Major Medical Claim Form unless requested to do so by the member, who supplies the form. Payment for covered Supplemental Benefits will be made to the member by Group Hospitalization, Inc.—Medical Service of District of Columbia, Washington, D.C.

Supplemental Benefits include the following services covered under both the High Option and the Low Option:

Services of physicians, including specialists, in and out of a hospital, for surgery, in-hospital medical care, in-hospital consultations, office visits and home calls, administration of anes-



"Frankly, one in my position can't be too careful — that's why I've chosen Blue Shield for my family!"

Blue Shield

Mutual Medical Insurance, Inc.
110 N. Illinois St., Indianapolis 9, Ind.
Phone MElrose 5-9411

Sponsored by the Indiana State Medical Association

Letters

to the editor

Dear Doctor Ramsey:

I thank you, sir, and Hawaii thanks you, for your gracious "Special Medical Salute to Hawaiian Statehood" in your June issue, with the beautiful cover depicting the *noni* apple. It was a kindly gesture and we are appreciative!

I cannot repress a shudder, however, at the author's failure to use the word "lore"—or similar expressions—more freely throughout the text; indeed, her failure to use such expressions at all. The note of humor in paragraph four is about all the indication she gives the reader that she is merely kidding; aside from this, these utterly unfounded legends are recounted with the straightest possible face. As a legend collector, she has few peers; but her "bump" of skepticism is a dangerously deep depression instead of a bump.

Her remark about *okolehao's* having been banned for many years is one of the few truths in her article. It was indeed banned—no doubt you in Indiana have heard of the Volstead Act? This is the ban to which she refers. Okolehao is about 100 proof.

Most of the Hawaiiana was pretty accurate: an exception was "NUI" (which means "big") for "NIU" (which is the correct word for coconut).

On the whole, it was really an affectionate and kindly article. I just wanted to make sure your readers would know that only Miss Wilson and a few old-timers believe any of these things. Thanks again!

Cordially yours,
Harry L. Arnold, Jr., M.D.
Editor *Hawaii Medical Journal*

Dear Sir:

Your editorial, "Dangers of Mail-Order Dispensing," in the August issue of the *Journal of the Indiana State Medical Association* has come to our attention and has been circulated among our staff. Likewise, we have added this title to a current and continuing bibliography of articles about the pharmaceutical industry that have appeared in the medical press.

We are appreciative of your interest in publishing this timely editorial for the many readers of the *Journal of the Indiana State Medical Association.*

Sincerely,
Robert J. Benford, M.D.
Director of Medical Relations
Pharmaceutical Manufacturers Association

FEDERAL PROGRAMS

Continued

thesia, x-ray and diagnostic laboratory procedures, radiation treatment and blood transfusions. Supplemental Benefits will be paid without regard to any fee schedules for reasonable and necessary expenses.

After the Deductible has been met by the member, Co-insurance then provides for the following:

High Option: Plan pays 80% of remainder of covered expenses and the member pays 20%, up to a maximum of $10,000 during any one Benefit Period. Maximum for two or more Benefit Periods is $20,000.

Low Option: Plan pays 75% of remainder of covered expenses and the member pays 25% up to a maximum of $2,500 during any one Benefit Period. Maximum for two or more Benefit Periods is $5,000.

When the $20,000 or the $5,000 maximum benefit has been paid for an individual, it can be reinstated upon acceptable evidence of his insurability.

A Benefit Period begins on the first day a member receives care by a physician for the treatment of any covered illness or injury. It ends 12 months after it began, or upon the expiration of 90 consecutive days during which no covered expenses were incurred, whichever occurs first. There is a separate Benefit Period for each covered member of the member's family.

For more complete information about Federal employee programs, see the September 1960 issue of *NewsVane,* which has been mailed to all Indiana doctors.

W. C. Huddlestone
Public Relations Division ◄

The Journal of the INDIANA STATE MEDICAL ASSOCIATION

Supervised by THE COUNCIL

Volume 53 — September 1960 — Number 9

First Place Medical Essay

Sickle Cell Anemia: Case Report and Review

*ARTHUR S. MORSE, JR., M.D.**

Muncie

SINCE THE DISCOVERY of hemoglobin S by Pauling *et al.* in 1949,[4] many forms of the hemoglobin molecule have been isolated by many methods including electrophoresis. These include the normal Hgb A and Hgb F from adult and newborn, respectively, and various "abnormal" hemoglobins, such as Hgb C, Hgb D and Hgb I, to name but a few. These discoveries have made possible accurate study of a group of several previously poorly understood hemolytic anemias.

The author encountered such a case of an abnormal hemoglobin in a patient with sickle cell anemia (also known as meniscocytosis and drepanocytic anemia). This patient and his family have been studied in an effort to gather as many details as possible concerning a known hemoglobinopathy—its manifestations, laboratory findings and hereditary pattern. Data collected are presented herein, as well as review of the essential knowledge concerning this condition.

Methods

A patient with homozygous Hgb S disease was studied by history, physical examination and detailed hematological survey. His and his immediate family's genetic hemoglobin pattern was determined by paper electrophoresis.

Electrophoretic studies were performed by a modification of the method recommended by the Spinco division of Beckman Instruments, Inc.

After washing with saline, the cells were lysed with distilled water and the stromal fraction extracted with toluene. The hemoglobin fraction was then mixed with six percent bovine albumin

* Pathology Resident, Ball Memorial Hospital; First Place, *Journal* Medical Essay Contest, 1960.

Hemoglobin	10.6 Gm.	WBC	8600/mm^3
RBC	3.32M/mm^3	Differential	
Hematocrit	30%	Eosinophils	2
Indices		Basophils	1
Color index	1.09	Lymphocytes	36
MCV	106 u^3	Monocytes	4
MCH	32 uug	Bands	1
MCHC	35 g/100 ml. packed cells	Segs	56
		Anisocytosis	+
Reticulocyte count	2.2%	Hypochromasia	+
Sedimentation rate, corr.	7 mm/hr.	Target cells	40/100 WBC
Fragility studies		Normoblasts	10/100 WBC
Osmotic	.45% saline	Sickle cell prep	++
Mechanical	6.4% hemolysis	Alkali denaturation	7% Hgb. F
Mazzini	Negative	Urobilinogen, urine	1:16

TABLE I

SUMMARY OF LABORATORY DATA of patient. Note positive sickle cell preparation, and presence of target cells and normoblasts on blood smear.



FIGURE 1

NEGATIVE FIVE-MINUTE intravenous pyleogram. Notice splenomegaly and absence of aseptic necrosis of femoral heads.

solution. Hemoglobins were migrated in a Spinco paper electrophoresis cell in a Veronal buffer (pH 8.6) at 11 milliamperes per cell for four hours. Paper strips were then stained by standard methods and analyzed in a Spinco analytrol apparatus.

Case Report

A 15-year-old Negro male complained of sudden onset of exquisite pain in the right shoulder and arm and both elbows.

Past History: He had been hospitalized on numerous other occasions with pain in other joints, most commonly the right hip. Tentative diagnoses considered were acute rheumatic fever and rheumatoid arthritis. No history of jaundice or blood transfusion was obtained.

Family History: All members of the immediate family, i.e., father, mother and two half brothers had intermittent "arthritis" of various joints characterized by moderate swelling and tenderness, but no jaundice. The mother's sister and her children had similar complaints of "arthritis." A niece, who died at age 13, had complaints similar to those of the patient.

Physical examination revealed blood pressure 120/80. Pupils reacted to light and accommodation and eye grounds appeared normal. Examination of heart and lungs produced results

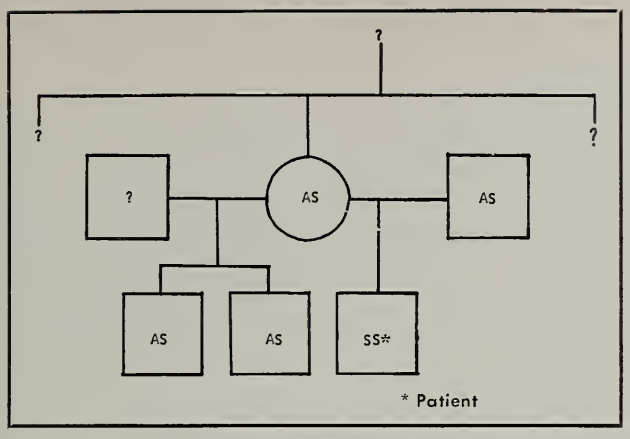


FIGURE 2

PEDIGREE of patient's family genetic hemoglobin pattern.

within normal limits. Liver and spleen were not palpable. No abnormal masses or tenderness were noted, no leg ulcers were present and neurological examination was within normal limits.

Laboratory findings were as tabulated in Table I. Roentgenologic studies of the genitourinary tract, which were taken for a subsequent urinary tract infection, revealed a normal intravenous pyelogram but did demonstrate splenomegaly of moderate degree (Figure 1).

The patient was given symptomatic care throughout his hospital stay. Sedatives and even narcotics were required for relief of pain and restlessness. There was no fever during this period. After approximately eight days, the symptoms abated and the patient was sent home.

Analysis of Laboratory Data

Table II represents a comparison between the expected laboratory results of a case of homozygous Hgb S disease and the case presented herein.

Hemoglobin, erythrocyte count and hematocrit gave evidence of the existing moderate anemia, as was expected. Erythrocyte indices were within the expected range except the MCV, which was elevated. A macrocytic tendency of the erythrocytes may occur in severe cases of sickle cell anemia, however.

Reticulocyte count gave evidence of only a slight bone marrow response to the anemia. The reason for this poor response was not fully understood since a bone marrow examination was not performed. Target cells and normoblasts were in the expected range of a case of

Test	*Usual Results*	*Patient*
Hemoglobin (Gm.)	8-11	10.6
RBC (/mm^3)	2-3M	3.32M
Hematocrit (%)	25-35	30
Indices		
Color index	1	1.09
MCV(u^3)	70-80	106
MCH (uug)	30-32	32
MCHC (g% packed cells)	33-36	36
Reticulocyte Count (%/1000 RBC)	5-25	2.2
Sedimentation rate, corr. (mm/hr.)	0-8	7
Fragility studies		
Osmotic (% saline)	.25-.45	.45
Mechanical (% hemolysis)	5-8	6.4
Alkali denaturation (% Hgb. F)	0-40	7
Target cells (per 100 WBC)	0-40	40
Normoblasts (per 100 WBC)	0-10	10

TABLE II

COMPARISON BETWEEN USUAL laboratory results of "typical" homozygous Hgb S case and patient.

sickle cell anemia[5] as were the osmotic and mechanical fragility tests.

Alkali denaturation test showed that seven percent of the total hemoglobin was fetal Hgb F. In some cases of sickle cell disease Hgb F may comprise 40% of the total hemoglobin. In fact the high levels of Hgb F in newborn infants accounts for the low incidence of symptoms in this age group.

Pedigree

The pedigree chart (Figure 2) presents the available data on the patient's family. Letters in the blocks and circle are the genetic pattern of the genes for hemoglobin. Each member of the immediate family—father, mother and two half brothers — were heterozygous Hgb SA; whereas, the patient was homozygous SS. Figure 3, by use of superimposing the graphs, enables a comparison between various cases to demonstrate their relationships. Table III lists the percentage of each hemoglobin type in each case as determined from data as in Figure 3.

Patient	% Hgb. S	% Hgb. A	% Hgb. F
Patient reported	93	0	7
Father	41	59	
Mother	42	58	
Brother (age 18)	44	56	
Brother (age 14)	42	58	

TABLE III

DISTRIBUTION OF HEMOGLOBIN TYPES in patient's family as determined by electrophoresis.

The sickle cell gene behaves like an allelomorphic recessive gene requiring a homozygous state for manifestation of what is known as sickle cell anemia. On the other hand, a heterozygous complex may be represented clinically by only slight symptoms as seen in this family or there may be no symptoms whatsoever.

Review Discussion

General—The phenomenon of sickling can be demonstrated readily in seven to 10% of the American Negro population. Of these it is estimated that only two to four percent are homozygous Hgb S, i.e., have sickle cell disease. These figures vary slightly in Negro populations in other parts of the world. Most patients die in the first decade and few survive past the third.

Symptomatology—Sickle cell disease is a severe chronic hemolytic anemia usually manifested clinically by symptoms called "crises." Three principal types of crises are generally recognized—namely, fever, pain and hemolytic crises.

Fever may be the only manifestation of the disease, but it is usually accompanied by pain. Pain crises, which are by far the commonest form, are the result of intravascular thromboses. Abdominal pain may be so severe that unless this diagnosis is considered, the patient may undergo unnecessary surgery.

Hemolytic crises are not uncommon. They are manifested by clinical jaundice; however, a small amount of hemolysis is almost always taking place so that there is usually jaundice present which can be detected only by laboratory means.

It is surprising to perform random blood counts on a sickle cell anemia patient with no clinical symptoms and discover that a moderate to severe anemia is present. Indeed, the erythrocyte count may be as low as 2,000,000 per cubic mm and the patient be completely asymptomatic, indicating an extraordinary physiological compensatory mechanism of the cardiovascular system.

Sinus arrhythmia is common, as well as tachycardia. Pulsations about the neck and precordium may be noted. A systolic decrescendo-type murmur of varying degree may be noted, and this may be accompanied by a thrill and presystolic tap. The second sound may be accentuated. Cor pulmonale may occur because of abnormal hemodynamics and repeated multiple pulmonary infarctions. The electrocardiogram may bear evidence of extrasystoles, various sinus arrhythmias, and a prolonged P-R interval.

Body habitus is often useful in diagnosis. The patient is characteristically tall, lean and underweight with narrow shoulders and hips. The hands and feet may also be long and narrow, and the secondary sex characteristics underdeveloped.

Splenomegaly is often present in younger patients but disappears later in life. Hepatomegaly is almost always found.

Chronic leg ulcers over the external and internal malleoli are common in the older-age patients. Epistaxis is a common complaint.

Neurologic complaints are common, including stupor, coma, hemiplegia, headache, cranial nerve palsies and occasionally, blindness. Retinal microaneurysms, venous dilation and hemorrhages may be seen.

X-ray examination[2] may reveal the classic "hair-on-end" appearance of the skull, osteoporosis of vertebrae and flat bones, aseptic bone necrosis, especially of the femoral heads and various spinal deformities resulting from collapsed vertebrae. Osteosclerosis is the general rule in the long bones with radiographic evidence of cortical thickening and new bone formation.

Pathology

All of the findings significant of this disease found at autopsy are related either directly or indirectly to the presence of the abnormal hemoglobin in the erythrocyte affecting its shape. Sickling occurs in blood with low oxygen tension. Distortion of the cells can be accelerated by raising the temperature of the cell preparation to body level and lowering the pH. Reticulated erythrocytes rarely become distorted, but when they do they more readily assume their normal shape than the mature cells when the oxygen tension is raised.

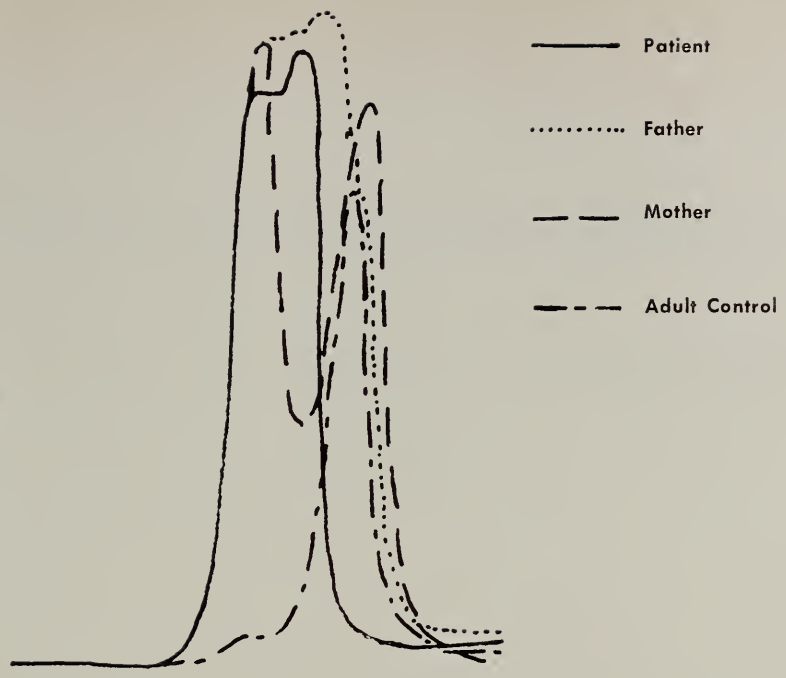


FIGURE 3

ELECTROPHORETIC PATTERNS of patient, his mother, father and a normal adult control overlayed to demonstrate their relative relationships.

Death usually occurs from infarction of vital centers, infections, or cor pulmonale. The chief anatomic lesions are gross and microscopic evidence of thrombosis, infarction, necrosis and hemorrhage of recent and long duration. Right sided heart failure, with hypertrophy and dilatation (cor pulmonale) may be noted. There may be thickening of the walls of the small and medium sized arteries, chiefly produced by intimal proliferation, adding to the danger of infarction which already exists.

In young patients the spleen is usually engorged with sickled erythrocytes, but as they get older and the disease becomes more chronic repeated thrombosis and infarction occur, resulting in "auto-splenectomy." This phenomenon is the result of progressive loss of splenic parenchyma by repeated infarction and resultant fibrosis. Hemosiderosis of the spleen, liver, lymph nodes and kidneys may be seen occasionally.

Bone marrow study (not performed in this case) usually reveals evidence of erythroid hyperplasia. From 50 to 70% of the marrow cells may be orthochromatic normoblasts. More immature forms are usually absent. Differentiation from other severe forms of hemolytic anemia, however, can be made only by studying the shape of the more mature erythrocytes present.

Hemoglobins separated by electrophoretic migration may demonstrate the presence of homozygous Hgb S or heterozygous mixtures with normal adult hemoglobin or still other abnormal hemoglobins. When one electrophoretic pattern is superimposed on another, various cases may be compared as in Figure 3. Likewise, the percentage which each hemoglobin type comprises of the total hemoglobin may be determined as in Table III.

Remarks

Difficulty in establishing a diagnosis in this case was chiefly due to failure to achieve a positive sickle cell preparation. Although the disease was suspected clinically on several occasions, sickle cell preparations were continually negative. However, one finally was positive and the diagnosis was established before electrophoretic studies were done. The reason for the negative sickle cell preparations is not fully understood, for even after the diagnosis had been made by electrophoresis, sickling did not occur on one occasion. Whether this represents a blocking phenomenon or technical error remains

to be clarified when further technics are available.

The remainder of the laboratory findings and genetic pattern of the family comply with expected values in a case of this type.

Summary

1. A case of homozygous Hgb S disease is presented.

2. The usual laboratory data in a case of this type are given for comparison.

3. The patient's genetic background is given.

4. A review of the general knowledge concerning this disease is discussed in the light of the case presented.

BIBLIOGRAPHY

1. Callender, S. T. E., Nickel, J. F., Moore, C. V., Powell, E. O.: Sickle Cell Disease: Studied by Measuring the Survival of Transfused Red Blood Cells. *J. Lab. and Clin. Med.* 34:90, 1949.
2. Carroll, D. S., Evans, J. W.: Roentgen Findings in Sickle Cell Anemia. *Radiology* 53:834, 1949.
3. Itano, H. A., Pauling, L.: A Rapid Diagnostic Test for Sickle Cell Anemia. *Blood* 4:66, 1949.
4. Pauling, L., Itano, H. A., Singer, S. J., Well, I. C.: Sickle Cell Anemia, A Molecular Disease. *Science* 110:543, 1949.
5. Singer, K., Fisher, B.: Studies on Abnormal Hemoglobins. *J. Lab. and Clin. Med.* 42:193, 1953.
6. Wintrobe, M. M.: The Cardiovascular System in Anemia. *Blood* 1:121, 1946.
7. Wintrobe, M. M.: *Clinical Hematology.* Philadelphia: Lea & Febiger, 4th ed., 1956. ◄

The Journal is pleased to announce that the following physicians were chosen winners of the 1959-60 Journal Medical Essay Contest:

First Prize: **ARTHUR S. MORSE JR., M.D.**

Pathology Resident
Ball Memorial Hospital, Muncie

Title: *Sickle Cell Anemia: Case Report and Review.*

Second Prize: **HARLEY P. PALMER, M.D.**

Former Pathology Resident
Indiana University School of Medicine, Indianapolis

Title: *Pheochromocytoma and Neurofibrosarcoma in a Patient with Neurofibromatosis.*

Third Prize: **ROBERT C. CODDINGTON, M.D.**

Former Resident, Orthopedic Surgery
VA Hospital, Indianapolis

Title: *Neurogenic Ossifying Fibromyositis in Paraplegia.*

Gout

The newest news on an ancient disease.

*JOHN H. OYER, M.D.**
Fort Wayne

IN MY 25 YEARS of general practice I never made a single diagnosis of gout; and in looking back, I can't see that I probably even missed one. I had the idea that gout was a medieval disease, that today we didn't see it anymore. Just recently I found out how wrong I was.

There are many paradoxes in the study, diagnosis and treatment of gout. As you know, basically we presume and usually find a hyperuricemia as a basis for gouty conditions; and yet, relatives of gouty patients often have rather markedly elevated uric acid levels for years and never come down with symptomatic gout.

My first impression was that if you find a high uric acid level you should treat the patient for gout. I now feel that you should probably wait, the patient should know about it, you should know about it, he should be warned. But when and if the characteristic symptoms begin to appear, then I would put that man, or less frequently a woman, on a lifetime program to keep the uric acid level down.

Another paradox is that the uricosuric agents almost always nullify each other. In other fields if two drugs have a similar action, you frequently use them together and get not only an augmentation but really a synergistic action. This is not true of the uricosuric agents.

To use one while you are using another is to nullify all effect. Again, if in an acute case of gout you give a large dose of uricosuric agents to begin with you can actually increase the gouty symptoms, pain and distress.

Large Doses Augment Excretion

Large doses of uricosuric agents usually increase excretion, where small doses can actually suppress the excretion of uric acid in the urine. Sometimes in treating certain cases in acute attack, the heavy administration of uricosuric agents can actually precipitate and prolong the attack; sometimes the acute or sudden withdrawal of these agents can precipitate an attack. The pain of the acute attack is not due to the uric acid deposits; it is due to some other factor, unknown to us—probaby one of the intermediate metabolic steps in the uric acid synthesis.

The swelling usually extends much farther around the joint than the joint itself. It is controlled by colchicine, if the colchicine is started early in the attack; it has to be started in the first one to three hours. The sooner colchicine is started after the patient gets the first twinge of pain the more likely he will be to have relief.

This is so striking that it is used as one of the diagnostic criteria to determine whether or not you are dealing with an actual clinical gout.

There are usually four recognized stages in the disease. In the prodromal, or some call it the larval stage, there is a hyperuricemia. These

* Presented at a scientific session of the Indiana Academy of General Practice, Feb. 23, 1960, Fort Wayne.

patients may or may not have pain. If they have pain, it is more of a muscular rheumatism type. In fact, Dr. Stollerman, in Chicago, frequently quizzes the patient when he is trying to diagnose gout to see if the patient wakes at night and feels uncomfortable, aches all over, gets up and walks around, and then goes back to sleep. That seems to be one of the very earliest phases in the promodal stage of gout!

Next, is the stage producing acute swelling of a joint; characteristically, it is the first metatarsophalangeal joint, but it does not have to be. It can be any joint. Dr. Brown very gleefully pointed out to me recently that he did find a characteristic gout with swelling in this joint. He said it was the first time in eight years that he had seen one in that location. So do not assume that if the patient does not have a podagra he cannot have gout.

Joints usually are asymmetrically affected. This does not mean, however, that by pure chance you could not have symmetry. However, characteristically, the distribution is asymmetrical.

The acute attack of gout can be stopped very rapidly with the administration of colchicine; usually oral administration is sufficient. Unless the patient is particularly sensitive to oral colchicine and cannot tolerate enough for a therapeutic effect because of gastrointestinal irritation, there is really no excuse for giving it intravenously. However, if you do give it intravenously, you may give a dosage of from anywhere from 0.5 mgs to three mgs. Orally, we usually give 0.5 to .65 mgs every hour, up to maybe one mg every two hours. This we carry until there is either relief—beginning relief at least—of the pain, or beginning gastrointestinal irritation as evidenced by nausea and/or diarrhea. Usually, if they are going to get relief by the fifth, sixth or seventh doses, they will have rather marked relief. After the unwanted symptoms appear, then I like to cut it down to about three doses per day, if that much can be tolerated, as the attack finally wears off. In a few days go back to a prophylactic regime of one dose twice a day.

Attacks Increase in Frequency

Acute attacks may be anywhere from a year to two years apart at the beginning; then they will come with increasing frequency, until maybe the patient has two, three or four attacks per month. These attacks will subside without any treatment. However, the patient is very grateful if he can get more rapid relief from pain and does not lose as much time from work.

The third phase of gout is the inter-critical or intermediary period where the patient, if he is untreated, will have increasingly frequent acute attacks. Then he will begin to get into the chronic stage, where you actually see destruction of the joints and/or the formation of tophi.

This is the chronic phase. There is an aphorism of Hench that a tophus is never a tophus until the uric acid crystals are demonstrated. In examination, feel the helix of the ear for any bumpiness or roughness. Tophi may be formed any place in the body. But for diagnostic purposes, unless you get a patient in a really late stage where he is already draining urates from one of these tophi, it is probably well to biopsy one of these and look at it under the microscope for the presence of uric acid crystals.

There is also much that can be learned from an arthro-puncture. Synovial fluid in gout is characteristically that of an inflammatory lesion. Normal joint fluid is clear, pale yellow, viscous, and does not clot. Fluid from a gouty joint will be so cloudy that you will think at first that you have an infection of the joint. It will be thin and will have lost its viscosity and yet will later clot. You would think, also, that probably the cloudiness in the fluid would be due to its being filled with uric acid crystals. This is rarely so. Usually, the uric acid level in the joint fluid is roughly equivalent to the uric acid level in the blood stream. This is also true of sugar. So we get a characteristic, inflammatory reaction around these joints that may be a secondary reaction to the uric acid crystals deposited in the tissues surrounding the joints and in the synovia. But definitely, it is not due to the urate directly, as evidenced by the fact that during acute attacks or between attacks, you can inject uric acid into the blood stream to very significantly raise the level and yet never be able to intensify or precipitate an acute attack.

We have quite a number of drugs that are considered uricosuric agents. By this term we mean that they will lower the uric acid level in the blood stream. Usually, this is accomplished by aiding and expediting the excretion. Normally about 80 to 90% of the uric acid in the blood stream is excreted by the glomeruli, then, all but

about 10% is reabsorbed. Most of the uricosuric agents block this reabsorption and thereby facilitate the excretion.

Probenecid (the trade name Benemid) is probably the most popular uricosuric agent today. I am sorry to say that I have had virtually no experience with it for the simple reason that every gouty patient that has been sent to me has been on a program of Benemid with no apparent lowering of the uric acid level in the bloodstream. Probably this was due either to improper dosage, or to the fact that the patient did not take the medicine as ordered. However, for that reason, usually I change them over to the salicylates.

Success With Salicylates

In my hands I have had great success with the use of aspirin and other salicylates. There was some work done by a group of men in the Southeastern U. S. reported at a meeting in Feb., 1959, in Chicago. They said that the minimum dosage to get this effect was four gms per day. Other authors say five gms. Well, that is 12 to 16 five-grain tablets of aspirin per day and that is pretty high dosage. Some people cannot tolerate it. In that case, I would choose one of the other urocosuric agents. If the patient does not take those 12 tablets every day—for day after day—if he cuts down to four, five or six, then he will actually be increasing the uric acid level in his bloodstream.

There is another reason I like to use salicylates, if they can be tolerated. If a patient has twinges of pain, or has a headache, he is very likely to go to the medicine cabinet and take a dose of aspirin. If he is on any other uricosuric agent, this will immediately nullify its action. Another drug which is very good—and from it they have developed one which is even better—is phenylbutazone or Butazolidin. This is probably the uricosuric agent of choice to use in an acute attack. Usually it is used in much larger doses than we give for other purposes. We start out with 600 to 800 mgs per day. For any other arthritic condition, I would not dream of giving a patient a dose that high; I never exceed 400 mgs. However, the relief of pain is usually quite dramatic with this dosage, and you should then lower it within two to three days.

Phenylbutazone is a drug that you have to watch like a hawk because it knocks bone marrow substances. Drugs that cause this condition usually cause it very early and sometimes by small dosages; so always watch for aplastic anemia. Have a complete blood count and a platelet count early and frequently.

It has been found that Butazolidin has two actions: one is pain relief, and the other is uricosuric effect, and that these may be separated. So the molecule has been changed to enhance the uricosuric effect, and it is now called sulfinpyrazone, the trade name of which is Anturan. We are using this in the clinic at Northwestern at the present time, and it seems to be more effective in controlling the uric acid levels than does Benemid.

Use of Steroids

ACTH and steroids right on down the line—cortisone, hydrocortisone, prednisone, prednisolone, triamcinolone, dexamethasone, all have a uricosuric effect. But there again, if you stop them suddenly, you can actually precipitate an acute attack. Also, in a disease that tends to be as chronic as gout, requiring treatment to continue for years and years, we certainly do not want to use anything of this nature. However, if you are desperate and want to use it for just a few days to get relief in a certain acute attack, you may use it, remembering that if you stop it too suddenly, you will actually get a recrudescence of the symptoms.

One of the newer uricosuric agents that I have not had a chance to try is zoxazolamine, known in the trade as Flexin.

Pyrazinamide, the antituberculosis drug, Diuril and Hydro-Diuril have the opposite effect and can actually increase the hyperuricemia. There is another cause of hyperuricemia that so far has not been published. In a private communication Dr. Robert D. Leeper, who worked this out at Sloan-Kettering Institute, stated that 100% of his myxedematous patients had significantly elevated uric acid levels into the clinical range where you would expect gout to occur. In all of them, when treated for the myxedema, the uric acid level fell to normal.

Gout predominates in men; some authors say nine or 10 to one; others put it as high as 20 to one. That is the hereditary or the primary type. Women are supposed rarely to get gout. If they do, it is the secondary type due to the rapid breakdown of cells of any type in the bloodstream causing the body to throw an excess of nucleic acid into the bloodstream from which

the purines are derived. However, I have seen so many women with elevated uric acid levels and signs that could be interpreted as possible gout, that either I should be looking for some other reason why so many women have this elevated uric acid level, or wondering if some of the figures are wrong.

There is a great deal that I have left unsaid. Gout is a disease that has been recorded since ancient times. There is so much we know about this disease, and still much we need to know. However, gout is being considered in making diagnoses far more frequently at the present time than in previous years. ◄

New Clinical Center Studies on Colon and Rectal Carcinoma

The cooperation of physicians is requested in studies on colon and rectal carcinoma recently initiated at the Clinical Center, National Institute of Health, Bethesda. Encouraging results in the treatment of gastrointestinal carcinoma using the pyrimidine analogues 5-fluorouracil and 5-fluorodeoxyuridine have been reported. However, other reports have raised the question of their effectiveness.

The Chemotherapy service of the National Cancer Institute is conducting studies of these agents in carcinoma of the colon and rectum in order to better define their place in the treatment of metastatic gastrointestinal neoplasm. Side effects of these agents may be considerable so patients must be in good general condition in order to tolerate adequate doses. Also, the presence of tumor masses which can be either measured directly or demonstrated on roentgen films is necessary in order to determine the antitumor effect of the drugs in short trial periods.

Patients can be accepted for these studies if they are ambulatory, have normal leukocyte count, renal and hepatic function and if they have metastases in the lung, peripheral lymph nodes (such as supraclavicular or cervical) or skin.

Referrals of such patients are greatly appreciated. Physicians who wish to have their patients considered for study at the National Cancer Institute may write or call Dr. Clyde O. Brindley or Dr. Paul P. Carbone, National Cancer Institute, Bethesda 14, Maryland (OLiver 6-4000, Ext. 4251).

Meckel's Diverticulum Presenting as a Pelvic Tumor

JOHN P. BAXTER, M.D.
DENNIS S. MEGENHARDT, M.D.
KENNETH E. THORNBURG, M.D.
*Indianapolis**

SINCE THE YEAR 1812, when Meckel described the diverticulum of the small intestine, many interesting symptoms and signs of a diseased Meckel's diverticulum have been described. Disease of this structure simulates almost any acute abdominal condition, as the literature on this subject well indicates.

This case is reported because of the appearance of a Meckel's diverticulum as a pelvic tumor in a 43-year-old female, and because of the presence in the diseased organ of numerous fecaliths, the largest of which was six cms in diameter.

Case Report

A 43-year-old white female was admitted to Methodist Hospital, Indianapolis, on July 10, 1959, because of a pelvic tumor palpated by her family doctor. She had visited him because of persistent lower abdominal discomfort of two years duration, which she described as a "dragging sensation."

There was no history of nausea or vomiting, but on two occasions within the past two years, she had experienced severe, cramping, abdominal pain which caused her to double up. She had increasing constipation with occasional spells of diarrhea. There was no history of hematemesis, rectal bleeding or melena. She had been on estrogen for two years with a period of amenorrhea of 6-7 months, followed by bleeding in April 1959 for 17 days, followed by a second period of amenorrhea and spotting for a period of two weeks prior to admission.

Physical Findings

On physical examination she was found to be apprehensive. The chest was normal to percussion with no adventitious sounds. Her blood pressure was 120/80 and the pulse was regular at the rate of 80 per minute. No murmurs or arrythmias were present on auscultation. There was no peripheral edema. The abdominal wall was normal, the abdomen was not distended and no tenderness or rigidity was encountered. Liver, spleen and kidneys were not palpably enlarged and no abnormal masses were felt. Bowel sounds were slightly hyperactive. Pelvic examination on two occasions showed a hard round tumor to the right of the uterus, and on two other occasions only a normal sized uterus could be felt. The digital rectal examination was negative, and peripheral neurological signs were normal.

An upper gastro-intestinal series, a cholecystogram and barium enema with a contrast film were all negative. Laboratory data were essentially within normal limits.

Pelvic examination under anesthesia revealed a stony-hard mass to the right of the uterus, measuring approximately 10 cms in diameter. At laparotomy a large Meckel's diverticulum, ap-

* From the departments of Medicine and Surgery, Methodist Hospital, Indianapolis.



FIGURE 1

PHOTOGRAPH OF Meckel's Diverticulum measuring 8 cms x 5.5 cms in diameter, containing numerous faceted fecaliths, some protruding into the lumen of the ileum. Note edematous wall.

proximately 20 inches above the ileo-cecal valve, was found. It contained large fecaliths that protruded into the ileum through the stoma of the diverticulum. Proximally, the ileum was distended and edematous. The diverticulum was edematous but not adherent to any organ and was freely mobile in the peritoneal cavity. A segmental resection of ileum, with an end-to-end anastomosis, was done.

The pathology report described the specimen as ileum, 11 cms in length by 4 cms in diameter. The diverticulum measured 8 cms by 5.5 cms in diameter, and contained numerous faceted fecaliths, some protruding into the lumen of the ileum. The largest of these was 6 cms in maximum dimension. The patient had an uneventful recovery.

Clinical Picture

The anatomic location, the histology and the embryology of this organ explain many of the more frequently presenting symptoms and signs to be described:

1. *Peptic activity resulting in hemorrhage, ulceration or perforation:* the presence of gastric mucosa in a Meckel's diverticulum can lead to peptic ulceration of adjacent mucosa, which in turn may lead to one of the commonest presenting symptoms, that of gastro-intestinal hemorrhage. Perforation, as a natural consequence, is not infrequent.

2. *Acute inflammation:* because of the similarity in form and the location of the organ, the presenting symptoms may simulate appendicitis with its anorexia, nausea and vomiting and crampy abdominal pain. Tenderness may well localize in the right lower quadrant if the particular anatomic site of the organ happens to be in this area.

3. *Intestinal obstruction:* intussusception, started by a diverticulum, is a frequent cause. The distal portion of the diverticulum which can become a fibrous cord connecting the patent diverticulum to the umbilicus, may cause a volvulus of the small intestine or act as a constricting band, causing obstruction. The inflamed diverticulum may, by adherence, be the cause of an internal hernia with its consequences of obstruction or strangulation of the small intestine. The weight or mere presence of a calculus may, by shifting and twisting, result in obstruction.

4. *Perforated viscus:* peptic activity may result in perforation. Foreign bodies and calculi have often been noted to cause perforation.

5. *Umbilical fistula:* the embryology of this organ well explains this manner of presentation and thus this is a certain sign that this organ is present.

6. *Mobile abdominal mass:* the presence of large calculi may result in a mobile hard mass in the true abdominal cavity or the pelvis, as reported above.

Discussion

The mimicry of a Meckel's diverticulum in the abdomen demands that we consider disease of this organ in any careful differential diagnosis of the acute abdomen. It should be remembered that it is said to occur in two or three percent of all cases examined at autopsy.

A careful case history is beyond doubt the most important contribution. Complications usually arise in early life, with approximately 45% of cases presenting before the age of two years, according to Gross. A high index of suspicion is necessary in order to incriminate a diverticulum.

Physical examination is of value, particularly in case the organ is diseased, but not usually otherwise. Tarry stools, signs of intestinal obstruction, signs of peritonitis, an umbilical fistula or an abdominal or pelvic mobile mass may all help in establishing a diagnosis.

Roentgen studies, although controversial, are certainly of value as many reports have shown. Although radiographical demonstrations of concretions are rare, some are still demonstrated.

An opaque calculus lying within a bubble of gas is a reliable sign. Indirect signs or the signs of a complication, such as free air in the peritoneal cavity, are certainly of value. Barium enemas have filled the diverticulum. Ingestion of barium with serially taken films often demonstrate a filled diverticulum.

Summary

1. An unusual manner of presentation of a Meckel's diverticulum has been described: a pelvic mass.

2. The usual presenting symptoms and signs of a Meckel's diverticulum are reviewed.

3. The value of a careful history and physical examination is stressed.

4. The importance of roentgenologic studies is noted.

ACKNOWLEDGMENT

We wish to thank the Department of Pathology of the Methodist Hospital of Indiana, Inc., Indianapolis, and Mr. McKinley A. Leapley of the Methodist Hospital Photolab, for their help and cooperation.

BIBLIOGRAPHY

1. Gile, J. F., MacCarty, Wm. C. Jr.: Calcified concretions within a Meckel's Diverticulum. *Radiology* 41:491-494, 1943.
2. Bischoff, M. E., Stampfli, W. P.: Meckel's Diverticulum. *Radiology* 65:572-577, 1955.
3. Boldero, J. L.: Calculi in a Meckel's Diverticulum. *J. Fac. Radiologists,* Lond. 9:157-160, 1958.
4. Berne, A. F.: Meckel's Diverticulum X-Ray Diagnosis. *N. England J. M.* 260:690-696, 1959.
5. Ruffin, J.: Lithiasis of Meckel's Diverticulum. *Gastroenterology* 18:287-289, 1951.
6. Allen, A. W., Donaldson, G. A., Meckel's Diverticulum containing calculi. *A. M. A. Arch. Surg.* 50:286-287, 1945. ◄

Telling the Patient

The doctor must reply in some way to his patient's question regarding his blood pressure readings. Just what should the doctor tell the patient in order to satisfy him, to reassure him, and, above all, not to frighten him? How bound is the doctor to tell the patient the truth about each reading? Patients are accustomed to knowing, for example, the level of their hemoglobin concentration, and physicians do not hesitate to acquaint the patients with their progress in treatment of anemias by telling them how high or low the blood count is. . . . The hypertensive patient, too, in spite of almost any explanations given him, will ultimately be most contented if he is told what his blood pressure readings are. The vast majority of patients assume that if the doctor does not want to give them the readings, it can only be because they are bad.—Milton M. Hurwitz: A Practical Approach to the Diagnosis, Management and Treatment of Hypertension. Reprinted from the *Armed Forces Medical Journal,* August 1960.

Sex and Chromosomes

The chromatin pattern may be determined easily by examining somatic cells in the female.

KEITH HAMMOND, M.D.
Muncie

THE LICENTIOUS aspects of sex have invaded our newsstands and threaten our pleasure-loving civilization, while moralists point with foreboding to ancient Greece and warn of how Eros brought her downfall. In recent years our medical literature has also become studded with reports of brilliant studies concerning the subject, but on a higher intellectual plane and with fascinating implications completely divorced from anything even suggesting eroticism. There are indications that some things we have taken for sex are not; but, on the other hand, there would also seem to be more to sex than meets the naked scientific eye.

Going back to 1949, we find that Barr and Bertrum made the observation that in the nerve cells of mature female cats there were certain characteristic chromatin bodies.[1] To make a protracted story short it has since been shown that somatic cells of the normal human female have these chromatin bodies in their nuclei, while cells from the normal male lack them. These cells came to be designated as chromatin positive cells and individuals with such cell bodies were considered to be genetic females regardless of what their physical examination, clothing or choice of mate might suggest.

This is still true in most instances, but, as we shall see later, exceptions have since been discovered and then partially elucidated. It was felt that this sex chromatin was not actually absent in male cells but that it was undetectable by the technics in use.[2] The chromatin could be found in all female cells but was easiest to see in preparations obtained by scraping the inside of the cheek.[3] Thus, it became useful in clinical medicine; pseudohemaphrodism, among other things, lost its mask more completely in the laboratory. Mixing of the sexes in the newborn nursery is much less likely now, for instance.

Klinefelter's Syndrome Described

In 1942 Klinefelter described a condition which has come to bear his name as a syndrome.[4] He noted that there were rare unfortunate male individuals who were infertile and had gynecomastia and certain other associated findings. What seemed to be an incidental condition in one of his patients at the time was mental deficiency, but this has since been shown to be more than a chance concomitant association. Then, in 1955, Nelson found that the cell nuclei in a 19-year-old youth with this syndrome had a positive sex-chromatin pattern.[5] In other words, here, seemingly, was a male with female sex chromatin.

In 1938 Turner described a syndrome which has also come to bear his name, amongst others.[6] These patients were apparently females and had such features as webbed neck, cubitus valgus, congenital heart disease and sexual infantilism.

Later they were found to have gonads which consisted only of vestiges of undeveloped stroma and the disorder was designated as ovarian agenesis. In 1954 Wilkins and Polani demonstrated that the nuclei of the cells of some of these patients had an absence of the expected female sex chromatin.[7] Since the gonadal tissue consisted of little more than a poorly defined stroma the term "ovarian agenesis" was replaced with the name "gonadal dysgenesis," the implication being that the gender might be open to question. Here, then, seemed to be females who had male sex characteristics—or rather an absence of female characteristics—in their cell nuclei—a switch from Klinefelter's malady.

Since mental deficiency had been a finding in some instances of Klinefelter's syndrome it occurred to Mosier and associates that a study of chromosomal sex in a population of mental defectives would be in order. They found that in 1,252 male defectives in an institution there were 10 with positive sex-chromatin patterns and nine of these had features characteristic of Klinefelter's syndrome.[8] Other interesting observations are continually being made. Hemophilia A (classic hemophilia) has been generally recognized as a male affliction, with only an extremely rare case being reported in females. Consequently, when Nilsson and fellow workers found the disease in an apparent female they checked the chromosomal sex pattern and found it to be male.[9]

In recent months studies of chromosomes as they relate to sex and various syndromes have taken new turns. Ford and Hamerton as well as Tjio and Levan have shown that instead of 48 chromosomes in man there are actually only 46.[10,11] Chromosome counts have become technical realities. The normal female has 23 pairs of chromosomes, one of which consists of the sex chromosomes with an XX constitution. The normal male also has 23 pairs of chromosomes, one of which consists of the sex chromosomes with an XY constitution. Cells from patients with Klinefelter's syndrome usually have 47 chromosomes, but the sex chromosomes have an unusual XXY constitution.[12] On the other hand, in Turner's syndrome there are only 45 chromosomes.[13] As might be expected, someone has recently uncovered a "super female" who has XXX chromosomes.[14]

Leukemia Findings Not as Clear

The findings in leukemia are not so clear-cut. It seems that one finds nothing remarkable about the chromosomal make-up in chronic leukemia. There are changes in acute leukemia, but for our purposes we need only point out that the question is under investigation.[15] It is interesting to speculate upon what might develop, considering the fact that leukemia has been thought to be associated with mongolism oftener than would be predicted from chance alone.[16] Mongols have already been shown to have 47 chromosomes, but Jacobs and his associates feel that the extra chromosome is autosomal (somatic) rather than sexual.[17,18] Again, as one might expect someone would do, Ford found a patient with Klinefelter's syndrome who is also a mongol.[19] There was the extra XXY chromosome of that syndrome plus an additional one which might be anticipated for mongolism, a total of 48.

CLINICAL CONDITION	NO. OF CHROMOSOMES	SEX CHROMOSOMES
Normal	46 (44 autosomal)	XX or XY
Turner's Syndrome	45 (44 autosomal)	X
Klinefelter's Syndrome	47 (44 autosomal)	XXY
Mongolism	47 (45 autosomal)	XX or XY
"Super Female"	46 (44 autosomal)	XXX

The implications for the future of chromosomal sex findings and related associations are exciting. Since Klinefelter's syndrome may have mental deficiency as a feature and since mongols also have a chromosomal aberration one wonders about the relationships between many abnormal mental and nervous conditions and the chromosomal make-up. When these detailed chromosome studies become more commonplace and more accurate there is little doubt that all sorts of new and unexpected things will be uncovered. Light will be shed upon already recognized but poorly understood relationships between certain clinical conditions. It is thrilling to contemplate the previously undreamed of cause and effect connections which may be disclosed.

For those who like their sex with a capital "S" it will perhaps come as a disappointment

to find that transvestism and homosexuality still retain their identity as conditions of the mind rather than of the body. The sex chromatin pattern accurately reflects the physical make-up and sexual deviation remains psychic rather than somatic.[2, 20] In the meantime it is difficult to suppress the expression of facetious anticipation with which we await the chromosomal make-up of the web-necked, color blind, hemophiliac, pseudohemaphroditic, microcephalic mongol with acute leukemia.

BIBLIOGRAPHY

1. Barr, M. L., Bertram, E. G.: *Nature* 163:676, 1949.
2. Barr, M. L., Hobbs, F. E.: Chromosomal sex in transvestites. *Lancet* 1:1109, May 29, 1954.
3. Marberger, E., Boccabella, R. A., Nelson, W. O.: Oral smear as a method of chromosomal sex detection. *Proc. Soc. Exper. Biol. and Med.* 89:488, 1955.
4. Klinefelter, H. F. Jr. et al.: Syndrome characterized by gynecomastia, aspermatogenesis, without aleydigism and increased excretion of follicle-stimulating hormone. *J. Clin. Endocrin.* 2:615, 1942.
5. Nelson, W. O.: Evaluation of testicular function in reproduction and sterility. *Michigan State University Centennial Symposium Report,* East Lansing, Mich., 79-85, 1955.
6. Turner, H. H.: Syndrome of infantilism, congenital webbed neck and cubitus valgus. *Endocrin.* 23:566-574, Nov., 1938.
7. Quoted from Nelson, W. E.: *Textbook of Pediatrics,* Ed. 7, p. 1198, W. B. Saunders Co., 1959, Philadelphia.
8. Mosier, H. et al.: The frequency of the positive sex-chromatin pattern in males with mental deficiency. *Pediatrics* 25:291—297, Feb., 1960.
9. Nilsson, M. I. et al.: Haemophilia A in a "girl" with a male sex-chromatin pattern. *Lancet* 2:260-264, Sept. 5, 1959.
10. Tjio, J. H., Levan, A.: The chromosome number of man. *Hereditas* 42:1, 1956.
11. Ford, E. E., Hamerton, J. L.: Chromosomes of man. *Nature* 178:1020-1023, 1956.
12. Jacobs, P. A., Strong, F. A.: A case of human intersexuality having a possible XXY sex-determining mechanism. *Nature* 183:302, 1959.
13. Editorial: Symposium on nuclear sexing. *Lancet* 2:628-629, Sept. 28, 1957.
14. Jacobs et al.: Evidence of the existence of the human "super female." *Lancet* 2:423-425. Sept. 26, 1959.
15. Baike, A. G. et al.: Chromosome studies in human leukemia. *Lancet* 2:425, Sept. 26, 1959.
16. Krivit, W., Good, R. A.: Simultaneous occurrence of mongolism and leukemia, report of a nation-wide survey. *A. M. A. J. Dis. Child.* 94:289, 1957.
17. Editorial: Human chromosomal abnormalities. *Lancet* 2:448, Sept. 26, 1959.
18. Jacobs, et al.: The somatic chromosomes in mongolism. *Lancet* 1:710, April 4, 1959.
19. Ford, et al.: The chromosomes in a patient showing both mongolism and Klinefelter syndrome. *Lancet* 1:709, April 4, 1959.
20. Raboch, J., Nedoma, K.: Sex chromatin and sexual behavior. *Psychosomatic Medicine* 20:55, 1958. ◄

2112 Petty Road
Muncie, Ind.

. . . Three Personal Ideals

I have three personal ideals. One, to do the day's work well and not to bother about tomorrow. . . . The second ideal has been to act the Golden Rule, as far as in me lay, toward my professional bretheren and toward the patients committed to my care. And the third has been to cultivate such a measure of equanimity as would enable me to bear success with humility, the affection of my friends without pride, and to be ready when the day of sorrow and grief came to meet it with the courage befitting a man.—From *Life of Sir William Osler* (1849-1919).

The Adrenal Cortex and Reproductive Failure

*RICHARD W. STANDER, M.D.**

Indianapolis

INTEREST IN THE ACTIVITY of the adrenal cortex and its relationship to reproductive function in the female began with the intense investigative work concerning the adrenogenital syndrome a decade ago. Prior to this time a form of female pseudohermaphroditism was shown to be related to hyperplasia of the adrenal cortex and associated with an increased excretion of neutral urinary 17-ketosteroids. Attempts were made to reduce the virilizing manifestations of this condition by subtotal removal of the adrenal glands, but these were generally unsuccessful.

Steroid Therapy Found Helpful

Wilkins and his co-workers were the first to demonstrate reduction of excretion of 17-ketosteroids by administration of parenteral cortisone. They later demonstrated the efficacy and practicability of long-range adrenal steroid therapy, resulting in partial regression of virilization while increasing feminine attributes in young females with this disorder.[12, 13] It was postulated that reduction of 17-ketosteroid excretion was mediated through the pituitary gland. Subsequent research demonstrated that the adrenogenital syndrome was characterized by increased blood levels of ACTH, reduced adrenal production of glucocorticoids and increased urinary excretion of pregnanetriol as well as 17-ketosteroids.[2, 4, 10]

It was also shown that administration of ACTH to patients with the adrenogenital syndrome resulted in marked increase in excretion of 17-ketosteroids without significantly increased glucocorticoid output.[1] From these data, it has been postulated that the adrenogenital syndrome has its origin in the faulty biosynthesis of glucocorticoids in the hyperplastic adrenal cortex.

Figure 1 illustrates at least one pathway for synthesis of hydrocortisone (compound F) as it is thought to occur in the adrenal gland. In certain forms of adrenal dysfunction and hyperplasia there is faulty conversion of 17-alpha hydroxyprogesterone to hydrocortisone, resulting in a deficiency of glucocorticoids and an increased excretion of the metabolites of the glucocorticoid precursors as pregnanetriol and 17-ketosteroids.

It is felt that one or more of the intermediate metabolic products is androgenic resulting in the virilization characteristic of the adrenogenital syndrome. The exact compound responsible for the virilization has not been conclusively identified and is known only as an "adrenal androgen." The latter is biologically sufficiently analagous to sex steroids normally produced by gonadal tissue to suppress the pituitary output of gonadotrophin resulting in decreased ovarian function and disturbances of ovulation and menstruation in female patients with this disease.

As indicated in Figure 2, the abnormal situation is further aggravated by failure of the adrenal cortex to produce glucocorticoids in sufficient quantity to control pituitary output of ACTH. Thus uninhibited ACTH production continues at a high level, resulting in accumulation of more "adrenal androgen" rather than increased secretion of glucocorticoids. As a consequence, virilization progresses, the secretion of pituitary gonadotrophins is further depressed and urinary excretion of pregnanetriol

* From the Department of Obstetrics and Gynecology Indiana University School of Medicine.

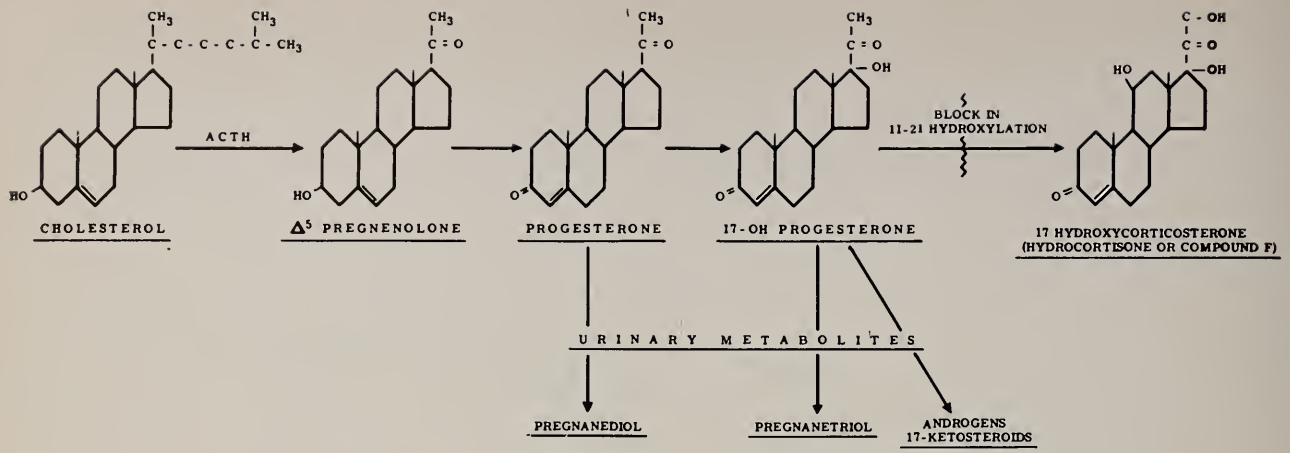


FIGURE 1

A PATHWAY for the synthesis of hydrocortisone from cholesterol in the adrenal cortex.

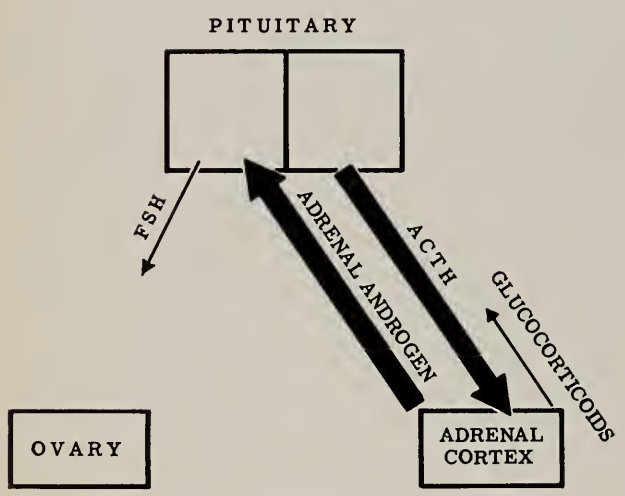


FIGURE 2

A MECHANISM for suppression of menstruation in adrenocortical dysfunction.

and 17-ketosteroids continues at an abnormally high rate.

Cortisone therapy of patients with the adrenogenital syndrome causes a depression of endogenous ACTH production. With the abnormal stimulus removed, the production of "adrenal androgen" via faulty synthesis decreases, resulting in regression of virilization, a fall in the urinary excretion of pregnanetriol and 17-ketosteroids and an increase in pituitary gonadotrophic activity. In many of these patients, ovarian function has been restored during cortisone therapy as attested by the appearance of ovulation and menstruation after years of amenorrhea. Pregnancies have also occurred in such patients during cortisone therapy.[3, 11, 14, 15]

Jones and her co-workers were the first to suggest that other patients with oligomenorrhea or amenorrhea, hirsutism and infertility might represent mild or variant forms of the adrenogenital syndrome.[8] They reported the successful treatment of a small group of such patients with cortisone. Although their patients did not demonstrate the marked virilization of the patient with a severe adrenogenital syndrome and values for 17-ketosteroid excretion were not as high as the latter, further work indicated such patients had much in common with those manifesting severe degrees of adrenocortical hyperplasia.[9] Others have agreed that cortisone therapy may be effective in the treatment of infertile patients who exhibit varying degrees of hirsuitism and menstrual irregularity.[5, 6, 7] On the basis of the foregoing reports the following study was instituted.

Material

Twelve patients with oligomenorrhea or amenorrhea were screened by determination of urinary 17-ketosteroids. Hirsutism was not considered in the selection of patients for screening. It was arbitrarily decided to institute adrenal steroid therapy in all patients whose 17-ketosteroid values were in the high normal range, (13-15 mg per 24 hours) or elevated (above 15 mg per 24 hours). Six patients had 17-ketosteroids in excess of 13 mg per 24 hours and were treated with oral prednisone. Brief summaries of these six cases follow.

Cases

Case 1: a 31-year-old white female was first seen 10-19-58 because of infertility. Conception had not occurred in five years of marriage. Since the menarche at age 15, the patient had menstruated two or three times yearly, but had not had a period for a year prior to consultation.

The patient was normotensive and weighed 136 pounds. She was of normal female habitus with developed secondary sexual characteristics, normal hair distribution and no clitoral enlargement. Except for a slightly atrophic appearance of the vaginal mucous membrane, pelvic examination was normal.

Blood count and urinalysis were normal. A vaginal cytologic preparation indicated only minimal estrogen activity as did endometrial biopsy. Protein-bound iodine was 7.9 gamma percent. No pituitary gonadotrophin was detectable in a 24-hour urine specimen while determination of urinary 17-ketosteroids yielded values of 17.1 and 17.7 mg per 24 hours on two occasions. Skull x-rays were normal and during a 4-month period of observation, basal body temperature records failed to demonstrate ovulation. On 2-9-59, oral prednisone, 2.5 mg every eight hours, was begun. On 2-26-59, 17-ketosteroids were reported as 11 mg per 24 hours.

Although menstruation had not occurred, the patient reported on 5-1-59 that mild nausea had been present for two weeks. Pelvic examination suggested early intrauterine pregnancy and a biologic pregnancy test was positive. Prednisone dosage was reduced to 2.5 mg every 12 hours and was continued throughout pregnancy. The patient remained normotensive and albumin-free. During the last six weeks of gestation, mild edema appeared but was readily controlled by sodium restriction and diuretics.

On 11-22-59 a normal, eight-pound female infant was delivered by low forceps under spinal analgesia following a five-hour labor. The patient received 50 mg of aqueous hydrocortisone at the onset of labor and an additional 50 mg at delivery. The postpartum course was uncomplicated and oral prednisone was discontinued three weeks after delivery. The infant was not given prophylactic steroid therapy following delivery and showed no signs of adrenal insufficiency. At three months postpartum the patient is breast feeding and has not menstruated.

Progressive Oligomenorrhea, Weight Gain

Case 2—this patient first sought consultation 8-4-58 because of amenorrhea and secondary infertility. She was 26 years old. She stated that menstruation had begun at age 12 and indicated that there had been progressive oligomenorrhea from age 19. Spontaneous menstruation had not occurred for 18 months prior to examination. Past history included full term delivery of a female infant with spina bifida in 1954. The following year, a second pregnancy had terminated in spontaneous abortion at 10 weeks. The patient stated that there had been steady weight gain since age 19 and a perceptible increase in hair growth for six months prior to consultation. There had been no noticeable voice change.

Examination revealed an obese female with numerous abdominal striae. Her weight was 187 pounds and blood pressure was 140/100. Sparse hair was present on the upper lip, chin and in the periareolar areas of the breast. Moderately heavy hair growth was noted on the thighs. A male type pubic escutcheon was present, but the clitoris was of normal size. Pelvic examination revealed no abnormality.

The urinalysis and hemogram were normal. Urinary excretion of 17-ketosteroids was measured on two occasions with values of 28.6 and 40 mg per 24 hours. Pituitary gonadotrophin in a 24-hour urine assay was negative at six hours and positive at 12 hours (below normal for women of this age group). Protein-bound iodine was 8.4 gamma percent and a glucose tolerance test yielded a normal curve. Excretory pyelograms and x-rays of skull and chest were reported as normal.

On 10-10-58 the patient was begun on oral prednisone, 2.5 mg every eight hours. A month later, urinary 17-ketosteroids had fallen to 12 mg per 24 hours and the patient's first menstrual period began 11-26-58. Menstruation continued to occur at intervals of 28-35 days. Basal body temperature records indicated that ovulation was occurring prior to each period. There was no apparent regression of hirsutism during the course of therapy. The patient's last menstrual period occurred 6-4-59 and examination in August confirmed early intrauterine pregnancy. Prednisone dosage was reduced to 2.5 mg every 12 hours and to date the pregnancy

has been complicated only by intermittent edema which has been treated by sodium restriction and diuretics.

Case 3—a 29-year-old white female, first seen 2-16-59, complained of menstrual irregularity. Since the menarche at age 16, her periods had varied between 50 and 80 days.

Examination revealed a slender woman of female habitus with normally developed secondary sexual characteristics. Her weight was 115½ pounds and blood pressure was 120/70. Hair distribution was of the feminine type and there was no clitoral enlargement. The pelvic examination was normal except for a non-tender, freely movable four cm right ovarian cyst. Re-examination after a menstrual period in mid-April indicated regression of the cyst. The next period did not occur until 8-13-59, representing the longest interval between menses that the patient had experienced.

A protein-bound iodine was 5.6 gamma percent while urinalysis and blood count was also normal. Endometrial biopsy on 9-10-59 yielded a proliferative endometrium although the patient had not menstruated for 29 days. The first urinary 17-ketosteroid determination was reported as 33 mg per 24 hours, but a value of 14.2 mg was reported on repeat determination.

On 10-19-59 oral prednisone, 2.5 mg every eight hours was begun. Subsequent menstrual periods have occurred at intervals of 30-32 days with basal body temperature fluctuations suggesting ovulation. Endometrial biopsy on the 25th day of one cycle substantiated ovulation by demonstrating a well-developed secretory endometrium. The patient has continued to employ contraception.

Case 4—a 26-year-old white female was first seen in consultation on 6-29-59 because of infertility. She had been married for three years and conception had not occurred. Since the menarche at age 12, menstruation had occurred at intervals of two to six months. Her last menstrual period prior to initial examination had occurred 5-7-59.

The patient had a normal female bodily configuration with well-developed secondary sexual characteristics. Blood pressure was 110/70 and weight was 116½ pounds. There was no evidence of abnormal hair growth or distribution and the clitoris was not enlarged. Pelvic examination was normal except for a five cm right ovarian cyst. The patient's next menstrual period occurred 7-23-59 and re-examination a few days later revealed no evidence of the previously palpated cyst.

Urinalysis and hemogram were normal but the 17-ketosteroid excretion was measured at 26.4 mg per 24 hours.

Prednisone, 2.5 mg every eight hours was begun 8-31-59 and the patient's next menstrual period began 9-14-59. Endometrial biopsy on the first day of menstruation indicated a poorly-developed secretory endometrium histologically comparable to the first post-ovulatory day. Five weeks after institution of steroid therapy, 17-ketosteroid values had fallen to 9.8 mg per 24 hours. Menstruation has continued to occur at intervals of 30-35 days and temperature charts indicate that ovulation is occurring.

Case 5—A 22-year-old single white female, was first seen 2-27-59 because of amenorrhea. The patient's menarche had been at age 12, and periods had been regular until early 1957 at which time menstruation abruptly ceased. The past medical history suggested no cause for the amenorrhea. Withdrawal bleeding had occurred twice as a result of exogenous hormone administration, but spontaneous menstruation had not occurred for two years prior to consultation.

Fine Hair on Upper Lip

Physical examination revealed a slender female weighing 105 pounds with a blood pressure of 105/60. There was a mild growth of fine hair on the upper lip, but the patient stated this had been present for several years. No abnormal hair growth was noted elsewhere. The breasts were normally developed, but the external genitalia, including the clitoris, were somewhat small. Pelvic examination was normal, but no tissue could be obtained by endometrial biopsy. A cytologic preparation from the vaginal mucosa suggested minimal estrogen activity.

Routine blood count and urinalysis were normal while a BMR was reported as –15%. No pituitary gonadotrophin was detected in a 24-hour urine sample and the initial value for 24-hour urinary 17-ketosteroids was 13 mg. Cyclic estrogen therapy resulted in withdrawal bleeding in April, May and June, 1959. Estrogen therapy was discontinued and no further vaginal bleeding occurred.

A repeat determination of 17-ketosteroids on 1-5-60 yielded a value of 14.2 mg per 24 hours

and prednisone therapy, 2.5 mg orally every eight hours, was begun. A spontaneous menstrual period began 1-26-60 and determination of urinary 17-ketosteroids a month after institution of therapy showed the value to have been depressed to 8.6 mg per 24 hours.

Case 6—A 27-year-old white female was first seen 9-3-59 because of irregular menstruation and infertility. Conception had not occurred during six years of marriage and menstrual periods occurred at intervals of one to seven months. The patient had menstruated twice in the year prior to consultation.

Examination revealed a well-developed woman with normal secondary sexual characteristics. Blood pressure was 120/70 and weight was 135 pounds. A moderate amount of hair was present on the chin and upper lip. There was also hair on the lower abdomen and a male pubic escutcheon was present. The clitoris was normal size and pelvic examination was normal.

Urinalysis and blood count were normal. Protein-bound iodine was 6.1 gamma percent while a BMR was reported as +1%. A vaginal cytologic preparation indicated normal estrogen stimulus but the significance is open to question since the patient had been on intermittent estrogen therapy prior to consultation. No pituitary gonadotrophin was detectable in a 24-hour urine sample while excretion of 17-ketosteroids was determined at 13.5 mg per 24 hours. X-rays of skull and chest were normal.

On 10-31-59, prednisone 2.5 mg every eight hours was begun. Menses have since occurred at intervals of 28 days and basal body temperature records indicate that ovulation is occurring.

Discussion

Patients with severe forms of adrenocortical dysfunction resulting in marked virilization and disturbances of menstrual function usually offer little trouble in diagnosis. However, this current evaluation of females with infertility and/or menstrual disturbances indicates that milder degrees of adrenocortical dysfunction can occur but that clinical evidence of excessive androgenic activity may be scant or lacking entirely.

None of the six patients had enlargement of the clitoris. Two patients had hirsutism of a moderate degree while a third had only mild hypertrichosis involving the upper lip. Three of the patients had no evidence of excessive hair growth or abnormal hair distribution.

All of the patients had normally developed secondary sexual characteristics. In addition to oligomenorrhea or amenorrhea, the only characteristics common to the six patients presented were 17-ketosteroid values of 13 mg per 24 hours or more as well as evidence of decreased pituitary gonadotrophic and ovarian function. It would thus appear that patients with oligomenorrhea and amenorrhea and associated infertility deserve determination of urinary 17-ketosteroid excretion even when clinical signs of virilization are absent.

In one patient, Case 2, the 17-ketosteroid excretion rates were high enough to evoke concern about the possibility of adrenal tumor rather than dysfunction associated with hyperplasia. Although intravenous pyelograms were reassuringly normal, the fall in rate of excretion of 17-ketosteroids after institution of prednisone therapy was of even greater significance. The secretory activity of adrenal tumors is generally independent of pituitary stimulation; thus, depression of endogenous ACTH by exogenous adrenocortical steroids does not reduce their output of abnormal metabolites. In the five patients who have been tested following initiation of prednisone therapy, 17-ketosteroid values have been depressed below pretreatment levels.

Of interest is discovery of ovarian cysts of a transient nature in two patients. These were functional rather than neoplastic as was indicated by their subsequent regression. It is felt that they represented disturbances in follicular development secondary to inadequate pituitary secretion of gonadotrophin. The recognition that cystic ovarian enlargement may be found as a result of endocrine dysfunction should preclude their surgical removal as a cause of the menstrual abnormality.

Steroid therapy has been continued throughout pregnancies achieved after prednisone was begun, for some have postulated that discontinuance of treatment might result in increased adrenocortical activity with subsequent abortion or premature labor.[3]

The status of such individuals following pregnancy is unknown. Pregnancy may prove to be beneficial and temporary or permanent improvement in reproductive capacity may result. It is our intention to accord no steroid therapy following pregnancy unless it is justified by a rise in 17-ketosteroids and return of oligomenorrhea or amenorrhea.

Therapy with adrenal steroids is not without danger. Prolonged suppression of endogenous ACTH may result in some degree of atrophy of the adrenal cortex, seriously impairing the latter's ability to produce glucocorticoids in times of stress. On this premise, it seems wise to fortify such patients with supplemental steroids in times of physical stress as with severe infections, surgical procedures, trauma, labor and delivery. The first patient was given supplemental hydrocortisone during labor and other patients will be managed in a similar manner.

Theoretically, suppression of fetal ACTH output occurs with administration of adrenocorticosteroids to the mother. Under these circumstances, newborn infants treated in this fashion might exhibit signs of adrenal insufficiency. Prophylactic steroid treatment was not given the newborn infant of the first patient and no difficulties were encountered. Wilson and Keating did not find steroids necessary in the treatment of the infants of two mothers with adrenogenital syndrome who had been on prolonged cortisone therapy.[14]

Summary

Twelve patients with marked disturbances of menstruation were surveyed for 24-hour excretion of total neutral 17-ketosteroids. Those with values of 13 mg or above were treated with prednisone, resulting in improved menstrual rhythm in all six patients. Thus far two pregnancies occurred among four patients who had been infertile prior to treatment.

ACKNOWLEDGMENT

I am deeply indebted to Dr. William Ragan of Indianapolis for supplying the data in Case 6 and according me the privilege of including the patient in this study.

BIBLIOGRAPHY

1. Barter, F. C., Albright, F., Forbes, A. P., Leaf, A., Dempsey, E., Carroll, E.: The Effects of Adrenocorticotropic Hormone and Cortisone in the Adrenogenital Syndrome Associated with Congenital Adrenal Hyperplasia. *J. Clin. Invest.* 30:237, 1951.
2. Bongiovanni, A. M., Eberlein, W. R., Cara, J.: Studies on the Metabolism of Adrenal Steroids in the Adrenogenital Syndrome. *J. Clin. Endocrinol. & Metab.* 14:409, 1954.
3. de Alvarez, R. R., Smith, E. K.: Congenital Adrenal Hyperplasia. *Obst. & Gynec.* 9:426, 1957.
4. Eberlein, W. R., Bongiovanni, A. M.: Partial Characterization of Adrenocorticosteroids in Adrenal Hyperplasia. *J. Clin. Invest.* 34:1337, 1955.
5. Gold, J. J., Frank, R.: The Borderline Adrenogenital Syndrome: an Intermediate Entity. *Am. J. Obst. & Gynec.* 75:1034, 1958.
6. Greenblatt, R. B.: Cortisone in the Treatment of the Hirsute Woman. *Am. J. Obst. & Gynec.* 66:700, 1953.
7. Jeffries, W. M., Weir, W. C., Weir, D. R., Prouty, R. L.: The Use of Cortisone and Related Steroids in Infertility. *Fertil. & Steril.* 9:145, 1958.
8. Jones, G. E. S., Jones, H. W., Langford, H.: The Use of Cortisone in Follicular Phase Disturbances. *Fertil & Steril.* 4:49, 1953.
9. Jones, H. W., Jones, G. E. S.: The Gynecological Aspects of Adrenal Hyperplasia and Allied Disorders. *Am. J. Obst. & Gynec.* 68:1330, 1954.
10. Sydor, K. L., Sayers, G.: ACTH in Rat and Man. *Proc. Endocrinol. Soc.*, 1952.
11. Wilhelm, S. F., Marks, R. G.: Cortisone and Adrenalectomy in Treatment of Sterility in Women with Adrenogenital Syndrome. *J. Urol.* 73:17, 1955.
12. Wilkins, L., Lewis, R. A., Klein, R., Rosenberg, E.: The Suppression of Androgen Secretion by Cortisone in a Case of Congenital Adrenal Hyperplasia. *Bull. John Hopkins Hosp.* 86:249, 1950.
13. Wilkins, L., Lewis, R. A., Klein, R., Gardner, L. I., Crigler, J. F., Rosenberg, E., Migeon, C. L.: Treatment of Congenital Adrenal Hyperplasia with Cortisone. *J. Clin. Endocrinol.* 11:1, 1951.
14. Wilson, R. B., Keating, R. F.: Pregnancy Following Treatment of Congenital Adrenal Hyperplasia with Cortisone. *Am. J. Obst. & Gynec.* 76:388, 1958.
15. Yashimata, T. and Kozakae, F.: Pregnancy and Delivery at Term by Long Term Cortisone Treatment of a Congenital Adrenocortical Hyperplasia. *Endocrinologia japonica.* 3:176,1956. ◄



Ross Allen, Silver Springs, Fla.

EASTERN DIAMONDBACK rattlesnake *(Crotalus Adamanteus)*, one of the most deadly snakes in the United States.

Treatment of Poisonous Snakebites: Present Status of Incision and Excision

*HENRY M. PARRISH, M.D.**

Indianapolis

IT IS CHARACTERISTIC in medicine that when many forms of treatment are suggested for a disease, little factual information is known about that disease. The proper treatment of snake venom poisoning remains a controversial issue. There is an urgent need for more basic research on snake venoms and on the treatment of snake venom poisoning.

The treatment of poisonous snakebites should be based on both clinical and experimental studies. Clinical studies of snakebite accidents, however, are limited by the following features: (1) the species and size of the offending reptile often are not known; (2) the amount and potency of the venom injected cannot be determined; (3) some victims would survive poisonous snakebites without any treatment whatsoever; (4) the interval from the time of the bite to the time of treatment often is forgotten and (5) where multiple therapy (incision, suction, tourniquet, antivenin, blood transfusions, etc.) is used it is difficult to ascertain which measure produced the beneficial effects.

Minton[1] and Wood[2] are in agreement with many of these limitations of clinical studies. Furthermore, death versus survival of human victims cannot be used to measure the effectiveness of snakebite treatment in the United States. During the five-year period, 1950-1954, there were only 71 deaths in the United States attributed to snakebites—an average of only about 14 deaths per year.[3]

Experimental studies eliminate many of the undesirable features of clinical studies in that the type, amount and potency of venom are known, the route and depth of venom injections can be kept constant and single therapeutic measures can be compared with each other and with a control group of untreated animals. Also, differences in host responses to venom may be controlled partially by using one species of test animal and administering the venom on a dose per body weight basis. In evaluating the experiments of various workers one must constantly

* Medical Director, Marion County General Hospital.

INCISION AND SUCTION TREATMENT OF DOGS POISONED WITH CROTALUS ATROX VENOM*

Experiment No.	Sex	Weight in kilos	No. MLD's (1 MLD = 2 mg/kilo)	Total no. mg	Treatment	Time Begun	Results
7	M	11.4	2	45.6	None	———	Death 22 hrs.
8	M	6.4	2	25.6	None	———	Death 41 hrs.
9	M	6.0	2	24.0	I.S.	5 min.	Death 112 hrs.
10	M	9.0	2	36.0	I.S.	60 min.	Death 96 to 112 hrs.
14	M	10.0	2	40.0	I.S.	5 min.	Recovered
15	M	10.0	2	40.0	I.S.	60 min.	Recovered
18	F	20.0	2	80.0	None	———	Death 48 to 70 hrs.
19	M	10.0	4	80.0	I.S.	63 min.	Recovered

TABLE I

* Modification of the data presented by—Jackson, D., and Harrison, W. T.: Mechanical Treatment of Experimental Rattlesnake Venom Poisoning. *J. A. M. A.* 90:1928-1929, 1928.

keep in mind the following factors: (1) the type of venom used; (2) criteria for estimating the LD_{50}, the LD_{100} or the MLD of the venom; (3) the species of the experimental animal used; (4) the route of injecting the venom; (5) what each author means by terms such as tourniquet, incision, excision, etc.; (6) criteria used for judging success or failure of the experiment and (7) statistical evaluation of the results. Of course, the basic design of the experiment is of primary importance.

Incision and Suction

In most experimental studies incision has been performed for the purpose of sucking venom and/or its toxic by-products from snakebite wounds. The ancients used suction or cupping to remove poison from venomous wounds. However, Jackson and his associates[4, 5, 6, 7] were the first to study experimentally the effects of I.S. (incision and suction) on rattlesnake venom poisoning. By injecting western diamondback rattlesnake (*Crotalus atrox*) venom subcutaneously into the hind hocks of dogs, they established an MLD (minimum lethal dose) of venom as two mg per kilogram of body weight. While this dose of venom may have been more than an MLD, it uniformly killed the dogs.

The results of Jackson's experiments are not recorded in an altogether clear manner, making a statistical evaluation difficult. (See Table I.) However, the following observations were made: (1) dogs given one, two and four MLD's of venom and treated by incision and suction survived, while the untreated controls died; (2) dogs given two MLD's of venom treated with incision and suction (I.S.) five and 60 minutes later survived and (3) bloody fluid, aspirated from the incisions, when injected into other dogs killed them. Although there may be some limitations and criticisms of Jackson's work, his experiments stand as a landmark in the experimental treatment of snake venom poisoning.

Pope and Peterson[8] confirmed Jackson's experiments in a somewhat limited way. They used *Crotalus atrox* venom in dogs and found that two mg per kilogram of body weight uniformly killed the animals. The venom was injected subcutaneously into the dog's hind leg,

about halfway between the ankle and the knee. They treated two dogs given three and four MLD's of venom, immediately with I.S. (no tourniquets) and these animals survived. Two other animals given eight MLD's of venom died in less than 24 hours when treated in this manner. Next they treated two dogs given eight MLD's of venom with a tourniquet immediately, followed by I.S. in 30 minutes. One of these animals survived.

Leopold, Huber and Kathan[9] provided evidence that incision and suction decreased the survival time of rabbits which had been injected with eastern diamondback rattlesnake (*Crotalus adamanteus*) venom. However, these authors pointed out that, "these experiments did not follow the standard method of tourniquet-incision and suction." Leopold injected *C. adamanteus* venom into the intramuscular tissue of rabbits, whereas Jackson injected *C. atrox* venom into the subcutaneous tissue of dogs; Leopold made one incision and maintained suction for 15 minutes, while Jackson made multiple incisions and maintained suction for several hours. Also, Leopold injected venom in the concentration of 20 mg per ml, whereas Jackson used a concentration of 50 mg per ml.

The criterion of effectiveness of treatment was somewhat different in these two experiments: Leopold used the length of the survival time, whereas Jackson used survival or death. These comments are made only to point out the differences in experimental methods.

Ya and Perry[10] recently conducted experiments with incision and suction in dogs which had been poisoned with *C. adamanteus* venom. An MLD of venom for dogs was established as eight mg per kilogram of body weight. These investigators injected the venom into the subcutaneous tissues of dogs' thighs and treated them with 15 incisions and suction either immediately or after a delay of 30 minutes. Six of 11 dogs survived when treated by I.S. immediately; however, six dogs treated by I.S. after a delay of 30 minutes all died. Ya and Perry concluded that I.S. must be performed within 30 minutes to be effective in treating *C. adamanteus* venom poisoning.

Excision

Allen[11, 12] was among the first to investigate excision as a method of treating snakebite wounds. He used rattlesnake (*Crotalus atrox*) and moccasin (*Ancistrodon piscivorus*) venoms.

Allen injected 40 mg of venom intramuscularly into the posterior thigh muscles of rabbits and cats and excised a small mass of tissue surrounding the site of injection in one hour. All of the cats and rabbits treated in this manner died, although they lived longer than the controls. Allen also injected 200 mg of venom into these animals and excised around the area of swelling in five to 15 minutes. These animals also died. One cat survived when it was given 1.5 MLD's of venom and was treated by excision in one hour. Allen concluded that excision must cover a wide area and be performed early if it was to be effective in treating snakebites.

Parrish[13] compared the effectiveness of I.S. (incision and suction) with E.S. (excision and suction) in dogs poisoned with *Crotalus atrox* venom. An MLD of venom was established as 2 mg per kg of body weight. Each dog received 6 MLD's of venom injected ¼ inch deep into the leg. Three minutes after the injection of venom a tourniquet was applied and kept in place for 30 minutes. Thirty and 60 minutes after the venom was injected the animals were treated by either I.S. or E.S. Fifteen incisions were made for the I.S. treatment. An area seven cm in diameter was excised in the E.S. treatment. As seen in Table II, all of the animals treated by I.S. 30 minutes after envenomation died. On the other hand, two-thirds of the animals receiving E.S. 30 minutes after envenomation survived as did two-thirds of the animals treated by E.S. 60 minutes after envenomation. These results were statistically significant at the $P = .05$ level using the Chi-square test. Thus, early E.S. was more effective than early I.S. in treating dogs with *C. atrox* venom poisoning.

Discussion

Although incision and suction has been used for snakebite treatment in the United States since Jackson's work in 1927,[4] only Pope and Peterson's study[8] confirms Jackson's experimental findings. Both of these studies were carried out using *Crotalus atrox* venom in dogs. The results of other investigators[9, 10] who used I.S. in *Crotalus adamanteus* venom poisoning have not been as promising. Leopold and his associates[9] provided data which suggest that I.S. may be of no benefit, and even harmful, in *C. adamanteus* venom poisoning. Ya and Perry[10]

COMPARISON OF EXCISION AND SUCTION WITH INCISION AND SUCTION IN CROTALUS ATROX VENOM POISONING IN DOGS*

Experiment No.	Sex	Weight in kilos	No. MLD's (1 MLD = 2 mg/kilo)	Total no. mg	Treatment	Time Begun	Results
1	M	8.0	1	16.0	Control	———	Death after 22 hours
2	M	16.0	6	192.0	E.S.	60 min.	Survived
3	F	11.3	6	135.6	E.S.	60 min.	Death after 5 hours
4	F	7.0	6	84.0	E.S.	60 min.	Survived
5	F	13.6	6	163.0	E.S.	30 min.	Survived
6	F	10.4	6	125.0	E.S.	30 min.	Death after 16 hours
7	M	12.0	6	144.0	E.S.	30 min.	Survived
8	M	8.0	Injected with 40 cc. suction fluid withdrawn from dog #7 after 1 hour treatment				Death after 40 hours
9	M	6.8	1	13.6	Control	———	Death after 13 hours
10	M	8.6	6	103.0	I.S.	30 min.	Death after 13½ hours
11	F	11.8	6	142.0	I.S.	30 min.	Death after 12 hours
12	F	10.9	6	131.0	I.S.	30 min.	Death after 7 hours
13	F	7.3	6	88.0	I.S.	30 min.	Death after 19 hours
14	M	11.5	6	138.0	I.S.	30 min.	Death after 16 hours
15	F	6.7	6	80.0	I.S.	30 min.	Death after 6 hours

TABLE II

* From Parrish, H. M.: Early Excision and Suction of Snakebite Wounds in Dogs. *North Carolina M. J.* 16:93-96, 1955.

found that I.S. must be performed within 30 minutes to be effective in treating *C. adamanteus* venenation.

These conflicting results may be due to differences in the toxic effects of the venoms studied. For example, these venoms contain varying amounts of spreading factors.[14] Other factors which may be involved are the binding capacity various venoms have for tissues, the ease by which the venom can be removed mechanically, subcutaneous versus intramuscular spread of venoms and other biochemical characteristics of venoms. It seems entirely possible that I.S. may not be of value in all types of venom poisoning. This may explain why the British do not have a favorable clinical impression of using I.S. for treating cobra bites. In the United States all of the poisonous snakes are pit vipers, except the coral snakes. For the present time I.S. probably should be used for treating bites by North Amer-

ican pit vipers if the victims are seen early. Additional surgical experiments are needed to determine if I.S. is effective in treating venenation by the various species of North American pit vipers.

Parrish[13] found that excision and suction were capable of saving dogs which had been poisoned with six MLD's of *Crotalus atrox* venom. However, animals receiving six MLD's of this venom and treated 30 minutes later by I.S. died. These results *do not* indicate that I.S. is of no value. Perhaps I.S. would save animals given two or four MLD's of venom. This preliminary study[13] would seem to suggest that additional work with E.S. is indicated. The author did not recommend that E.S. be used in treating all poisonous snakebites. E.S. might prove beneficial in serious rattlesnake venenations, if the victim is seen within 30 to 60 minutes and if an adequate amount of tissue is excised. The experimental work of Parrish needs to be confirmed by other investigators.

Preliminary experiments with I.S. and E.S. in the treatment of snake venom poisoning look promising. Additional studies using various types of venoms are needed to prove the effectiveness of these surgical measures in treating poisonous snakebites. The following measures are suggested to eliminate many of the inadequacies of previous studies: (1) an LD_{50} of venom should be established so that the results of various investigators can be compared; (2) large pooled venom samples should be used for experiments since the toxicity of venom from individual snakes of the same species varies tremendously; (3) dogs or some other large animal should be used in the experiments, because the legs of small animals are not suitable for extensive surgical treatment and (4) survival or death, rather than the length of survival time, should be used as the criterion for judging the effectiveness of treatment.

Summary

1. The use of incision and suction (I.S.) and excision and suction (E.S.) in the treatment of snake venom poisoning is reviewed. Most surgical experiments on snake venom poisoning in the United States were conducted using western diamondback rattlesnake (*C. atrox*) and eastern diamondback rattlesnake (*C. adamanteus*) venoms.
2. Apparently I.S. is more effective in removing *C. atrox* venom than in removing *C. adamanteus* venom. On the basis of the present evidence, I.S. probably should be used in treating poisonous snakebites if the victim is seen within 30 minutes. After the venom has become widely disseminated throughout the body, I.S. is of no benefit.
3. Preliminary experiments suggest that excision and suction (E.S.) is more effective than incision and suction (I.S.) in treating *C. atrox* venom poisoning. The area of excision must be wide and E.S. must be used within 30-60 minutes to be effective. E.S. is not recommended for treating all poisonous snakebites. It should be reserved for serious venenations, especially those involving the trunk.

REFERENCES

1. Minton, S. A., Jr.: Polyvalent Antivenin in the Treatment of Experimental Snake Venom Poisoning. *Am. J. Trop. Med.* 3:1077-1082, 1954.
2. Wood, J. T.: A Critique on the "L-C" Treatment of Snakebites. *South M. J.* 49:749-751, 1956.
3. Parrish, H. M.: Mortality from Snakebites, United States, 1950-54. *Public Health Rep.*, 72:1027-1030, 1957.
4. Jackson, D.: First Aid Treatment of Snake Bite. *Texas State M. J.*, 23:203-209, 1927.
5. Jackson, D.: Treatment of Snake Bite. *South M. J.*, 22:605-608, 1929.
6. Jackson, D., Harrison, W. T.: Mechanical Treatment of Experimental Rattlesnake Venom Poisoning. *J. A. M. A.* 90:1928-1929, 1928.
7. Jackson, D., Githens, T. S.: Treatment of Crotalus Atrox Venom Poisoning in Dogs. *Bull. Antivenin Inst. Am.*, 5:1-6, 1931.
8. Pope, C. H., Peterson, L. W.: Treatment of Poisoning With Rattlesnake Venom: Experiments with Negative Pressure, Tourniquet and Bulb Suction. *Arch. Surg.* 53:564-569, 1946.
9. Leopold, R. S., Huber, G. S., Kathan, R. H.: An Evaluation of the Mechanical Treatment of Snake Bite. *Mil. Med.* 120:414-416, 1957.
10. Ya, P. M., and Perry, J. T., Jr.: Personal Communication. Feb., 1960.
11. Allen, F. M.: Observations on Local Measures in the Treatment of Snake Bite. *Am. J. Trop. Med.* 19:393-404, 1939.
12. Allen, F. M.: Mechanical Treatment of Venomous Bites and Wounds. *South M. J.* 31:1248-1253, 1938.
13. Parrish, H. M.: Early Excision and Suction of Snakebite Wounds in Dogs. *North Carolina M. J.*, 16:93-96, 1955.
14. Duran-Reynolds, F.: A Spreading Factor in Certain Snake Venoms and Its Relation to Their Mode of Action. *J. Exper. Med.* 69:69-81, 1939. ◄

The Case of the Bloated Bartender

*ARNOLD LIEBERMAN, M.D.**
New York, N. Y.

THE HIGH SQUEAKY shrill ululated the length of the corridor leading from the receptionist's desk to the inner consultation room; both closed doors only muffled the voice, giving it a banshee unintelligibility. The monologue rose crescendo as the patient waddled into view. The nurse placed the nice new folder on my desk, murmured, "This ought to be good" and then withdrew discreetly.

The creature was a gross caricature of the familiar "fat boy" type. The card bore the standard information: Isaac Witkowsky; age, 64; occupation, bartender; married, two grown sons; height 65"; weight 251; B.P. 150/80; Temp., 98F (orally); routine preliminary c.b.c. was normal; urinanlysis, ditto; the routine EKG clipped to the folder was very ordinary and the still wet chest film appeared to be in the same category.

Watch Chain Rests on Paunch

The folder said nothing about his enormous waistline that produced a girth equal to his height; it said nothing about his shrieking, garish, checked suit, the ridiculous, purple vest hiding in shame within the stained creases of the coat and the huge gilded watch chain resting on the mound of his bulging paunch. A Humpty-Dumpty like head sat neck-less over the broad torso; the head was glisteningly bald; the bulbous, potato-like nose beaked askew over a pair of weary cavalry moustachios partially concealing the feeble, receding chin and separated from it by a slitted mouth that was going clackety-clack and giving glimpses of a few remaining snags of discolored teeth. There was some dried tobacco juice stained spittle in the corner,

* One of a series of case reports. Dr. Lieberman formerly practiced in Lake County, Ind.



. . . the absurd reminiscence of a Fatty Arbuckle at his sloppiest . . .

smeared heedlessly over the unshaven stubble greying on the cheek.

The skin was a wrinkled saffron, dull-grey, icteric yellow; the hands were large with spade-shaped, stubby fingers, quite dirty and with grimy nails; the nondescript trousers sagged over disreputable old shoes with run-down heels, obviously unpolished since the day of acquisition.

All in all Witkowsky was the absurd reminiscence of a Fatty Arbuckle at his sloppiest, a Charlie Chaplin in tramp attire at his most woebegone, pitiful worst. And then this quivering tub of greasy jelly plumped into the chair which he promptly overflowed; he sat there rocking back and forth; he rested his folded hands on the protuberance that passed for his abdomen; and all the while there was that absurd boyish, high-pitched tremolo so characteristic of the more severe eunuchoid endocrine disturbances.

Witkowsky wore no hearing aid, but he was almost totally deaf; I had to shout and almost shake him to get a question across. While he appeared under a manic compulsion to talk, at first I had difficulties with his mangled, mongrelized English; fortunately, his native Ukrainian peasant dialect was understood. After that, the story tumbled out, of course, with many asides and rambling diversions; I had to interrupt him constantly and guide his discourse back into the main channel.

His native village was in a remote part of Galicia where the rolling plains blended into the forested slopes of the Carpathian Mountains; at the end of the 19th century it was a part of the Austro-Hungarian Empire. Life was very medieval and feudal; "Pan Polkovnik Voyevoda" (translated literally: "Lord Colonel Warmaster") owned vast chunks of the country and—in that region—he still dispensed the law: the high justice, the middle, and the low. No one ever



. . . He began to sample his wares . . .

thought of challenging his right of the first night; the peasantry did corvee labor for the lord as a matter of obvious custom. The Witkowskys were old family retainers since time out of mind, and as a signal mark of his benign favor, the "old lord" permitted Isaac to be named after him. As a further sign of his benevolence, the old lord of the manor assigned young Witkowsky to be the constant companion of the "young lord" of the baronial manor.

Isaac Witkowsky wore his young master's cast-off clothing; he ate in the manor kitchen; he cleaned daily the commode in their joint bedroom; he laid out and kept in order the young lord's accoutrements; he was his master's constant companion. The relationship was exactly the same as prevailed, before our Civil War, on Southern plantations where young slave boys were assigned to be at the beck and call of the sons of the white masters.

No Soldiering Beyond Shining Boots

When World War I broke out, the dashing young lord went off as a cavalry officer; Isaac Witkowsky was taken along as his master's orderly. Isaac went through four years of the fighting as a private in the Austrian army; actually, he did no soldiering beyond shining his master's impeccable boots, grooming his high-spirited horse and continuing to perform all the other chores that had been his life on the Voyevoda demesne. He never shouldered a rifle or learned squads right and left.

Being a total illiterate, Isaac had no knowledge whatever of politics; the words socialist, communist, democracy, revolution—all were completely beyond his ken. Galicia was now under Polish dominion, but Isaac continued serving the young lord exactly as he had before. The old lord gave Isaac Witkowsky a wife and a dowry; the first son bore a remarkable resemblance to the Voyevodas; Witkowsky was rather proud of the honor.

The years passed; the "old lord" died; the "young lord" aged, became a grey-haired *pater familias* in his own right—and the sun set and the moon rose and the year was 1939. Isaac did not know the years as such but he did tell me in his picturesque dialect that "Nemchura vorvalos" — the Germanians (not Germans) — intruded violently, a flavorless translation of a colorful phrase. In any case, the Voyevodas fled with what movables they could salvage; the Witkowskys went along as a matter of natural course. They went through "several large towns," they crossed a "big ocean"; they landed in New York; and then they all settled in a suburban community not too far away.

Life went on much as before except that Isaac learned about indoor plumbing, automobiles and other such newfangled notions. And then the Voyevodas found themselves financially unable to maintain a feudal menage. Isaac Witkowsky could not just be turned out by the Voyevodas; the master was able to hire Isaac out as a bartender in suburban Nyack. The Witkowskys moved into town and Isaac learned how to dispense beer and serve hard liquor; he also acquired a minimum of tavern English. In addition, he began to sample his wares, get paunchy, and be quite sluggish. "Exactly, how much sampling each day?"; "Oh! a few leftovers of beer and such. Yes, also brandy! exactly how much? Oh, never enough to be drunk but—tochno, ne znam—don't know."

More years passed; the Voyevoda family scattered here and there; the "young lord" himself died and Isaac Witkowsky was pretty much on his own. Within the last year his hearing had begun to fail very badly, he began to gasp for breath on the least exertion, his belly and legs had begun to swell, and he could barely waddle around behind the bar; also, his memory had begun to fail so that the simplest orders confused him. His children were all grown; his wife worked as a maid for "some fine people"; she had spoken to her mistress concerning Isaac's health and that is how he found his way to my office. A light dawned as I saw the name of

the referring family that was footing the bill: they were very charitable, grateful patients of mine.

Physical examination only accentuated the humdrum expected findings. Isaac Witkowsky had a basically sound heart embarrassed by the enveloping fatty layers; the lungs were fairly clear; the liver was easily palpable at least two fingers below the costal margin, its edge being fairly smooth and not tender or pulsating to palpation. The legs were somewhat edematous but no more than could be expected. The enormous belly was tapped and several quarts of a clear ascitic fluid drained—care being taken not to drain off too much too suddenly. The diagnosis of Laennec's cirrhosis of the liver seemed beyond cavil but, still, other tests were ordered. In the meantime, routine treatment was instituted.

VDRL Is Plus

The following week, many of the tests were back. The Papanicolau smears showed no signs of malignancy; skull films showed a rather small sella turcica and not much else; blood chemistry showed a mild azotemia, protein-bound iodine of only 4.8 and a normal sugar level; the VDRL was plus-minus. Careful neurological re-evaluation showed one pupil to be slightly irregular and smaller than the other; still they both reacted to light and accommodation.

The prostate was small but not hard or nodular; the gag reflex was absent as was the cremasteric, but all other reflexes were unexceptional. Obvious alcoholic cirrhosis combined with thyroid deficiency could explain the data even including the tiny external genitalia and the very evident depression of all glandular functions including the secondary sexual. The equivocal test for syphilis made us order another blood serology and also suggested the attempt at a spinal tap. This was easier said than done, as Isaac proved quite uncooperative, squirming in such fashion that all we could get was a "dry tap"—the usual lame excuse for botched mechanics.

We desisted from this exercise in futility and sent Isaac for an IQ test. Making all allowances for language barriers, illiteracy, and myxedema, we still came up with low moronic, almost imbecilic, readings. All this would explain, even if not fully, the squeaky voice, the slovenly attire, the evident deterioration, but why the hysteria and the incongruous optimism and the compulsive logorrhea? Why the decreasing contact with his environment? Why the progressing deafness—inner ear, at that? Neither myxedema nor alcohol should do things like that.

Anyway, rather energetic therapy was instituted and we made sure that alcohol was no longer available to him. I grilled Isaac rather thoroughly on any history that would suggest—even remotely—venereal disease. Of course, he knew such things only in the coarsest of Ukrainian idiom but he protested quite vigorously that he had had relations only with his wife; it was transparently certain that he spoke only the truth. She was checked and proven well; so were all the children; yet the second serology came back a "plus two."

We wanted to try a course of antiluetic therapy just as a precaution but the Witkowskys moved to the Bronx and went to a clinic in the big city. I lost track of them until I received a call from Mrs. Witkowsky's patron, the person who had sent Isaac to me in the first place. After some preliminary amenities, she came to the point.

"Please go over when you have time and take a look at Isaac; his wife tells me he is unmanageable; it might be he'll have to go to the city hospital."

Mrs. Witkowsky was contacted and I found my way to that drab household. I had called the city clinic Isaac had attended; by phone I was briefed on the therapy that Isaac had been given. Digitalis, diuretics, vitamins parenterally and orally, numerous paracenteses, rigid dieting—apparently the usual, vigorous therapy; "thyroid?" "Oh! yes! pushed to the limit." Isaac had continued downhill in spite of all therapy; he had begun to hallucinate a bit and lose all contact with the world; he had begun to imagine himself as the "young lord" riding off to the wars. All this had prepared me for what I found; let us skip the grimy details. We committed Isaac; he went on the male service in the hospital.

A big slug of thorazine and two husky orderlies held Isaac long enough for us to accomplish a successful spinal puncture. The fluid was quite diagnostic: it was under increased pressure, the cell count was in the hundreds, the serology was four plus, and the colloidal curve was indubitably paretic. Still, I was surprised at the continuing abdominal findings of ascitic fluid not responding to the standard anti-alcoholic therapy; a Vim-

Silverman needle was handy and a liver biopsy proved not too difficult. Well, the numerous gummata seen under the microscope gave an answer quickly enough. Of course, cirrhosis can be on a luetic basis, too.

Routine penicillin therapy wrought an almost miraculous cure: within months, the mind cleared, the abdomen went down, and Isaac's hearing improved also! The spirochetes certainly had gotten around.

Light Suddenly Breaks

Before discharging Isaac Witkowsky from the hospital, I questioned him again as to a possible source of the primary lesion. After prolonged fruitless prodding and probing, a light suddenly broke on his guileless face; in fluent Ukrainian, he said,

"Oh, yes! That sort of thing! Well! When I was a little boy of nine, a bad kitchenmaid in Pan Polkovnik's scullery took me out in the hay meadow one summer day; she took off all of my clothing.

"Then, she took me (and here Isaac made an eloquent, indescribable gesture) and rubbed me against herself between her legs. Heh, heh! I still remember how it tickled!"

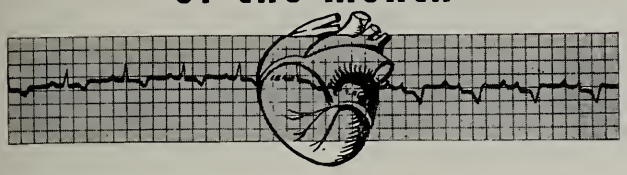
Isaac Witkowsky laughed uproariously at the recollection.

"Oh, no! I was too young to give her a baby! You know! Of course, I never told anyone about it! That maid said she'd choke me if I ever blabbed. Yes! I did have a sore there but that was a month later and it went away all by itself! I never thought any more about it." ◄



. . . a bad kitchenmaid . . . took me out in the hay . . .

Electrocardiogram of the month



*Presented as a regular feature of The JOURNAL, Electrocardiogram of the Month is a series of short talks on cardio-vascular diagnosis and treatment, edited by the staff of the Robert M. Moore Heart Clinic of the Marion County General Hospital, Indianapolis.**

Atrial Fibrillation, Atrial Tachycardia with Block And Ventricular Tachycardia due to Digitalis Intoxication

CHARLES FISCH, M.D.

Indianapolis

CASE 1—A 72-year-old female was admitted to the Marion County General Hospital on 7-17-60 because of acute pulmonary edema. No details as to previous therapy were available. On physical examination the neck veins were slightly distended, the heart was enlarged to the left, the rhythm was irregular and the rate was rapid. Many coarse, moist rales were heard throughout both lung fields. No other pertinent findings were noted. The electrocardiogram (Figure 1), taken at 11:20, showed what was considered to be atrial fibrillation with aberrant conduction probably due to pre-existing intraventricular block. The rate was approximately 170.

Because of rapid atrial fibrillation it was assumed that the patient would benefit from digitalis, and since a history of previous medication was lacking, we elected to give her a 0.4 mg of a rapid acting glycoside (lanatoside C) and observe the effect on the ventricular rate. In 20 minutes (11:40) a definite slowing of the atrial fibrillation was observed and two more doses of 0.2 mg of the drug were given at 11:40 and 12:40. Clues of impending digitalis intoxication were present on the 12:40 strip and consisted of ventricular prematures and a number of evenly spaced QRS complexes with an R-R interval of 0.56 sec., representing A-V nodal beats (N).

The suspicion of digitalis intoxication was confirmed on the 1:00 p.m. strip at which time the rate became absolutely regular at 150, indicative of A-V nodal tachycardia followed by normal sinus rhythm. Administration of an additional 0.2 mg of lanatoside C at 1:30 resulted in ventricular bigeminy in presence of what appears to be A-V nodal rhythm. One cannot be absolutely sure of the latter because artifacts preclude positive identification of P waves.

Case 2—This patient, a 65-year-old female, was admitted on 7-18-60, with a supraventricular tachycardia varying from A-V nodal to atrial tachycardia with block (top row, 7-18-60, Figure 2). On 7-20-60 at 8:00 a.m. obvious paroxysmal atrial tachycardia with a varying degree of block was present and at 4:00 p.m. the rhythm converted to an atrial fibrillation. On 7-21-60, after 1.6 mg of digitoxin was given over the preceding

* Supported by the Herman C. Krannert Fund of the Indiana Heart Association, the Indiana State Board of Health, Indianapolis, and the National Heart Institute (H.T.S. 5363).

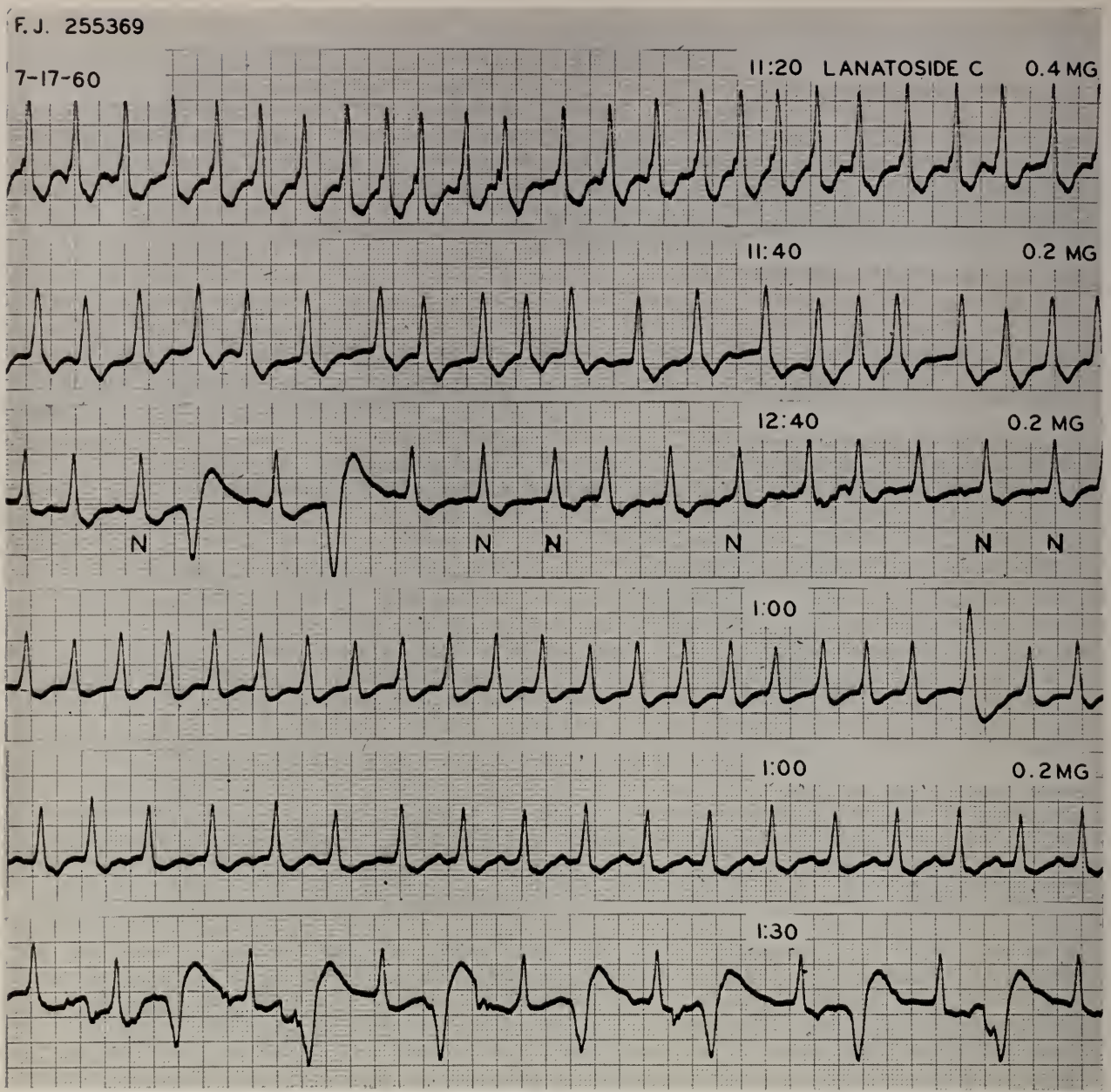


FIGURE 1, Case 1

THE 11:20 A.M. strip shows atrial fibrillation with intraventricular block responsible for aberrant conduction. At 11:40 atrial fibrillation is still present but now the rate is somewhat slower. Two ventricular prematures and A-V nodal beats (N) are noticed at 12:40 p.m. At 1:00 p.m. A-V nodal tachycardia with a run of normal sino-atrial rhythm appeared followed at 1:30 p.m. by ventricular bigeminy. The A-V nodal beats, ventricular prematures and A-V nodal tachycardia are indicative of high degree of digitalis intoxication.

72 hours, the patient exhibited paroxysmal atrial tachycardia (P.A.T.) with block and runs of ventricular tachycardia as exemplified by the first 3 beats of the second row (7-21-60, 8:00 a.m.). The ventricular arrhythmia was still present at 1:15 at which time it was elected to treat the patient with potassium. Fifty mEq of potassium was given orally at 1:15 and at 2:15 p.m. the patient was free of ventricular tachycardia with a normal sinus rhythm at 2:45 p.m. The latter was transient in character and P.A.T. with block reappeared at 3:45 p.m. Atrial fibrillation was recorded on the next day (7-22-60).

Previous Digitalis Therapy

Assuming that the two patients were not digitalized prior to admission, the amounts received after entry to the hospital were not sufficient to cause such severe intoxication; therefore, in spite of the supposedly negative history of digitalis medication, the sensitivity to the drug exhibited by the two patients indicates that they

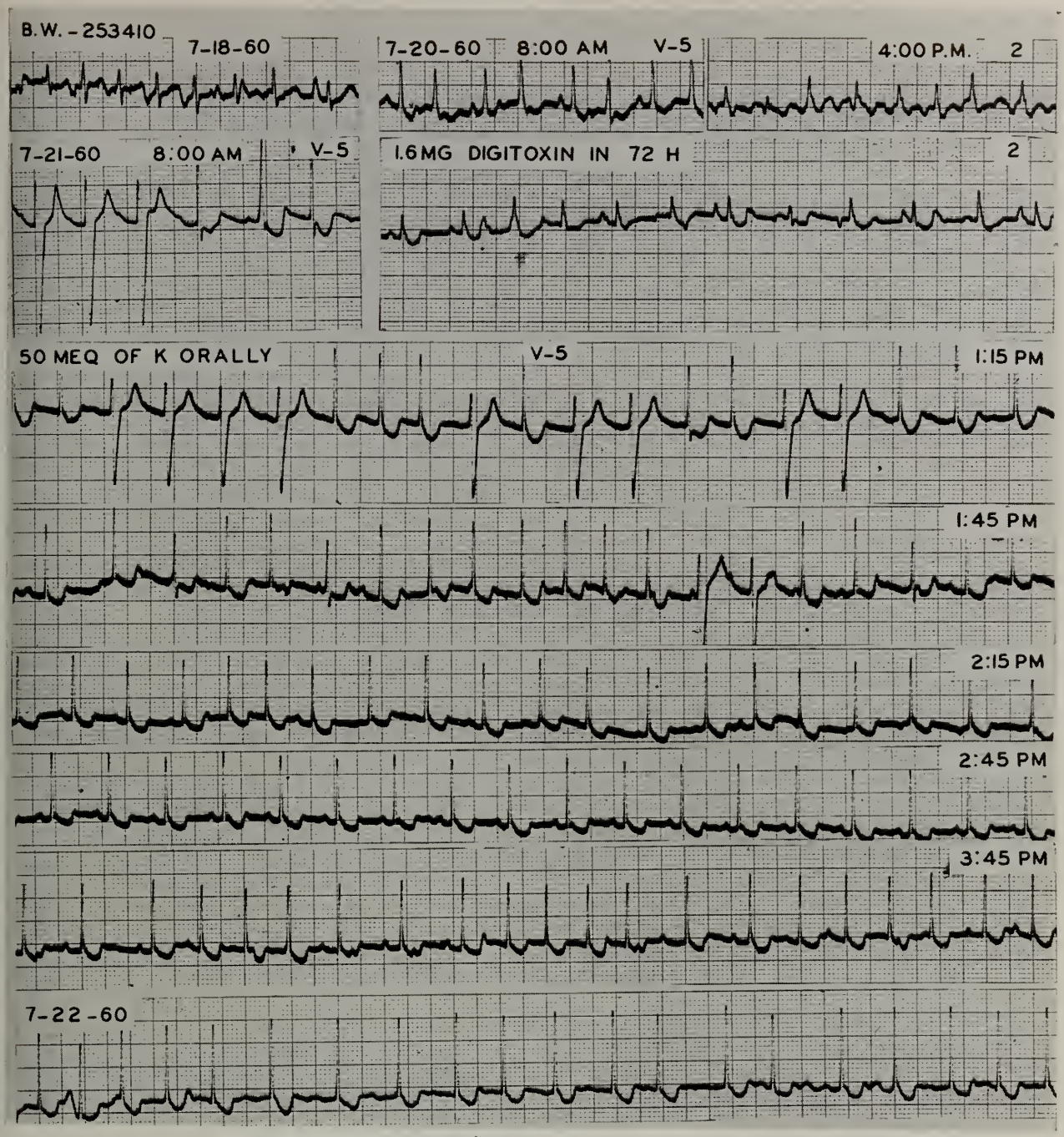


FIGURE 2, Case 2

NODAL AND PAROXYSMAL atrial tachycardia (P.A.T.) with block and atrial fibrillation were present on 7-18-60 and 7-20-60. Short runs of repetitive ventricular tachycardia and P.A.T. with block are obvious at 8:00 a.m. and again at 1:15 p.m. on 7-21-60. As a result of administration of potassium phosphate the ventricular tachycardia disappeared at 2:15 p.m. and P.A.T. with block at 2:45 p.m. with resultant normal sinus rhythm. The latter, however, lasted only one hour with recurrence of P.A.T. with block at 3:45 p.m. A follow-up tracing on 7-22-60 shows atrial fibrillation. In this instance the appearance of ventricular tachycardia signaled high degree of digitalis intoxication.

were on digitalis therapy prior to admission to our hospital. The arrhythmias observed in these cases, namely, nodal tachycardia, ventricular bigeminy and ventricular tachycardia are indicative of a rather high degree of digitalis intoxication.

The response of ventricular tachycardia to potassium in Case 2 again emphasizes the fact that this cation is an excellent anti-arrhythmia drug. Awareness of increased sensitivity to this cation of digitalis-intoxicated patients and the transient nature of beneficial effect of potassium will lead to a more successful use of this salt. Potassium should not be used to treat other parameters of digitalis intoxication unless depletion of body potassium can be shown to exist. There is every reason to believe that other manifestations, e.g. A-V blocks, are aggravated by potassium salts.

Another practical point referable to behavior of atrial fibrillation is emphasized by Case 1. There exists a common misconception that development of a regular rhythm in course of treatment of atrial fibrillation with digitalis is a beneficial therapeutic response. Occasionally conversion to normal sinus rhythm may take place during administration of digitalis to patients with atrial fibrillation. Whether this is due to digitalis per se remains a question. More often, however, normalization of rhythm is due to digitalis toxicity. When the rate is regular and rapid, either nodal tachycardia (Case 1, 1:00 p.m.) or less likely, ventricular tachycardia, (Case 2, 7-21-60) are responsible. More often, however, toxicity is manifested by a slow and regular rate due to complete heart block. In any event the sudden appearance of a regular rhythm in course of administration of digitalis to patients with atrial fibrillation calls for immediate re-evaluation of the treatment. ◄

Danger of Becoming Satisfied

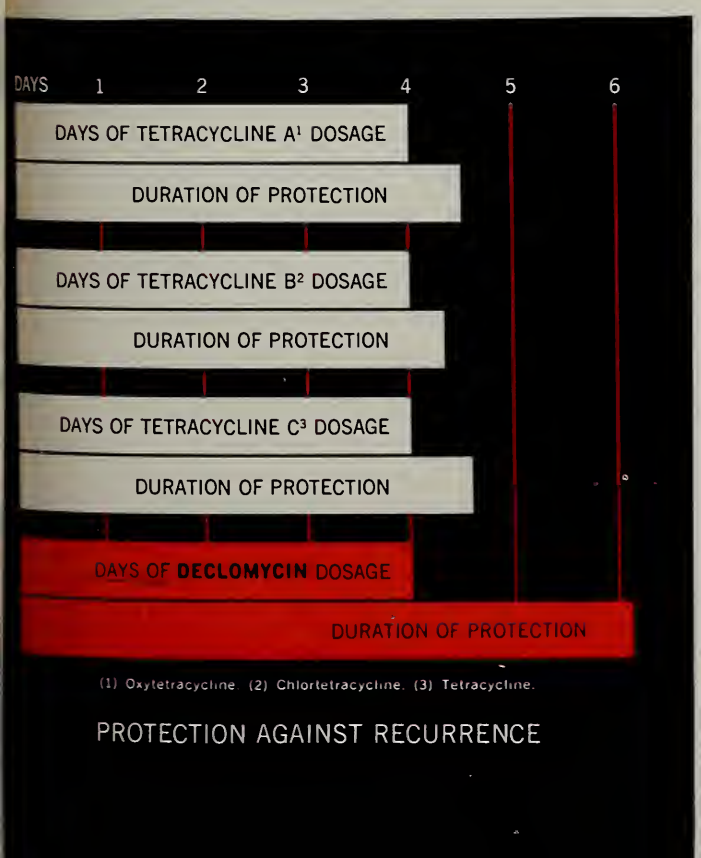
The technical excellence of a surgeon's art is important, for it is this quality more than any other that makes his operations safe and effective. In the period of training it is an advantage for him to master the standard techniques so that they may become the scaffolding on which his surgical philosophy is built. Yet there are dangers in perfecting techniques: the dangers of becoming overly enamored of the craftsmanship involved and of being reluctant to adopt new methods. The surgeon knows that employment of new techniques may, until they are mastered, result in a temporary increase in postoperative complications. As a result of this knowledge his operations may become overstandardized. The decision as to what operation should be performed may be made on a basis of what operation the surgeon does most expertly instead of what operation would be best for the patient. When this happens and when a technique has become standardized too rigidly the operation may become a mere corollary to the diagnosis. In such cases the reflex centers of the surgeon have taken control. It is the hand that guides the mind.—G. Crile, Jr., M.D.: The Danger of Becoming Satisfied with Standardized Techniques, *Surgery, Gynecology & Obstetrics,* July 1960.

LOMYCIN®

DEMETHYLCHLORTETRACYCLINE LEDERLE

retains activity levels 24-48 hrs.

DECLOMYCIN Demethylchlortetracycline retains activity levels up to 48 hours after the last dose is given. At least a full, extra day of positive action may thus be confidently expected. The average, daily adult dosage for the average infection—1 capsule q.i.d.—is the same as with other tetracyclines...but **total** dosage is lower and duration of action is longer.



CAPSULES, 150 mg., bottles of 16 and 100. **Dosage:** Average infections—1 capsule four times daily. Severe infections—Initial dose of 2 capsules, then 1 capsule every six hours.

PEDIATRIC DROPS, 60 mg./cc. in 10 cc. bottle with calibrated, plastic dropper. **Dosage:** 1 to 2 drops (3 to 6 mg.) per pound body weight per day—divided into 4 doses.

SYRUP, 75 mg./5 cc. teaspoonful (cherry-flavored), bottles of 2 and 16 fl. oz. **Dosage:** 3 to 6 mg. per pound body weight per day—divided into 4 doses.

PRECAUTIONS—As with other antibiotics, DECLOMYCIN may occasionally give rise to glossitis, stomatitis, proctitis, nausea, diarrhea, vaginitis or dermatitis. A photodynamic reaction to sunlight has been observed in a few patients on DECLOMYCIN. Although reversible by discontinuing therapy, patients should avoid exposure to intense sunlight. If adverse reaction or idiosyncrasy occurs, discontinue medication.

Overgrowth of nonsusceptible organisms is a possibility with DECLOMYCIN, as with other antibiotics. The patient should be kept under constant observation.

Lederle

LEDERLE LABORATORIES
A Division of
AMERICAN CYANAMID COMPANY
Pearl River, New York

The Journal

of the INDIANA STATE MEDICAL ASSOCIATION

Devoted to the interests of the medical profession of Indiana

Editor: Frank B. Ramsey, M.D., 1802 North Illinois Street, Indianapolis 2, Indiana

Associate Editors: A. W. Cavins, M.D., 221 South Sixth Street, Terre Haute, Indiana; Lall G. Montgomery, M.D., Ball Memorial Hospital, Muncie, Indiana; David A. Bickel, M.D., 515 Odd Fellows Building, South Bend, Indiana; Stephen L. Johnson, M.D., 521 Sycamore Street, Evansville, Indiana.

Editorial Board: Term Expires

George M. Johnson, M.D., Richmond . . Dec. 31, 1960
Irvin W. Wilkens, M.D., Indianapolis . Dec. 31, 1960
Harold D. Lynch, M.D., Evansville . . Dec. 31, 1961
Jene R. Bennett, South Bend . . . . Dec. 31, 1961
Samuel R. Mercer M.D., Fort Wayne . Dec. 31, 1962
Franklin F. Premuda, M.D., Hammond . Dec. 31, 1962

Necrologist: James B. Maple, M.D., 117 West Washington Street, Sullivan, Indiana.

Assistant Editor: Sara M. Snyder

Business Manager: James A. Waggener

1019 Hume Mansur Building, Indianapolis 4, Indiana

Most Aged Don't Want Federal Help

AN INDEPENDENT SURVEY completed recently proves beyond doubt that most Americans over the age of 65 are satisfactorily providing for their own health needs and do not want any assistance from the federal government.

Trained sociologists interviewed the oldsters in numbers large enough to be statistically valid and came up with the following facts:

Sixty-one percent of the people considered their health to be good; 29% thought it was fair, and only 10% thought it was poor.

Ninety percent could think of no medical needs that were not being taken care of. Most of those who did have unmet needs attributed other reasons than financial for their failure to meet these needs. Lack of money was the most infrequent reason and this applied to only a few.

Sixty percent said that they were now covered by private voluntary health insurance.

The overwhelming majority (78%) favored voluntary programs for medical assistance. Twelve percent did not have an opinion on this question. Only 10% favored compulsory plans.

Dr. Leonard Larson, president-elect of the AMA, said that "The study disproves some dangerous misconceptions about the aged. It shows that most of these citizens are in good health, not sick, and are in moderately good financial condition, not hardship cases."

The study was conducted country-wide by hundreds of trained workers from more than a dozen universities and colleges. Its independent and unbiased nature makes its conclusions especially significant.

Diabetes Week

THE AMERICAN Diabetes Association together with its affiliates and over 900 diabetes committees of medical societies throughout the United States are sponsoring the annual detection week this year from Nov. 13 to 19.

The annual detection drive has become a customary and important event. It is based on the proposition that a disease such as diabetes which may be detected in the presymptomatic stage and in which early detection and early treatment

pays such large dividends should be the recipient of continuing vigilance during the year and of special attention at one particular time.

Diabetes Week is set aside each year to give an opportunity for medical societies in cooperation with service clubs, schools, labor unions and business and industrial firms to conduct simple glycosuria screening tests on large numbers of persons who think they are perfectly healthy.

It is estimated that one in approximately 140 people in the United States is the victim of undiscovered diabetes. Every time one of these unknown diabetic individuals is discovered and treated, his or her life is extended and many of the complications of the disease are avoided or minimized.

Editorial Notes

"The new **Sabin oral vaccine** for the prevention of poliomyelitis is going to cost considerably more than some early reports have indicated." Wyeth Laboratories state that the Sabin vaccine will present one of the most difficult production problems ever experienced in the biological field. They further say that while the vaccine may be cheap someday; it will cost about the same as Salk vaccine initially.

The **University of Kentucky** dedicated its new medical center at Lexington Sept. 23 and 24. Ceremonies included addresses by Governor Bert T. Combs, Dr. Rene J. Dubos of Rockefeller Institute and Dr. Konrad Bloch of Harvard University. The medical library was accorded a special dedication with an address by Dr. Frank D. Rogers. Director of the National Library of Medicine.

"Results indicate that **physicians prescribing meprobamate should warn patients of the greater effect from drinking alcoholic beverages while taking the drug**—especially if they are likely to operate motor vehicles or other complex machinery." Such is the conclusion of a study at the Madison (Indiana) State Hospital as reported in the August 20 issue of *JAMA*.

The researchers (George A. Zirkle, Ph.D., Ott B. McAtee, M.D., and Peter D. King, M.D., of the state hospital and Sgt. Robert VanDyke, Indiana State Police) stated they had not been prepared for the extent of the effects of the two taken simultaneously, since their own experiments with alcohol and chlorpromazine had produced less behavioral disturbance, although chlorpromazine is considered a stronger drug than meprobamate.

60% of All Prescriptions Cost $3 or Less

That today's prescription prices are by no means as high as the Kefauver subcommittee would have us believe, is made evident in a survey recently completed by Abbott Laboratories.

Based on an analysis of more than 27,000 prescriptions picked up at random from drug stores throughout the nation, the survey shows that in 1959:

- More than 60% of all prescriptions were priced at $3 or less.
- More than a third of all prescriptions were priced at $2 or less.
- Fewer than 9% of all prescriptions cost the patient more than $6.
- Only 1.7% of all prescriptions cost more than $10.
- The prescription price which showed up more often than any other was—$1.50. This price accounted for 4.7% of all prescriptions filled in the nation's pharmacies.

New Medical Materia, June 1960.

As of June 31, 1960, the receipts of the **American Medical Education Foundation** were 132% above those through June 31, 1959—a total of $259,302, as compared to $126,912 receipts of the previous year. The 1959 figure includes one extra month because the ending of the fiscal year was changed to January 31.

Forty-seven states have shown an increase over last year's figures. If this trend continues 1960 will be a banner year.

The recent AMA meeting in Miami witnessed the inauguration of the **Ethel Gastineau Award.** The cup, emblematic of the award, was given by Mrs. Gastineau. It will be presented each year to the state woman's auxiliary which does the most for AMEF during the year. The Woman's Auxiliary to the Tennessee State Medical Association was the first recipient.

The Indiana State Medical Association, Mrs. Gastineau, and the Woman's Auxiliary to the ISMA were presented with Awards of Merit for 1959. A new AMEF award, the "Citation" was presented to a long list of faithful and generous contributors over the years. One of the original recipients was **Dr. James McIntyre** of Indianapolis.

The World Medical Association has found a useful and advantageous disposal system for medical books and periodicals which U.S. physicians no longer wish to retain. **Doctors and medical organizations of Asia and countries of the North Pacific are starved for medical literature.** Organizations have been formed to furnish the shipping costs. Dr. Louis H. Bauer of the WMA invites physicians to report to him the title, volume numbers and year of publication of books or periodicals which they would be willing to have shipped overseas. These lists will be checked against want lists of overseas doctors, hospitals and medical schools. It is also possible for Dr. Bauer to furnish addressed mailing wrappers which will send single copies of current journals (after they are read) to a single physician. The address of the WMA is 10 Columbus Circle, New York 19.

Guest Editorial

Nation Fights No-vote-itis

PROMINENT LEADERS in American medicine have again warned all America against a possible epidemic of no-vote-itis, a disease affecting many adult Americans. These same leaders point out that although vast sums have been spent on research and education since the last great outbreak in 1956, there is always possibility of a flare-up. Because of the nature of this peculiarly American disease (of which too little is known), it can appear in many areas of the land at the same time. Although of short duration, the epidemic often leaves the nation with serious after-effects.

Researchers have found, however, that immunity from no-vote-itis is obtained through constant vigilance. They have also determined that the disease attacks both males and females beginning at the 21-year level, although one state reported cases among 18-year-olds.

During the past four years, the study showed that no-vote-itis is no respector of personalities, as it strikes at all levels of the nation's income groups. However, the facts show that a large number of cases occur among members of the professions, with doctors of medicine being among those often afflicted.

Temporary paralysis of the hand and loss of forward motion in the feet, both characterize the disease. Strangely enough, the diagnoses have been more readily made by political observers than by busy men of American medicine.

The implications of the above allegory are many. To the practicing profession, it is both a challenge and an indictment. To the medical student it can mean just one thing—the development and use of the strongest antibiotic known to politics—the individual doctor's vote.

Only when physicians-to-be and physicians-who-are accept their full and complete responsibilities of American citizenship, can there be hope of relief from the ravages of no-vote-itis—a disease welcomed by self-perpetuating politicians to the detriment of the people at large.

—Russell F. Staudacher, Exec. Dir., Student AMA, *The New Physician,* Oct. 1, 1960.

Guest Editorial

Rabies Trends - 1960

IN THE mind's eye, whenever one hears the word *"Rabies"* in Indiana, there is conjured up the image of a *"mad"* dog. This has been true ever since records have been kept. Yet there seems to be a change occurring. In recent years, if one looks at a listing of the species infected with rabies, it appears that wildlife infections are becoming more numerous. Certainly on a national basis this impression would be strengthened by the figures.

Ten years ago, in 1950, there were 4,979 dogs reported with rabies in the United States. In that year 1,375 miscellaneous species, including wildlife but excluding domestic animals, suffered the disease. The trend of the decade may be seen by comparing the 1959 rabies cases with those above. Last year, nationally, 1,124 dogs were reported rabid while the miscellaneous group increased to 1,925 cases confirmed as rabies. Thus, it appears that while the dog is still a serious factor in the occurrence of the disease, other species are becoming of greater concern.

In our state, there seems to be a similar trend although this is not clearly established. Cases of dog rabies have dropped from the 1950's 563 cases, to 77 in 1959. However, the increase in wildlife is but slight, from 14 cases to 19 in 1959. To date, in 1960, the number of wildlife cases is 18 compared with 28 in the dog. These trends in wildlife, perhaps, would not be significant except as related to the entire picture occurring in the north central states. In all states in this region, except Indiana, the great majority of cases are in wildlife, principally the fox and the skunk. With the reduction of rabies in the dog population in Indiana, it would appear that wildlife rabies will become of greater concern.

Southeastern Indiana currently is the focal point of rabies in wildlife, but cases have been reported from every area of the state in the past. Along with these cases there are also outbreaks of the disease in dogs. Of the 16 Indiana counties reporting rabies in 1960, eight are in the southeastern area of the state. These eight counties account for 22 of the cases in dogs and for nearly all of the fox cases.

Most exposures of humans to rabies occur as individuals are bitten by infected dogs. Exposures from wildlife bites are occasionally reported, but wildlife and human seldom tend to congregate as do man and his dog. Therefore, the incidence of bite is much less from wildlife.

Methods to control the disease in these species have not been reliably established. Vaccination of the unrestrainable animal population is, obviously, out of the question. Other types of controls attempted, such as poisoning and trapping, are repugnant to the people and have met with limited or no success. Solution of this problem will require extensive research upon the part of conservation and disease control investigators. Until such effort brings forth results, control of the disease in the dog population remains paramount.

It has been stated that the chain of infection of rabies is from wildlife to stray dogs and in turn to the owned dog population because of the nature of their associations. Man is most frequently in contact with the owned dog, hence, this dog is his most frequent source of exposure. Obviously then, preventing the owned dog from getting rabies and exposing humans is extremely important. This can be accomplished by eliminating stray and straying dogs to prevent their contact with wildlife and the owned dog population. This would break the theoretical chain of infection. Vaccination of owned dogs against rabies, an annual requirement in Indiana, would establish an immune population which would not support an epidemic should unapprehended infected strays mingle with these pets. Protect your family and friends—vaccinate your pet dog. —J. D. Salisbury, D.V.M., *The Monthly Bulletin,* Indiana State Board of Health, Aug., 1960.

Guest Editorial

Democracy is not a Spectator Sport

THE CONSTITUTION of the United States says nothing about political parties. The Founding Fathers, in fact, looked upon parties as an evil, but a necessary evil. Yet political parties have become as vital to the proper functioning of democratic government as have the legislatures, the executive and the courts.

The men who built this republic were proud to be politicians, because they were rugged individualists who had come to the new world to worship God in their own fashion and to run their own affairs. In their town meetings every man had his day and most spoke their mind boldly.

In Greece, the name for a town was "polis." Those who ran the town, its citizens, were "politikos." Our forefathers knew this and knew they had to be politikos, or politicians, to keep their freedom. They instituted government to secure our inalienable rights to life, liberty and the pursuit of happiness. Government derived its power only from their consent. They proudly gave their time for it, for they wished to govern themselves.

We still have self-government and it still works, but it must have the *active* support of all the citizens. Over the years our country has grown and prospered and life is becoming more and more complex. People are no longer able to attend to all their needs themselves. Therefore we have to specialize. Our professional politicians are specialists too—specialists in making the laws or in administering them. The rest of the people are largely content with voting for or against them, and only about 60 per cent do that much.

In 1958 a total of 104,600,000 Americans were of voting age, but only 44,550,000 of them went to the polls to select their senators, congressmen, governors, state legislators and so on. The senators and congressmen, governors and others are the men and women who have been taxing us, spending our money, regulating us, telling us—in many cases—how we can run our businesses, resolving our place in the world. But a good deal less than half of us seem to care.

In 1956 some 102,000,000 Americans were old enough to vote, but only a little more than 62,000,000 were counted in the presidential contest, while 59,000,000 were all that cared about who made up the House of Representatives, and only 44,000,000 expressed themselves on the Senate.

An active, intelligent interest in government is an inherent part of good citizenship. After all, we were citizens before we received our degrees in medicine, and even after retiring from practice we will continue to be citizens and must play our role with vigor and courage.

The first political obligation of each physician and his family is to register and vote in the party of his choice. Before he does register and vote, the physician should play an active role in the functioning of a party. As long as our country has a two-party system the candidates will be chosen and the platforms determined by those who participate actively in political affairs.

Most people confuse politics with issues. They do not know or they forget the "mechanics of politics," the mechanics of selecting, nominating and electing citizens to public office. It means that politics and government should be in the mainstream of every adult's life. They are America. Freedom is something that is maybe the most glorious of all things. The entire complexion of life, liberty and the pursuit of happiness changes abruptly when freedom passes by. Think of Hungary and some other countries. Think of many places where freedom does not exist.

History has demonstrated that governments begin to disintegrate when the people tend to depend on the "State" for everything. Paternalism is just as fatal as dictatorial power.

You, as an American, have an obligation to protect the independence and freedom which our forefathers gave to us. Nowhere else on earth

at that time did people know the joys of being proud and free. It was considered the American experiment. News of it spread like lightning from shore to shore. This experiment is not dead. It has proved itself through years of stress and years of brilliance, from the town meeting to the halls of Congress. But are we as free today and will we be as free tomorrow?

The best way to preserve this freedom is to have millions of Americans taking an active part in government through politics. Responsible people from all walks of life should and must take an interest. Remember that our government can be no better than the men you elect. More and more of our citizens must get to know the candidates, know the issues and take an active part in politics. Good government and freedom are your responsibilities. If any group neglects to participate actively in the election of political leaders and the formation of political decisions, to that extent the democratic processes fail to function as intended by the authors of our Constitution.

The time has come for us to plunge into the cold waters of reality and to take an active part in political campaigns. What we are going to be able to do as medical men will depend upon *what* we are doing as *citizens.*

Learn the value of one vote—YOUR OWN.

Democracy is not a spectator sport!—John F. Rogers, M.D. Reprinted with permission from the *New York State Journal of Medicine,* Sept. 1, 1960.

"Personal medical care is primarily the responsibility of the individual. When he is unable to provide this care for himself, the responsibility should properly pass to his family, the community, the county, the state, and only when all these fail, to the federal government, and then only in conjunction with the other levels of government, in the above order.

The determination of medical need should be made by a physician and the determination of eligibility should be made at the local level with local administration and control. The principle of freedom of choice should be preserved. The use of tax funds under the above conditions to pay for such care, whether through the purchase of health insurance or by direct payment, provided local option is assured, is inherent in this concept and is not inconsistent with previous actions of the House of Delegates of the American Medical Association."—Statement of policy adopted by the House of Delegates of the American Medical Association at its annual meeting, June 1960.

President's Page

In the past we have been told by our leaders, the president of the AMA, our Board of Trustees, our delegates, our state officers and our members that, as a profession, medicine is facing its most critical time. Legislation is being introduced at state and national levels which, to say the least, would be detrimental to our profession.

Physicians have been accused of living apart. We are accused of not taking part in civic affairs, of being detached and permitting others to do the work we should be doing. This may be true, in some instances, because doctors have been so busy caring for the health of their patients that they could not devote the necessary time and effort to community affairs.

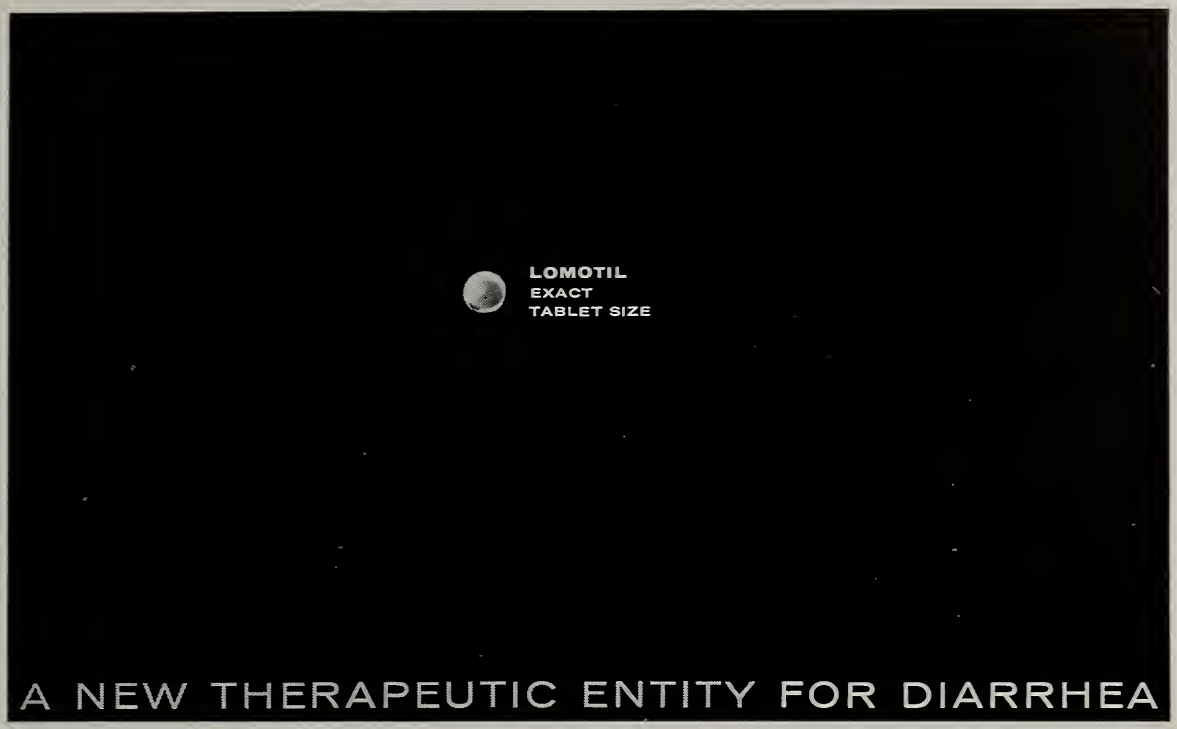


Conferences are being held at both the national and state level for the purpose of informing all members of our profession as to our political status. We have strong allies who think as we do. In the past we have depended largely on these people to help us and they have come through. Again, they are willing to help us. The organization opposing us, however, is strong. It has had a chance to entrench itself while medicine was occupied with other things. Nevertheless, this does not spell defeat—not even discouragement. If doctors, their families, friends, and associates in health fields, will devote some effort to national and state policy making, victory, again, can be ours. We will be compelled to work harder than ever before. It is well that we show our fellow countrymen that we are, first of all, citizens of our country and, secondly, physicians. There is no better way to do this than by showing an interest in the coming election. It is expected of the state organization that all members devote some time to seeing that proper candidates are elected. The auxiliary must be active in this too. In a combined effort of the auxiliary and state organization, a tremendous influence can be exerted to see that future legislation promotes the welfare and health of our citizens. Medicine must be left free and unhampered in its efforts to combat, prevent, and treat disease.

Perhaps the most ideal way that we can demonstrate our sincerity of purpose, to our patients and to the citizens of our state, is to close our offices on election day. Every doctor, with his wife, should give his efforts at the polls, or wherever needed, to help in the selection of the proper candidates. An effort of this kind, carried on at a state-wide level, would, I believe, leave a terrific impact in the minds of our patients and citizens at large. They would realize that we are interested in our country's future and are willing to roll up our sleeves and go to work to fight for what we believe is right.

I hope every physician in the state will find it expedient to close his office, except for emergencies, on election day and devote his efforts to the prevention and treatment of political ills in our society.

Earle W Arnold M.D.



A NEW THERAPEUTIC ENTITY FOR DIARRHEA

LOMOTIL®

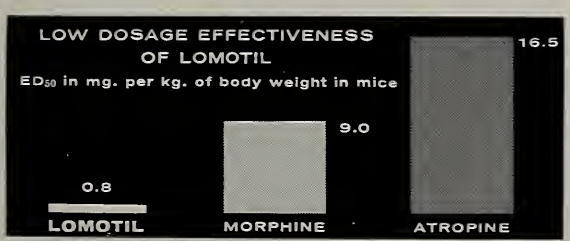
SELECTIVELY LOWERS PROPULSIVE MOTILITY

LOMOTIL represents a major advance over the opium derivatives in controlling the propulsive hypermotility occurring in diarrhea.

Precise quantitative pharmacologic studies demonstrate that Lomotil controls intestinal propulsion in approximately 1/11 the dosage of morphine and 1/20 the dosage of atropine and that therapeutic doses of Lomotil produce few or none of the diffuse untoward effects of these agents.

Clinical experience in 1,314 patients amply supports these findings. Even in such a severe test of antidiarrheal effectiveness as the colonic hyperactivity in patients with colectomy, Lomotil is effective in significantly slowing the fecal stream.

Whenever a paregoric-like action is indicated, Lomotil now offers positive antidiarrheal control . . . with safety and greater convenience. In addition, as a nonrefillable prescription product, Lomotil offers the physician full control of his patients' medication.



EFFICACY AND SAFETY of Lomotil are indicated by its low median effective dose. As measured by inhibition of charcoal propulsion in mice, Lomotil was effective in about 1/11 the dosage of morphine hydrochloride and in about 1/20 the dosage of atropine sulfate.

PRECAUTION: While it is necessary to classify Lomotil as a narcotic, no instance of addiction has been encountered in patients taking therapeutic doses. The abuse liability of Lomotil is comparable with that of codeine. Patients have taken therapeutic doses of Lomotil daily for as long as 300 days without showing withdrawal symptoms, even when challenged with nalorphine.

Recommended dosages should not be exceeded.

DOSAGE: The recommended initial dosage for adults is two tablets (5 mg.) three or four times daily, reduced to meet the requirements of each patient as soon as the diarrhea is controlled. Maintenance dosage may be as low as two tablets daily. Lomotil, brand of diphenoxylate hydrochloride with atropine sulfate, is supplied as unscored, uncoated white tablets of 2.5 mg., each containing 0.025 mg. (1/2400 gr.) of atropine sulfate to discourage deliberate overdosage.

Subject to Federal Narcotic Law.

Descriptive literature and directions for use available in Physicians' New Product Brochure No. 81 from

G. D. SEARLE & CO.
P. O. Box 5110, Chicago 80, Illinois
Research in the Service of Medicine

The Women's Auxiliary

REPORTS TO ISMA

A vote, one small vote, is a precious thing, something to be cherished, to be guarded, even fought for if necessary. But this one small vote, by the very nature of its oneness, pales into insignificance when compared to the multitude. Two votes, on the other hand, are also precious, but their insignificance now begins to fade because there was one, there are now two. A doubling of strength. A doubling of opinion. And thus it goes, until the votes number in the thousands, hundreds of thousands, even millions. Now the vote has become an unquestioned power, a hammer which shapes the laws we desire to guide us. It is called Democracy, the system under which we live; the system which we believe the best in the world.



But even with the proof before our eyes we tend to underestimate the power of that one vote. We are upset because forces in our nation's capital are shaping possible laws-to-be with which we disagree—which we believe will be harmful to our country. Yet we do nothing. Who are we? Just one, and what can one do? We forget that one and one make two.

The BIG election is almost here. The ballot boxes are quietly waiting. What enters their slots will determine what is to be done—what the future course of our country will be. Remember, the politician loves our one small vote, and he fears it too. It can raise him to heights of accomplishment or diminish his influence until it is only a small voice in a back corner. The politician knows this.

It is time we knew it too.

Ina. Rigley



NEW CHEMOTHERAPY SIMPLIFIES VAGINITIS CONTROL

CENASERT® IMPROVED TABLETS

for vaginal administration

Specifically effective against *Trichomonas vaginalis, Candida albicans* (monilia)—and the mixed bacteria associated with nonspecific vaginitis.

- provides clinically proved results without antibiotics or corticosteroids
- avoids sensitization and adverse systemic effects
- lowers cost of medication
- avoids messiness and staining

SUPPLIED: Bottles of 100 tablets, and combination packages of 30 with tablet inserter.

Each tablet contains: 1 mg. 9-aminoacridine undecylenate; 1 mg. N-myristyl-3-hydroxybutylamine hydrochloride; 1.8 mg. methylbenzethonium chloride; 12.5 mg. succinic acid; plus lactose and starch as excipients, in a rapidly disintegrating soluble vaginal tablet.

Complete literature available

THE CENTRAL PHARMACAL COMPANY *Products Born of Continuous Research* ■ SEYMOUR, INDIANA

A clinical condition with obscure etiology, diagnosed with increasing frequency.

Schizophrenia in Children

*GORDON T. BROWN, M.D.**
Indianapolis

A PREVIOUSLY UNRECOGNIZED entity, schizophrenia in children, is a clinical condition diagnosed with increasing frequency. While the precise etiology remains obscure, this paper summarizes the most common features of the illness.

Man does not live as a unit, but communally with his environment. This is true biologically from the one-celled egg stage to the adult. The cell dies if its interchange with the environment stops; positive changes depend upon this communion with the environment and regressive changes upon its restriction. The environment flows through the cell and becomes part of its very life, and the cell and the environment are indissolubly bound so long as life continues.

Life depends upon the being's relationship with its environment. Similarly, emotional life is contingent upon the emotional environment of interpersonal relationships with others. A person who does not form these relationships in a meaningful way has not truly lived, emotionally. The one who withdraws his emotional investment from these relationships to that extent dies emotionally.

Personality Incorporates Others' Attitudes

The infant develops in an interpersonal relationship of empathy, communion and participation, primarily with mother and secondarily with father, siblings and other significant persons. His personality develops as an incorporation of the attitudes toward the child of the parents and others. As these people in his emotional environment feel about the child and relate to him, so he is going to come to feel about himself. This forms his own self-concept and is reflected in his feelings about and his relationships with himself and with others. The child learns the attitudes and methods of interpersonal relationships available to him and they become a part of him and of his personality.

The child who is loved, wanted and accepted warmly and maturely, develops a self-concept of his own worthwhileness, acceptability and lovableness. Resting securely in this, he in turn becomes capable of loving and accepting others, and becomes thereby a lovable and a loving person. A child thus maturely loved has the foundation for a strong, healthy, mature personality. Conversely the child who has been unconsciously or consciously rejected, unwanted or related to in a cold, hostile fashion, will take unto himself these feelings and attitudes as an integral part of his self-concept. Having been an unloved child, he in turn will become an unloving, hostile, rejecting person, incapable of giving or receiving love. This is the surest criterion of emotional health.

There have been several interesting experiments described with animals. It was determined that in the training of young kittens, it is essential that they have meaningful contact with human beings during the first six weeks of their lives. Lacking this, their acculturation process remains forever incomplete; they maintain their

* Director, Child Guidance Clinic of Marion County, Inc.

Raise the Pain Threshold

WITH MAXIMUM SAFE ANALGESIA

Phenaphen with Codeine provides intensified codeine effects with control of adverse reactions. It renders unnecessary (or postpones) the use of morphine or addicting synthetic narcotics, even in many cases of late cancer.

Three Strengths —

PHENAPHEN NO. 2
Phenaphen with Codeine Phosphate ¼ gr. (16.2 mg.)

PHENAPHEN NO. 3
Phenaphen with Codeine Phosphate ½ gr. (32.4 mg.)

PHENAPHEN NO. 4
Phenaphen with Codeine Phosphate 1 gr. (64.8 mg.)

Also —

PHENAPHEN **In each capsule**

Acetylsalicylic Acid 2½ gr. . (162 mg.)
Phenacetin 3 gr. . . . . (194 mg.)
Phenobarbital ¼ gr. . . . . (16.2 mg.)
Hyoscyamine sulfate . . . . . (0.031 mg.)

PHENAPHEN® WITH CODEINE

Robins

A. H. ROBINS CO., INC., RICHMOND 20, VIRGINIA

Ethical Pharmaceuticals of Merit since 1878

basic wildness and are useless as pets. While the time may vary, this is no less true of human children. There have also been studies with young rats in which litter mates were divided into two groups and the experimental group picked up and stroked for periods each day. The control group was permitted to grow up as usual without this gentling process. At the end of the experimental period, it was found that the gentled rats were more secure, less anxious, and physiologically healthier. The implication is obvious.

Never Recover From Deprivation

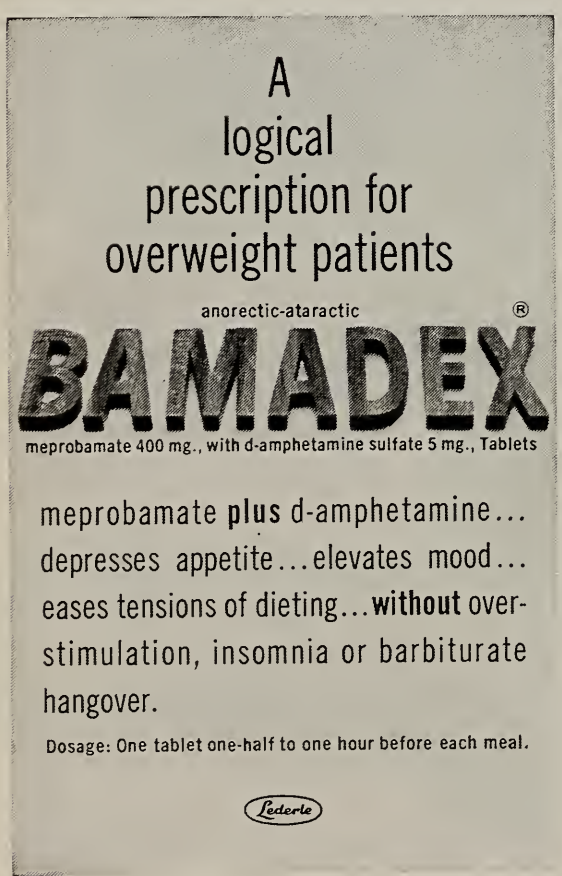
There have been studies of children deprived of secure, loving parents during the early weeks and months of life, and it was found that these children never completely recover from their early deprivation. The importance of parental love may be seen most clearly in the lives of those children where it is missing. While there are degrees and gradations between the extremes, the basic personality structure for good or ill is established in the early interpersonal relationships between the parents and the child. The child deprived of his basic emotional needs presents fertile soil for insecurity, frustration, inadequacy and reactive hostility to the world in general.

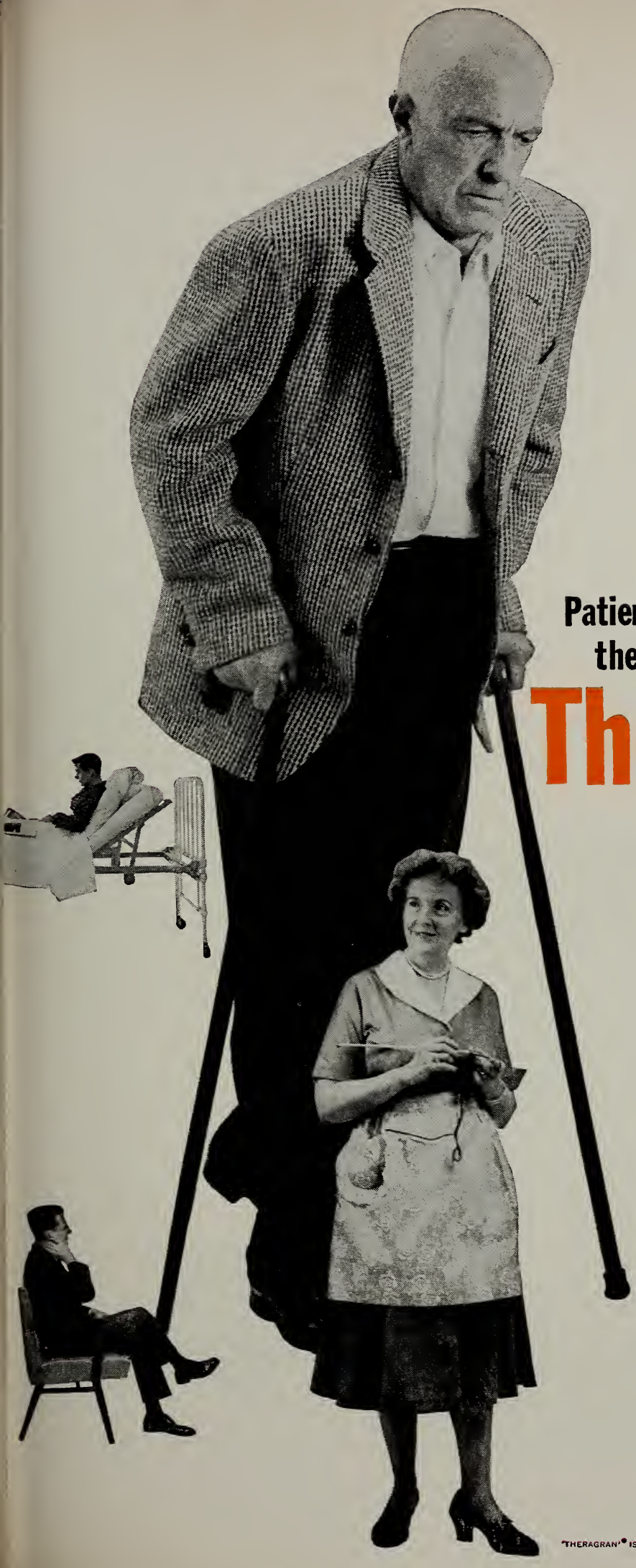
These early deprivations and rejections contribute to the child's inability to form meaningful relationships. The child needs the direction, support and loving care of a parent as much as he needs other essentials for life, growth and development. In order to grow out of his disorganized infantile state, a child must be in contact with a supporting, loving and adequately organized parent or substitute. Without these supporting influences, he is truly deprived and threatened.

Unfortunately, these ideally secure, warm, nurturing homes are not so easily provided. The family's and hence the child's status is deeply threatened by the unrealistic expectations many people bring to marriage. Frequently, two dissatisfied, ungratified people join in marriage, each harboring in secret fantasy the gratifications he hopes the partner is going to provide. Insofar as his needs are unrealistic or insatiable, the person is doomed to disappointment and reacts by withdrawal or bitter resentment. The marriage of two such empty, narcissistic people is not conducive to the establishment of a secure home. In such a relationship each tends to relate to the other not as a person, but as an object to provide gratification of their own narcissistic needs.

Expectations in marriage become rather complex. Each partner expects to be understood deeply and intimately and wants to be fully and permanently loved — more completely perhaps than either has been loved before. These satisfactions are most elusive and do not come automatically with marriage. Frequently, the very persons who expect the most of these intangible, complex qualities in their marriage, are the ones who have been most deprived of the love and understanding for which they are so hungry. Unfortunately, they have had little experience in responding fully to affection, in being able to reciprocate or even to attract that full sense of belonging that they crave. This inevitably makes for disillusionment and disappointment.

Many times these people beget children because it is customary, to provide the desired social and cultural background, or from the conscious or unconscious hope of providing meaning





in infectious disease[17,22,30,36]
in arthritis[18,19,20,29]
in hepatic disease[2,3,4,5,38]
in malabsorption syndrome[1,2,6,27]
in degenerative disease[6,7,19,20,40]
in cardiac disease[23,28,29,38,41]
in dermatitis[24,39]
in peptic ulcer[8,21,38]
in neuroses & psychiatric disorders[25,26]
in diabetes mellitus[31,32,33,38]
in alcoholism[9,11,35,37,38]
in ulcerative colitis[10,14,16]
in osteoporosis[13,19,20]
in pancreatitis[15]
in female climacteric[12,34]

Patients with chronic disease deserve the nutritional support provided by

Theragran-M

Squibb Vitamin-Minerals for Therapy

11 vitamins, 8 minerals
clinically-formulated and potency protected to provide
enough nutritional support
to do some good

with vitamins only
Theragran
also available:
Theragran Liquid
Theragran Junior

Theragran products do not contain folic acid.

1-41 a list of the above references will be supplied on request.

SQUIBB

"THERAGRAN"® IS A SQUIBB TRADEMARK

Squibb Quality—the Priceless Ingredient

to an essentially meaningless marriage. This is a tragic venture, particularly for the children. An infant cannot realistically be expected to assume the responsibility of which two adults are incapable. These parents merely perpetuate their own meaninglessness unto the children and they, in turn, grow up and repeat the cycle.

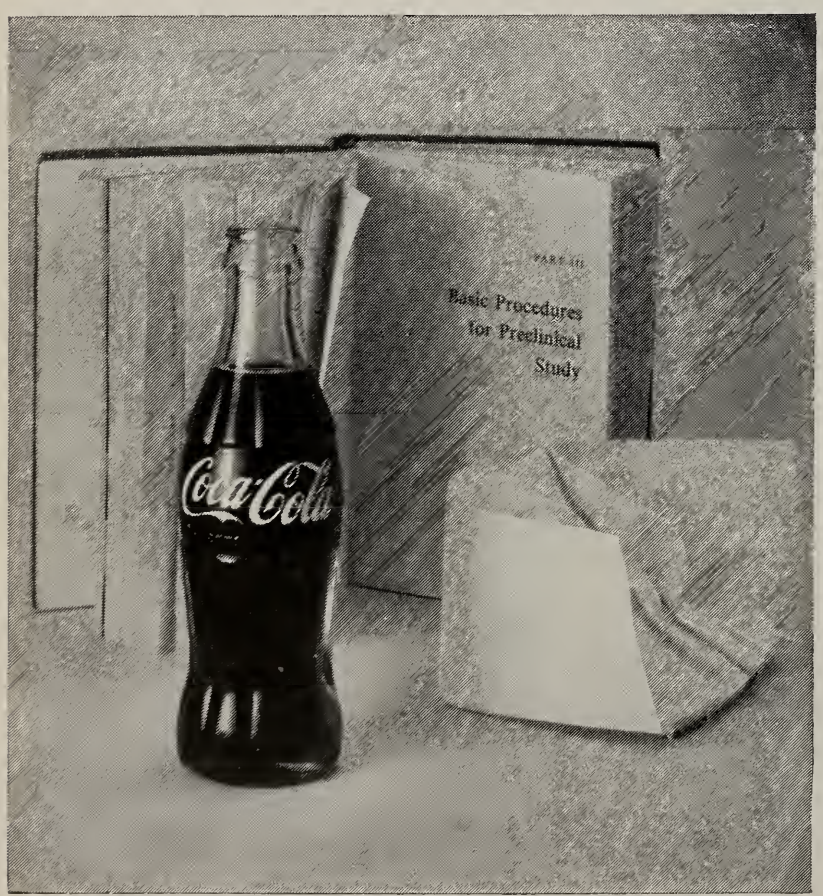
The sterility of these children's home environment is not always apparent. Some of the parents' marriages are such that they are able to avoid the usual outward evidence of their frustration and lack of fulfillment. The emptiness each senses may be bravely suffered and overt resentment avoided. With the missing of personal fulfillment, many partners find considerable compensation in constructive social and civic activities.

"Superficial" Adjustment Inadequate

Motivation for professional, social and economic success often stems from these deep inner dissatisfactions. The parents may not have any delight or real understanding together; consequently, their superficial adjustment is inadequate to convey to their children many feelings for which their need is intense. They resemble T. S. Eliot's description of the hollow people. These children somehow react to the fact that in their parents, and therefore in their universe, something essential is missing.

Many of the parents are seen to be cold, intellectual, compulsive, undemonstrative, efficient, detached, objective and mechanical in their attitudes toward their children. Kanner calls them "refrigerator parents." Their children tend to withdraw and seek some comfort in solitude, failing therein, to develop a normal ego capacity. These parents maintain an attitude of emotional objectivity toward their children, with a mechanical devotion to duty substituting for the parental warmth they lack.

The mothers are anxious, immature, narcissistic women. Because they are so barren of spontaneous manifestations of maternal feelings, they may study all the new methods of child rearing. Frequently, they insist on an aseptic environment and the child grows up in an orderly scientific atmosphere where routine and dietary prescriptions prevail. The warmth radiated by a spontaneous, tenderly devoted mother is missing.



When too many tasks
seem to crowd
the unyielding hours,
a welcome
"pause that refreshes"
with ice-cold Coca-Cola
often puts things
into manageable order.

DRINK
Coca-Cola
REG. U.S. PAT. OFF.

SCHIZOPHRENIA

Continued

The result may be passive inertia of the infant or restlessness and sleeplessness. A passive child is less of a threat because he does not make exaggerated demands upon the mother who feels constantly in danger of revealing that emotionally she has little or nothing to offer, that she is in fact a fraud.

This is observed in young mothers who want a child so they might lavish on him all those things of which they felt deprived. It is poor motivation and is rarely successful. The mother strives desperately for control and the struggles over weaning and toilet training are generally battles in which she tries to redeem herself. The child becomes the real victim. The mother's helplessness in turn creates an aggression in her that amounts to destruction. The only way for the child to survive is to retreat—to withdraw, not only from the danger of mother but from the entire world as well.

While it has become popular to place the responsibility for these children's illnesses at the feet of the mothers, the fathers obviously are not without blame, and make their own considerable contributions to the pathology. It is disturbing that a high proportion of professional men are fathers of these children. They are people strongly preoccupied with abstractions of scientific, literary or artistic nature, but having limited genuine interest in people. They are lonely people and are unable to provide the child with that which they have never had. Frequently, the sickest children have the most uncooperative and oblivious parents. They often relate a bland history and vigorously deny that there is anything really wrong with the child.

The symptom complexes of these children fall into the general areas of personal identity, body image, object relationships, interpersonal relationships, language and symbol formation and orientation in time, space and the social world.

In some children, the illness presents an acute onset. Prior to this they may have been regarded with pride as models in conduct and studiousness, resulting from their submissiveness and an oppressive desire for affection. They may rapidly evolve a turbulent psychotic condition with acute anxiety, sleep disorders, motor restlessness, disturbances of speech, occasional hallucinations, general perplexity, bizarre body sensations and loss of contact with people.

In other children, there is a gradual withdrawal from emotional contact with people, a progressive loss of interest in play and an increasing tendency to brood. Speech becomes more autistic and less communicative. Excessive preoccupations develop with abstract concepts and philosophical and religious ruminations. There is generalized seclusiveness and retraction of interest from the environment. They become irritable when this seclusiveness is disturbed. Thought disturbances appear as blocking, symbolization, perseveration, incoherence and mutism. There may be bizarre behavior with either an increase or decrease in motility. The children may whirl, rotate, gyrate, spin in circles, walk on their toes, or wander aimlessly and expressionlessly about the room. There is a loss of ego boundaries and the child is unable to differentiate self from "not self." They rock in bed and clutch tenaciously to objects in an effort to orient themselves in space.

The autistic child is one whose withdrawal tendencies are noted as early as the first year of

THE ADJUSTABLE LEG
for better fit and alignment

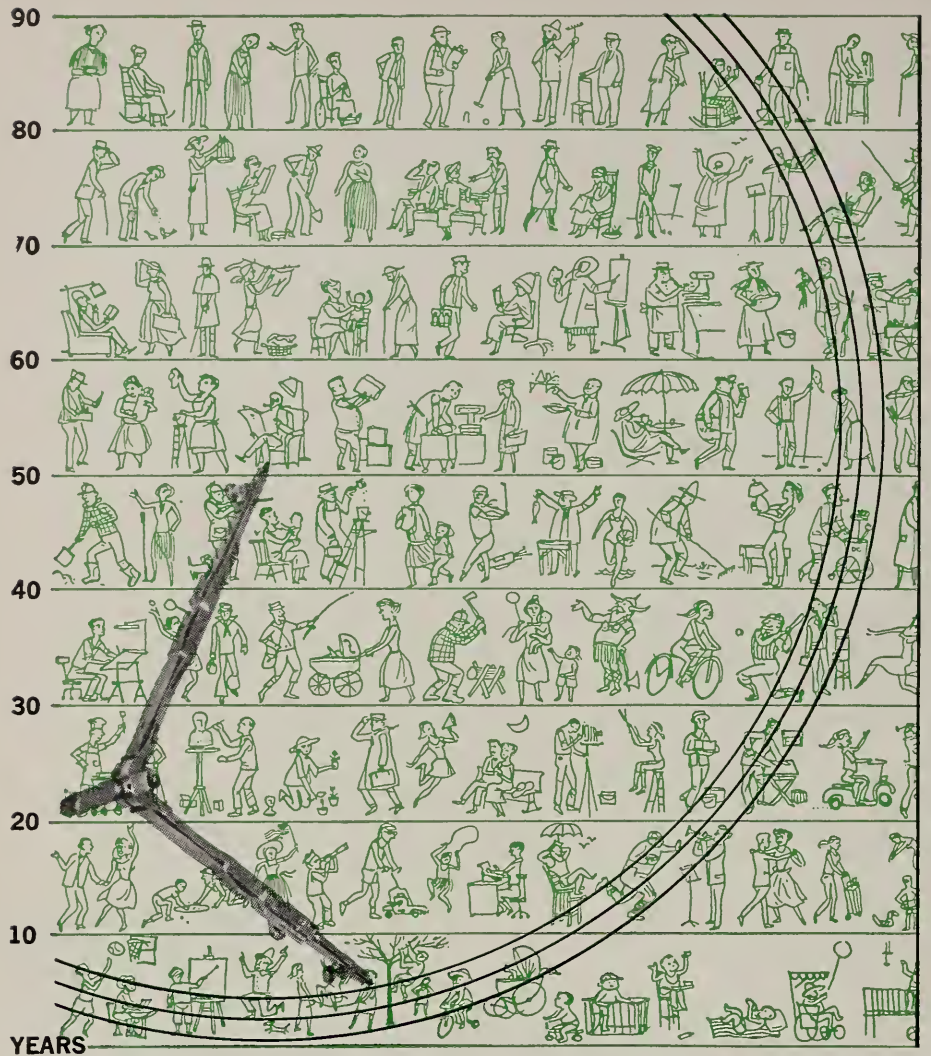


Two important factors affecting the success of an amputee with a prosthesis are the fit of the socket on his stump, and the alignment of the prosthesis. With the Adjustable Leg the trained Hanger Prosthetist is able to achieve the best possible fit and alignment, which he can duplicate in the finished prosthesis.

The Adjustable Leg is particularly helpful in fitting difficult cases. For further information about the Adjustable Leg in the rehabilitation of your patients contact the Hanger office nearest you.

Hanger PROSTHESES

1529-33 N. Illinois St., Indianapolis 2, Ind.
3108 Burnet Avenue, Cincinnati 29, Ohio
Fairfield at Pontiac, Fort Wayne, Ind.
418 N. Main St., Evansville, Ind.



ATARAX ENCOMPASSES MORE PATIENT NEEDS...LETS YOU CHART A SAFER, MORE EFFECTIVE COURSE TO TRANQUILITY

ATARAX has a wide range of flexibility . . . from mild adult tensions and anxieties to full-blown alcoholic episodes . . . from the behavior disorders of childhood to the emotional problems of old age. Why? Because it gives you maximum adaptability of dosage . . . works quickly and predictably . . . is unsurpassed in safety.

ATARAX offers extra pharmacologic actions especially useful in certain troublesome conditions. It is antihistaminic and mildly antiarrhythmic, does not stimulate gastric secretions. Hence it is well suited to the needs of your allergic, cardiac and ulcer patients.

Have you discovered all the benefits of ATARAX?

Dosage: Adults, one 25 mg. tablet, or one tbsp. Syrup q.i.d. Children, 3-6 years, one 10 mg. tablet or one tsp. Syrup t.i.d.; over 6 years, two 10 mg. tablets or two tsp. Syrup t.i.d.

Supplied: Tiny 10 mg., 25 mg., and 100 mg. tablets, bottles of 100. Syrup, pint bottles. Parenteral Solution: 25 mg./cc. in 10 cc. multiple-dose vials; 50 mg./cc. in 2 cc. ampules. Prescription only.

Complete bibliography available on request.

ATARAX®

(BRAND OF HYDROXYZINE)

PASSPORT TO TRANQUILITY





New York 17, N. Y.
Division, Chas. Pfizer & Co., Inc.
Science for the World's Well-Being™

VITERRA® for vitamin-mineral supplementation
- capsules • tastitabs®
- therapeutic capsules

SCHIZOPHRENIA

Continued

life. These children can almost be called schizophrenic from lack of progression rather than from a regressive form of illness. The history is frequently obtained that these children were simply ignored emotionally. Their physical and material needs were attended to but they were reared in an emotional vacuum. They have been left alone in the nursery, fed, changed and cared for physically but otherwise left to their own devices. One parent reported typically of such a child "for the first year we just ignored him." Through lack of opportunity, these children fail to develop ego boundaries. Their relationship and contact with their environment is tenuous. They perceive people as objects rather than persons. A capacity to communicate remains undeveloped. They may fail to acquire the ability to speak, remaining mute. The language, if present, maintains an autistic quality, failing to convey meaning to others, despite the fact they may have a rote memory for songs and numbers. Their speech may be a parrot-like repetition of word combinations, but with no power of communication.

They have a pervasive sense of aloneness and strive to preserve the sameness of their living. Changes of routine, furniture arrangement and the like drive them to despair. They perceive objects and will play with toys but frequently misuse them, not understanding their purpose or their relationship to other things. They feel constantly threatened by destruction Living is a subjective experience of being permanently in danger and at the mercy of insensitive, incomprehensible powers.

The overall recovery rate for these children is less than 20%. The prognosis of those who have not learned to talk by five years of age is most guarded, and the majority of them become chronic, institutionalized patients Many of these are almost indistinguishable from mentally defective children and this represents a difficult differential diagnosis.

While several children diagnosed as schizophrenics are currently in treatment at the Clinic, the consensus, generally, is that it is like attempting to stem a flood with a teaspoon to try to treat these children while leaving them in the home environment by which they have been so severely damaged. Residential treatment is the

The Harding Sanitarium

WORTHINGTON
OHIO

For the Diagnosis and Treatment of Psychiatric Disorders
and with
Limited Facilities for the Aging

GEORGE T. HARDING, M.D.
HARRISON S. EVANS, M.D.
Medical Directors

CHARLES W. HARDING, M.D.
Clinical Director

DONALD H. BURK, M.D.
CLARENCE E. CARNAHAN, M.D.
GEORGE T. HARDING, Jr., M.D.
HERNDON P. HARDING, M.D.
C. RICHARD JOHNSON, M.D.
ARNOLD L. NIELSEN, M.D.
R. EUGENE PROUT, M.D.

GRACE M. COLLET, Ph.D.
VERNON W. SHAFER, Ph.D.
Clinical Psychologists

MARY JANE McCONAUGHEY, M.S.W.
BENJAMIN E. WHEATLEY, M.S.W.
Psychiatric Social Workers

PAULINE L. TOOILL, R.R.L.
Medical Record Librarian

JAMES L. HAGLE, M.B.A.
Administrator

ESTHER L. SIMPSON, R.N.
Director of Nurses

Phone: Columbus TUXEDO 5-5381

SCHIZOPHRENIA

Continued

management of choice. Even in these ideal therapeutic settings, it seems to take about as many years for these children to develop a personality as it would normally in a good home, and two to four years of living uninterruptedly in a physical and human environment that promotes healthy personality growth is necessary.

In these secure settings the child is protected from hostility, provided maximum satisfaction of his emotional needs, and only those restrictions used which are clearly beneficial such as controlling the discharge of aggression. Under such conditions, the ego can begin to function and develop more adequately.

The child's emotional salvation lies in the dynamic, meaningful encounter with others in which he can affirm his own value and worth. In these accepting, warm, secure relationships, the child's own potential for growth may become freed. He can come closer to the experience of sharing himself. The child begins to find himself because others find him, and he is able to relinquish some of his terrifying aloneness. This increasing participation with his environment and with others involves a real measure of trust and ultimately of love. The aim is to free the withdrawn child and enable him to find the courage to affirm himself, to discover himself as being accepted and acceptable, of caring and being cared for. Only partnership can save the sick child from withdrawal from a dynamic encounter with his world. In this partnership he is enabled to face himself, his negative and his positive being, and thereby open contact with the world through his encounter with others. Healing is participation. ◄

When the mother found her infant daughter eating handfuls of sand from the sandbox, she was frantic. She rushed the child into the house, made her drink lots of water, and then called the doctor.

After explaining what had happened and what she had done, she asked the doctor what she should do next.

"Just don't give her any cement," the doctor replied.

—*The Fifth Wheel.*

It had to come—a German shaver operating on re-chargeable batteries which power, among other things, "two headlights for shaving in the dark." —*Printers Ink,* July 1, 1960.

Reliable

PROFESSIONAL LIABILITY
INDIVIDUAL INSURANCE

with proficient defense
that cuts the cost

Unparalleled Experience ● Specialized Service ● Saving in Cost

THE
MEDICAL PROTECTIVE COMPANY
FORT WAYNE, INDIANA

Professional Protection Exclusively since 1899

INDIANAPOLIS OFFICE: Kenneth W. Moeller, Rep.
P.O. Box 20132, Indianapolis 20 Tel. CLifford 5-6525

FORT WAYNE OFFICE: A. Russell Quilhot, Rep.
5814 Reed Road, Fort Wayne Tel. Trinity 1161

In active people who won't take time to eat properly, MYADEC can help prevent deficiencies by providing comprehensive vitamin-mineral support. Just one capsule a day supplies therapeutic doses of 9 important vitamins plus significant quantities of 11 essential minerals and trace elements. MYADEC is also valuable in vitamin depletion and stress states, in convalescence, in chronic disorders, in patients on salt-restricted diets, or wherever therapeutic vitamin-mineral supplementation is indicated.

Each MYADEC Capsule contains: VITAMINS: Vitamin B_{12} crystalline—5 mcg.; Vitamin B_2 (riboflavin)—10 mg.; Vitamin B_6 (pyridoxine hydrochloride)—2 mg.; Vitamin B_1 mononitrate—10 mg.; Nicotinamide (niacinamide)—100 mg.; Vitamin C (ascorbic acid)—150 mg.; Vitamin A—(7.5 mg.) 25,000 units; Vitamin D—(25 mcg.) 1,000 units; Vitamin E (d-alpha-tocopheryl acetate concentrate)—5 I.U. MINERALS: (as inorganic salts) Iodine—0.15 mg.; Manganese—1 mg.; Cobalt—0.1 mg.; Potassium—5 mg.; Molybdenum—0.2 mg.; Iron—15 mg.; Copper—1 mg.; Zinc—1.5 mg.; Magnesium—6 mg.; Calcium—105 mg.; Phosphorus—80 mg. Bottles of 30, 100 and 250.

a quick "bite"...
then back
to the grind?
nutritional
deficiency's
not far behind.
prescribe...

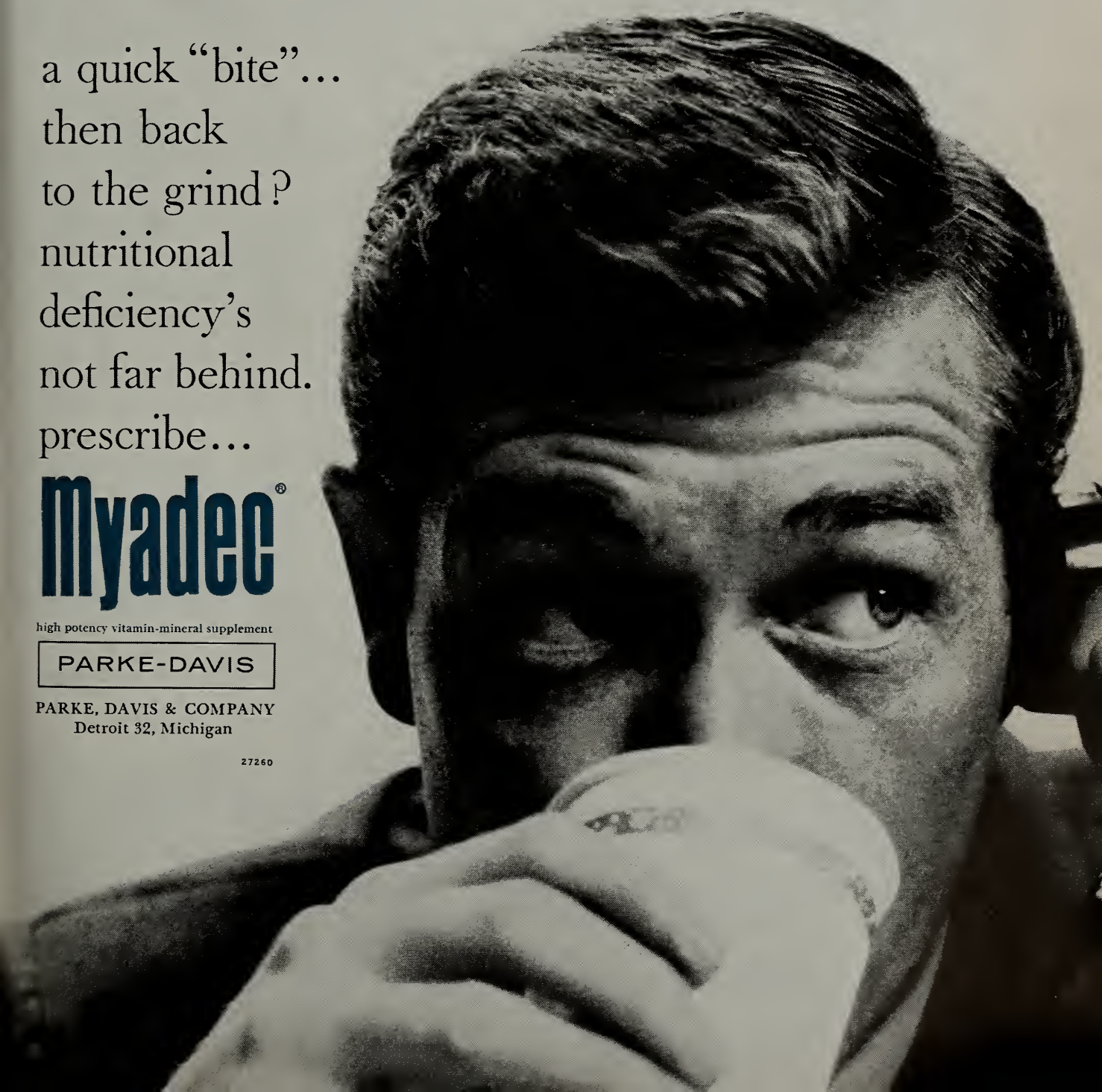
Myadec®

high potency vitamin-mineral supplement

PARKE-DAVIS

PARKE, DAVIS & COMPANY
Detroit 32, Michigan

27260



From the Bulletin of the Joint Commission On Accreditation of Hospitals, August, 1960.

Analysis, Review and Evaluation of Clinical Practice in the Hospital

Responsibility

Only physicians are capable of judging what is or what is not good medical practice. Patients and hospital personnel may learn to recognize good practice, but only the physician can accurately evaluate its quality.

The opinions of individual physicians vary, and rightly so. For that reason, the commission places heavy emphasis on group participation in evaluating clinical practice. It is the responsibility of the entire active medical staff to analyze, review and evaluate the clinical practice in the hospital and to insist on high standards of performance from each of its members.

This responsibility is not easily discharged. It requires hours of work which the busy physician can ill-afford to spend and which is usually done at the expense of his personal pleasures. It requires an objectivity which is perhaps even more difficult to achieve. To judge the work of a colleague on a fair, unbiased, impartial level calls for the intelligence and wisdom of a Solomon. That this is so well done in thousands of hospitals can be attributed to the integrity, effort and persistence of each member of the medical staff.

Essentials

In order to evaluate clinical practice the following are essential:

1. *Reliable Medical Records.* There must be evidence on the medical record that the diagnosis was made on the basis of information given by the patient in history, a careful physical examination and a scientific interpretation of the findings. There must be sufficient data recorded to justify the physician's treatment of the patient and the results. For the sake of both the group whose responsibility it is to review the record and the physician whose performance is being evaluated, a good medical record is indispensable.

2. *Reliable Reports of Diagnostic Tests.* The physician must rely on the accuracy of reports on laboratory and diagnostic tests. The medical staff cannot supervise all these areas, but it has a responsibility to make certain that there is supervision. This is done by recommending the appointment of qualified individuals to head these departments and to designate those on the staff qualified to interpret electrocardiograms, x-rays and other diagnostic tests. If laboratory work is done outside the hospital, it must be made certain that these laboratories are government approved, licensed and under the direct supervision of a pathologist.

3. *An Organized Medical Staff.* To insure a continual orderly process of evaluating clinical practice, the medical staff must be formally organized. This provides a framework in which the duties and functions of the staff can be carried out. The medical staff may decide to delegate the responsibility of clinical review to committees, to clinical departments or to the staff as a whole. Only the individual medical staff can determine the method which will be most effective in the local situation.

4. *A Competent Medical Staff.* Though listed fourth, the most important factor in evaluating clinical practice is a competent medical staff. The quality of medical care in the hospital is in direct ratio to the knowledge, experience and ability of the members of the medical staff. The

Continued on page 1922

stiffness and pain

"gratifying" *relief from stiffness and pain in 106-patient controlled study (as reported in J.A.M.A., April 30, 1960)*

"Particularly gratifying was the drug's [SOMA's] ability to relax muscular spasm, relieve pain, and restore normal movement . . . Its prompt action, ability to provide objective and subjective assistance, and freedom from undesirable effects recommend it for use as a muscle relaxant and analgesic drug of great benefit in the conservative management of the 'low back syndrome'."

Kestler, O.: Conservative Management of "Low Back Syndrome", J.A.M.A. 172: 2039 (April 30) 1960.

FASTER IMPROVEMENT—79% complete or marked improvement in 7 days (Kestler)

EASY TO USE—Usual adult dose is one 350 mg. tablet three times daily and at bedtime.

SUPPLIED: 350 mg., white tablets, bottles of 50.
For pediatric use, 250 mg., orange capsules, bottles of 50.

Literature and samples on request.

SOMA®

(CARISOPRODOL, WALLACE)

WALLACE LABORATORIES, CRANBURY, NEW JERSEY

ANALYSIS

Continued from page 1918

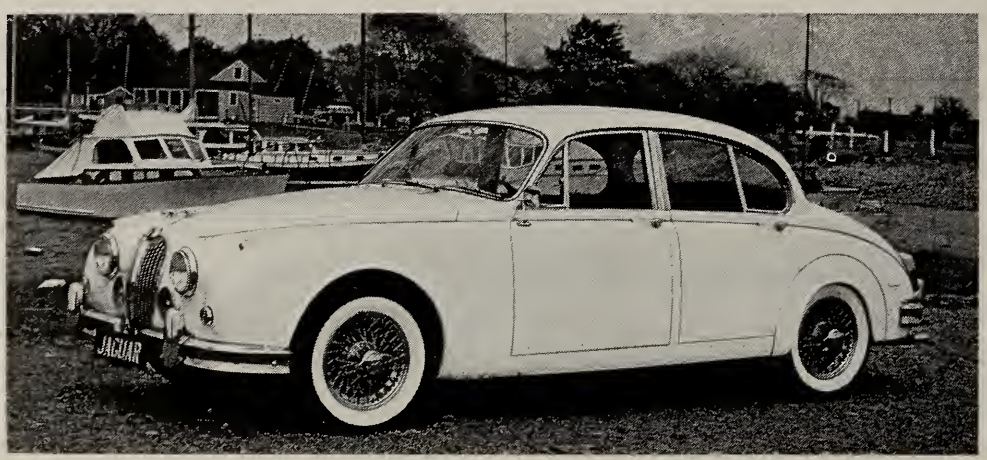
judgment necessary to evaluate clinical practice depends entirely on the ability of those who are doing the evaluating.

This makes the appointments to the staff and the delineation of privileges so important. To do this fairly and objectively, the medical staff should set up a system to evaluate each applicant and determine his hospital privileges on the basis of professional competence. Individual character, training, experience and ability should be the criteria for selection. Under no circumstances should the accordance of staff membership or professional privileges in the hospital be dependent solely upon certification, fellowship or membership in a specialty body or society. Neither should appointments be denied on the basis of hospital bed capacity or selfish competitive motives on the part of the staff.

Although the primary purpose of clinical review is to achieve and maintain high standards of patient care, the process also serves as a means of evaluating the performance of individual staff members. The judgment, ability and competence of a staff member can be assessed by his methods of diagnosis, his skill in treatment and his ability to recognize situations which call for consultation. These facts should influence the decision to extend or limit his hospital privileges. Each member of the staff should be given the opportunity to realize his full capabilities, and at the same time safeguards must be established to protect patients. By good clinical review both patient and staff member profit.

The Commission in accrediting a hospital places great emphasis on the extent and care with which the medical staff reviews and evaluates clinical practice. Since good medical records, reliable diagnostic services and a competent, well-organized staff are essential for good clinical review, these factors are closely surveyed. To be accredited, there must be evidence that the hospital medical staff is living up to its important responsibilities. ◄

We understand that one of the couples married by Univac recently became the parents of an eight-pound adding machine.—*The Fifth Wheel.*



For the Family Man of Adventurous Spirit...the Jaguar 3.8 Litre Family Sports Sedan

The brilliant new 5-passenger "Three-Point-Eight" sedan is the ideal Jaguar for the sports car enthusiast with a family! COMPACT, without sacrificing roominess, comfort and luxury, it incorporates such features as optional power steering, automatic transmission, 4-wheel disc brakes, polished walnut dashboard and glove leather upholstery. Powered by the new 3.8 litre XK engine, this proud new Jaguar has a top cruising speed of 120 m.p.h. . . . the "fastest sedan of its class in the world!" See the other 1961 Jaguars, too . . . the luxurious Mark IX sedan and the XK 150 sports models. Convenient terms!

JAGUAR
2330 NORTH MERIDIAN STREET

MIDWEST DISTRIBUTORS, Inc.
• INDIANAPOLIS

On the 1960 Election Scene

Physicians Gear for Political Action As New Hoosier Group Forms

A recent meeting of some 150 physicians representing each Indiana county resulted in the establishment of an organization, independent of organized medicine at all levels, for active participation in political issues.

Named the Indiana State Health Organization for Political Education (HOPE), the committee is comprised of two physicians representing each Indiana Congressional district, who were chosen in district caucus meetings after the general organizational meeting, Sept. 11 in Indianapolis.

HOPE is established on a permanent, statewide, nonprofit and bi-partisan basis. It is democratically and geographically representative, and membership is restricted to Doctors of Medicine licensed to practice in Indiana.

Organized under Indiana and federal laws governing political committees, HOPE will seek to raise funds through voluntary contributions to be used for support of candidates running for public office. It will work for passage or defeat of both national and state legislation, and supply educational material to the citizens of Indiana.

HOPE will constantly encourage and stimulate physicians toward more active citizenship and uphold the tradition of individual liberty and the system of free enterprise. It plans to study issues of government, records and platforms of candidates aspiring to state and national offices, and make such results publicly available. It will seek to stimulate and cooperate with similar committees of other groups throughout the state and to encourage, train and develop leadership for political education in Indiana.

In the past, doctors have had no effective tools with which to defend their rights and freedom in the practice of medicine, with exception of medical organizations operating within the limits of state and federal legislation, which prohibits active and financial support in politics.

The Sept. 11 meeting came about as a result of the enthusiasm encountered by a group of Indiana physicians who toured the state in an effort to discuss with representatives of all county physician groups the advisability of setting up an organization.

Officers elected by the committee are Drs. Kenneth Olson, South Bend, chairman; P. J. V. Corcoran, Evansville, vice-chairman; Don E. Wood, Indianapolis, secretary; and J. M. Black, Seymour, treasurer, in charge of voluntary contributions.

Members of the State committee are Drs. J. B. Nicosia, East Chicago; R. N. Bills, Gary; F. S. Crockett, West Lafayette; Ralph C. Eades, Valparaiso; G. O. Larson, LaPorte; E. F. Senseny, Fort Wayne; Truman E. Caylor, Bluffton; R. P. Good, Kokomo, and B. M. Merrell, Rockville.

Also Drs. J. G. S. Weber, Terre Haute; P. T. Holland, Bloomington; E. T. Edwards, Vincennes; B. E. Freeland, Batesville; Frank H. Green, Rushville; Charles R. Alvey, Muncie and Russell J. Spivey, Indianapolis..

The committee announced that Indiana Physicians will receive a letter in the near future urging financial support of HOPE. It is hoped that Indiana physicians will contribute liberally; contributions may be sent to Dr. J. M. Black, Seymour.

For Your Information:

National and state platform planks pertaining to health and medical legislation, as summarized by the AMA and the Indiana State Chamber of Commerce, are listed to aid and guide the doctor and his patient in preparing to vote on election day, Nov. 8.

Health and Medical Platform Summaries—1960

National

TODAY, PLATFORM issues of the two major political parties come before the American people—via an enormous system of mass communications—daily. The Democratic party and the GOP each point toward the same goals—the preservation of national security, the preservation and spread of freedom, a better life for all. . . . However, there is a sharp division in how the respective parties propose to attain their goals. . . . The Democratic theme is "leave it to government" . . . The Republican approach is "let government do for the individual only what he cannot do at all, or cannot do so well, for himself."

The philosophies of the two parties come to light in the health care planks of the two platforms. The Democrats approve a broad social security program to provide hospitalization and medical services for the aged. The Republican program would not use the Social Security System to provide health care for the aged. Generally following the Administration's proposal to Congress, the program would be voluntary and would cover "the aged needing it," rather than all senior citizens.

Following are highlights of the two parties' platforms in the area of health care:

REPUBLICAN

New needs . . . are constantly arising in our highly complex, interdependent and urbanized society. To meet the needs of the aging, we pledge:

—Expansion of coverage, and liberalization of selected social security benefits on a basis which would maintain the fiscal integrity of the system.

—Support of federal-state grant programs to improve health, welfare and rehabilitation services for the handicapped older persons and to improve standards of nursing home care and treatment facilities for the chronically and mentally ill.

—Federal leadership to encourage policies that will make retirement at a fixed age voluntary and not compulsory.

—Support of programs that will persuade and encourage the nation to utilize fully the skills, wisdom and experience of older citizens.

—Prompt consideration of recommendations by the White House Conference on Aging called by the President for January 1961.

We pledge the development of a health program that will provide the aged needing it, on a sound fiscal basis and through a contributory system, protection against the burdensome costs of health care. Such a program should:

—Provide the beneficiaries with the option of purchasing private health insurance—a vital distinction between our approach and Democratic proposals in that it would encourage commercial carriers and voluntary insurance organizations to continue their efforts to develop sound coverage plans for the senior population.

—Protect the personal relationship of patient and physician.

Include state participation.

For the needs which individuals of all age groups cannot meet by themselves, we propose:

—Removing the arbitrary 50-year age requirement under the disability insurance program while amending the law also to provide incentives for rehabilitated persons to return to useful work.

—A single, federal assistance grant to each state for aid to needy persons rather than dividing such grants into specific categories.

There has been a five-fold increase in government-assisted medical research during the last six years. We pledge continued federal support for a sound research program aimed at both the prevention and cure of diseases, and intensified efforts to secure prompt and effective application of the results of research. This includes emphasis on mental illness.

We pledge federal help in new programs to build schools of medicine, dentistry, public health and nursing and to provide financial aid to students in those fields.

DEMOCRATIC

Illness is expensive. Many Americans have neither incomes nor insurance protection to enable them to pay for modern health care. The problem is particularly acute with our older citizens, among whom serious illness strikes most often.

The most practicable way to provide health protection for older people is to use the contributory machinery of the Social Security System for insurance covering hospital bills and other high-cost medical services. For those relatively few of our older people who have never been eligible for social security coverage, we shall provide corresponding benefits by appropriations from general revenue.

—We pledge a campaign to eliminate discrimination in employment due to age. As a first step we will prohibit such discrimination by government contractors and subcontractors.

—We will amend the Social Security Act to increase the retirement benefit for each additional year of work after 65, thus encouraging workers to continue on the job full time.

—To encourage part-time work by others, we favor raising the $1200-a-year ceiling on what a worker may earn while still drawing social security benefits.

—We shall move ahead with the program of direct government loans for housing for older people initiated in the Housing Act of 1959, which the Republican administration has sought to kill.

—We shall take federal action in support of state efforts to bring standards of care in nursing homes and other institutions for the aged up to desirable minimums.

—We will step up medical research on the major killers and crippling diseases—cancer, heart disease, arthritis, mental illness. Expenditures for these purposes should be limited only by the availability of personnel and promising lines of research.

—Heart disease and cancer together account for two out of every three deaths in this country. The Democratic President will summon to a White House conference the nation's most distinguished scientists in these fields to map a coordinated long-run program for the prevention and control of these diseases.

—We will expand and improve the Hill-Burton hospital construction program.

—To ease the growing shortage of doctors and other medical personnel we propose federal aid for constructing, expanding and modernizing schools of medicine, dentistry, nursing and public health.

—We are deeply concerned that the high cost of medical education is putting this profession beyond the means of most American families. We will provide scholarships and other assistance to break through the financial barriers to medical education.

State

REPUBLICANS

Federal Aid: The Republicans of Indiana believe that we can more economically and more safely provide for our own needs than to rely on handouts from the Federal Government.

We recognize that the vicious feature of Federal grants in aid lies in the fact that the states, in economic self-defense, are forced to accept such at the price of inefficiency and surrendered control in order that they may recover even a pittance of the prodigious sums already extracted from their own citizens.

Social Security: The Social Security plan is now an integrated part of our economy. It has been expanded during the Eisenhower administration as follows: The minimum monthly payment has risen from $25 to $33 a month and the maximum from $85 to $127 a month. The num-

ber receiving benefits has grown from five million to 14 million, and the average payment per month has increased from $49 to $73. Today, Social Security payments to retired persons total $885 million per month, while they were $219 million per month in 1952 under the Truman administration.

Ministers, farmers and numerous other trades and professions that were not covered in 1952 now enjoy Social Security benefits. There are, in fact, 17 million more Americans covered under the Social Security Act.

We commend the Eisenhower administration for enlarging and strengthening the law to the advantage of nearly all of the citizens of our land.

Senior Citizens: In order that the wisdom, skills and experience of our senior citizens may not be lost, we pledge cooperation with all Federal statutes dedicated to their health, welfare and security.

We point with pride to the activities of the State Commission on Aging and Aged which came into being under a Republican Governor and which has, through its annual conference and activities, brought the problems of senior citizens into sharp focus in our Hoosier state. We pledge our wholehearted support to the program for senior citizens which the commission has developed.

We believe that senior citizens can contribute much to our society. We pledge continued leadership toward this end.

DEMOCRATIC

Health: We reaffirm our faith in the American system of private medical care.

We favor the training of more nurses and technicians for service to our people, and deplore the loss of service of the hundreds of registered nurses and practical nurses who would have been trained and in service in our institutions but for the refusal of the Republican administration to participate with our Federal Government in an expanded Nurses Training Program.

We favor the implementation for a Public Health Program to protect the health of our population living outside of cities, from the hazards of stream and soil pollution.

We favor the institution of a program which will insure older citizens adequate medical and hospital care, without the fear of financial disaster.

Mental Health: We share with all the citizens of Indiana our common shame as we view our inadequate mental health program. None of us can feel any pride in our existing facilities while needed treatment is denied our citizens because of lack of room and shortage of doctors and nurses. We feel that the present administration has been cruel and irresponsible in its sacrificing of our mentally ill upon the twin altars of states' rights and the dollar sign. We, as Democrats, pledge ourselves to place the highest priority upon the development of a complete program to meet the needs of our mentally ill; both because it is our responsibility as citizens, and because it is necessary to the social and economic health of our State.

Specifically, we recommend:

1. The creation of a separate Department of Mental Health, headed by a commissioner and including functional divisions of Child Mental Health and Mental Retardation;

2. The expansion of community psychiatric clinics in order to eliminate long waiting lists for diagnosis and treatment, and to prevent the need of future hospitalization;

3. The establishment of new residential treatment centers for children, to be located in areas where the need is greatest;

4. Expansion of the program of placing patients in private homes, private nursing homes and county homes, under the provisions of the Family Care Program;

5. Rehabilitation of existing state hospital buildings and facilities.

Mental Retardation: As a political party, we have no wish to play with the tragedy that lives with so many of our families, which include mentally retarded children, children who are denied the help of society, to which they are entitled. Indiana government, as such, however, is now the greatest offender in our social neglect of the problem of the mentally retarded and their families. We, then, as Democrats, have a responsibility to pledge ourselves as a Party, and as office-holders, to support the following program:

1. The creation of a Division of Mental Retardation, to direct an expanded state program;

2. The expansion of physical facilities to care for those who need custodial care and institutional training;

3. The inclusion in local school systems of classes for educable and trainable retarded children;

4. The creation of diagnostic, therapeutic and rehabilitation centers to give assistance to the mentally retarded and their families in the local communities;

5. Sufficient State financial support to make the expanded program effective.

Senior Citizens: We recognize the increased interest in the responsibility of the state, in cooperation with our senior citizens, in the development of a program that will enable older people, at work and in retirement, to contribute more fully to our society.

As a party, the Democrats have pioneered public programs such as Social Security and Old Age Assistance, which have removed much of the fear and burden of advancing years.

Continuing in its leadership in this important field, the Democratic Party recommends:

1. The educational institutions of the state should be encouraged to carry on research into the aging process and to provide education throughout life, for the needs of the aging and the aged;

2. The Old Age Assistance Grant should be raised to a realistic level;

3. Legislation should be enacted to establish and to improve public and private nursing and residential homes for senior citizens;

4. We pledge to participate fully in programs established by our Federal Government to improve the lives of our senior citizens.

Welfare: We affirm the historic support of the Democratic Party for the Welfare Program, and pledge continued support for its established benefits.

We condemn the incumbent governor for his irresponsible veto of legislation proposed by the Democratic Party to enable Indiana to care for its permanently and totally disabled citizens, and pledge ourselves to enact such a program into law.

We recommend that residence requirements for public assistance be made uniform in accordance with modern modes of living.

Highlights of various states' legislation pertaining to health and medicine, from *The Citation*, prepared by the Law Division of the AMA, Aug. 22, 1960.

State Legislation Roundup—1960

THIS IS A report of the highlights of state legislation during 1960 pertaining to health and medicine. It is part of the AMA's effort under its new state legislative program to keep the state medical associations informed of the legislative activities of the other state associations.

1960 was the "off" year for the state legislatures. Only 22 legislatures met and many of the sessions were limited to budgetary and financial matters. Next year all the state legislatures are scheduled to meet, except Kentucky, Mississippi and Virginia, and most of them will have extended sessions. The matters of key interest to the state medical associations during 1960 in those states where the legislatures met are as follows.

Medical Practice Acts

The West Virginia State Medical Association was faced with a bill (S.B. 31) which would have made it mandatory for the Medical Licensing Board of West Virginia to issue special permits to graduates of foreign medical schools to practice medicine and surgery for five years, if the graduate had been accepted to practice in a hospital in West Virginia as a house physician under the supervision of the medical staff. The bill did not require that the hospital be accredited and did not define "hospital." The state association vigorously opposed the bill on the grounds that it would lower the standards of medical practice, that it would usurp the power of the Board to pass on the qualifications of those li-

censed to practice medicine, and that it discriminated against graduates of American schools. The bill was killed.

The Michigan State Society supported a measure (S. 1144) which removed a restriction that graduates of foreign medical schools must serve their internships in the state in order to be licensed. The bill became law.

Alaska enacted a medical practice act (H. 277) and also a basic science law (H. 293).

A bill (H. 392) in Hawaii would have liberalized the licensing requirements for graduates of foreign medical schools. It passed the House but was not enacted.

In Massachusetts, a bill (H. 2741) was enacted requiring graduates of foreign medical schools to take the examination of the National Board of Medical Examiners in order to obtain a license to practice medicine. This law was then amended by another measure (S. 530) exempting diplomates of specialty boards recognized by the AMA from the necessity for taking this examination.

Chiropractic

The chiropractors were active in attempting to obtain legal status in states where they are not recognized. A proposal in Louisiana to legalize the practice of chiropractic (H. 259) was defeated by a substantial majority in the state Senate, due to active opposition of the state society.

There was no action in Massachusetts on a bill to establish a licensing board for chiropractors (H. 1442). Similarly, the bills in New York (S. 1053, A. 1550) proposing licensure received no action despite very active lobbying by the chiropractors in both houses. There was no chiropractic bill reported in Mississippi, the only other state which presently does not license them.

There were also attempts in New York (S. 1888, A. 2455) by the chiropractors to limit the operation of x-ray machines to those holding certificates as x-ray operators, and to exempt chiropractors from jury duty (S. 1614, A. 1209). Both proposals were defeated.

In Alaska, a bill (S. 93) to set up a state board of chiropractic examiners for the purpose of licensing chiropractors received no action, although chiropractic is recognized in that state.

The Rhode Island society managed to have a bill (H. 1098) vetoed by the Governor which would have allowed chiropractors to render "medical care" to public assistance recipients. (Note—an extensive and excellent study on chiropractic in California has just been published by the Stanford Research Institute of South Pasadena, Calif. The AMA has arranged to have one copy sent to each state medical association. Additional copies are available from the Institute for $5.00 each.)

Osteopathy

No action was taken on a bill (S. 429) in South Carolina which would have given osteopaths the right to use and prescribe drugs and to perform surgery. At present, the licenses of osteopaths in South Carolina do not include these privileges.

A Georgia bill (H.R. 370) to study legislation relative to osteopaths, with the view towards possible revision of the state laws, was vetoed by the Governor.

New York enacted a measure (S. 704) which allows the Board of Medical Examiners to accept the certificate of the National Board of Examiners of Osteopathic Physicians, in lieu of their own state examination, for the purpose of licensure.

A bill in South Carolina (H. 2572), apparently aimed at a particular individual, would have given a license to practice osteopathy to any one licensed to operate a nursing home in the state, and who was licensed to practice the healing arts prior to 1938. This bill was passed, vetoed and the veto was sustained.

Optometry

A bill (S. 230) was enacted into law in Kentucky which makes it mandatory for all state agencies and political subdivisions to accept and pay for the services of optometrists without discrimination between optometrists and "other persons" authorized by law to render the same professional services. The bill also made it mandatory for the testimony of optometrists to be accepted by state agencies with respect to any matter defined in the state law as constituting the practice of optometry.

Rhode Island enacted a measure (H. 1422) allowing the establishment of non-profit service corporations similar to Blue Shield for optometric services.

A bill (S. 1935, A. 2666) was vetoed in New York which would have allowed health insurance contract subscribers to have freedom of choice

between physicians and optometrists where the contract provides for opthalmic services. A proposal (S. 1005) which would make the fitting of contact lenses part of the practice of optometry failed of enactment in Michigan.

Licensure of Paramedical Groups

Numerous bills were introduced proposing the licensure, registration and control of the many paramedical groups. No attempt will be made to list all of them in this report.

In New York, bills to license and set up boards for radiation technicians (S. 2082) and medical technologists (A. 661) failed of enactment.

A measure (H. 8848) providing for the examination and registration of persons engaged in the practice of massage therapy received no serious action in Georgia.

The masso-therapists have indicated that they will push for licensure in California in 1961, as will also the x-ray technicians.

A New York bill (S. 1918) limiting the administration of physiotherapy by licensed physiotherapists to that prescribed in writing by a physician died in committee.

Anti-Cancer Quackery Legislation

In 1959, California passed the first anti-cancer quackery law. This statute gave the State Department of Public Health the power to investigate and test all drugs, medicines and devices proposed to be used in the diagnosis or treatment of cancer. The Department has a Cancer Advisory Council to assist it in its determinations. If, after investigation and testing, a remedy is found to be useless, the department is given the power to order its users to cease and desist. If this does not bring an end to the practice, the department may apply to the Supreme Court of the state for an injunction. The statute also forbids unlicensed persons to diagnose or treat cancer by the use of drugs, surgery or radiation.

Such laws were also enacted this year in Kentucky (H. 46) and in Nevada (S. 33). The Kentucky bill required the all-out effort of the state medical association inasmuch as it was opposed by the chiropractics, who attempted to have themselves exempted. In Kentucky the treatment of cancer is now limited to licensed physicians, osteopaths and dentists. It is likely that this type of legislation will arouse interest in many of the state legislatures during the coming year.

Health Insurance

The measures introduced in the state legislatures having to do with health insurance are too numerous to mention. The legislatures in New York, Massachusetts, Virginia and Rhode Island were particularly active in this area.

The bill causing the greatest concern to the state medical association was in New Jersey (A. 556). This measure would have allowed the Commissioner of Banking and Insurance to disapprove the rates of payment of any medical service corporation or medical service plan. The Commissioner would also have been given the power to obtain any data or information from a medical service corporation that he needed in order to make such a determination. The bill was vigorously opposed by the state society on the grounds that it would, in effect, allow the government to set physicians' fees without any participation by the doctors in these determinations. No final action was taken by the legislature on this measure although it was favorably reported out of committee to the Assembly.

Bills to set up commissions to study hospital charges, Blue Cross and Blue Shield rates etc., received no action in Rhode Island (H. 1662) and Michigan (S.R. 29).

Compulsory Polio Immunization Of School Children

Bills in New York (A. 2441) and Kentucky (S. 24) requiring the compulsory vaccination of school children against polio received no action. The Kentucky association took no position on the bill before its legislature, while the New York bill was opposed by the Medical Society of the State of New York. A similar bill (H. 29) in Michigan was enacted into law.

Exemption from Civil Liability For Emergency Care

California has a statute which exempts persons from liability for civil damages resulting from any mistakes or omissions committed by persons rendering emergency care, in good faith, at the scene of an emergency. Similar "Good Samaritan" laws were proposed in Mississippi (H. 833), Virginia (S. 211), and New York (S. 281). The Virginia bill passed the Senate but not the House. The New York bill was killed in committee, reportedly due to opposition by various non-medical groups. New York expects to have its bill enacted during the 1961 session. The state society in Maryland also intends to intro-

duce and support this type of bill in the next session of their legislature.

Miscellaneous

The Rhode Island legislature passed a resolution (H. 1227) endorsing the Forand bill, and the Teamsters Union in California served notice that they will push for a Forand-type bill in that state in 1961.

Physician lien laws failed to pass in New York (A. 2190) and Louisiana (H. 492).

A bill (H. 439), vigorously supported by the Kentucky State Medical Association, was enacted setting up a medical care program for public assistance recipients.

Mississippi reduced the statute of limitations on malpractice from six to three years (S. 1942).

Bills in Rhode Island (S. 543) and Georgia (S. 88), which would have allowed the services of chiropodists to be added to those services covered by medical services corporations, did not become law.

A bill was vetoed in New York (S. 2991, A. 3837) which would have allowed podiatrists to administer narcotic drugs.

No action was taken in the South Carolina legislature on a bill (H. 2258) which provided for the licensing of naturopaths.

Georgia enacted into law a measure (H. 598) setting up more humane commitment procedures, voluntary commitments and in general improving the mental health statute in that state.

The Georgia legislature failed to pass a bill (H. 847) which would have clarified the tax status of property owned by professional organizations.

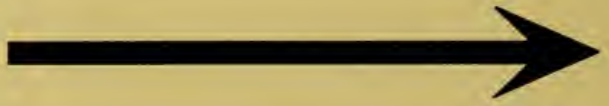
Is Non-Therapeutic Sterilization Illegal

In four states, Connecticut, Kansas, Montana and Utah, statutes provide that it is illegal to sterilize any person for other than eugenical or therapeutic reasons. As to the law on this subject in other states, there seems to be sharp disagreement among the medicolegal experts.

In *Christensen v. Thornby,* 192 Minn. 123, 255 N.W. 620 (1934), a vasectomy was performed upon a man whose wife could not have a child without hazard to her life. This was held not to be contrary to public policy even though the therapeutic necessity was on the part of the wife, not the husband.

A reported decision of a trial court in Lycoming, Pennsylvania, which has just come to our attention, squarely holds that a contract for a vasectomy, without therapeutic need, is not void because of public policy. In *Shaheen v. Knight,* 11 D. & C. 2d 41 (1957), the plaintiff, the father of four children, contracted with the defendant physician for a vasectomy because the plaintiff felt it to be economically necessary to limit the size of his family. Subsequent to the operation, the plaintiff's wife gave birth to another child, whereupon the plaintiff brought suit for breach of contract, seeking damages for the expense of rearing and educating the child. Held: action dismissed; the contract was not void because of public policy, but public policy forbade recovery of the damages sought. The court expressed the opinion that public policy does not recognize the "normal birth of a normal child" as damage. What would the court have said if the child was not normal, or if the mother had sustained injury or death during childbirth? Could the patient have asked for a refund of the physician's fee?

FOR DISPLAY IN DOCTOR'S OFFICE



for bacterial pneumonias

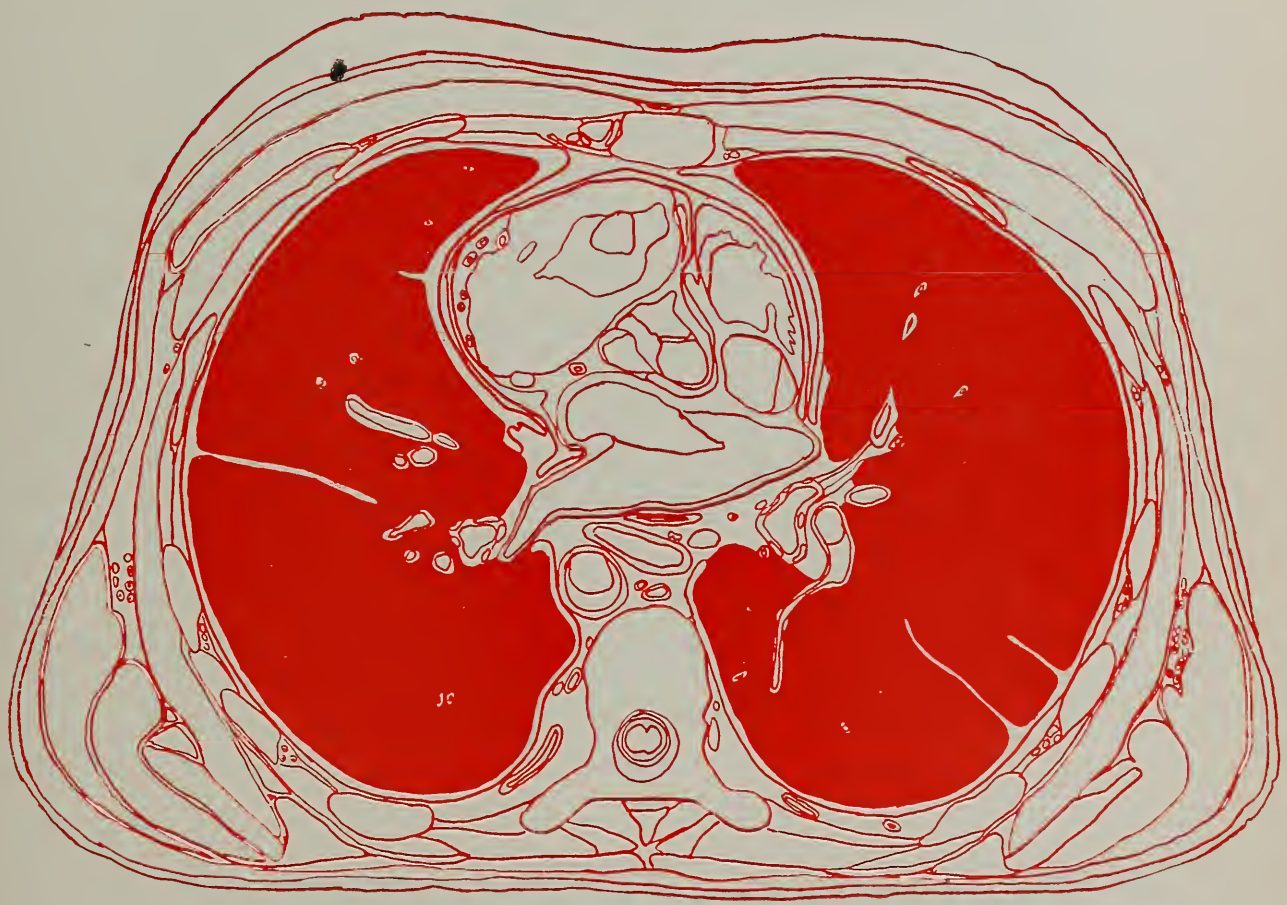
Tetrex®

capsules

The Original Tetracycline Phosphate Complex

U. S. PAT. NO. 2,791,609

effective control of pathogens...with an unsurpassed record of safety and tolerance

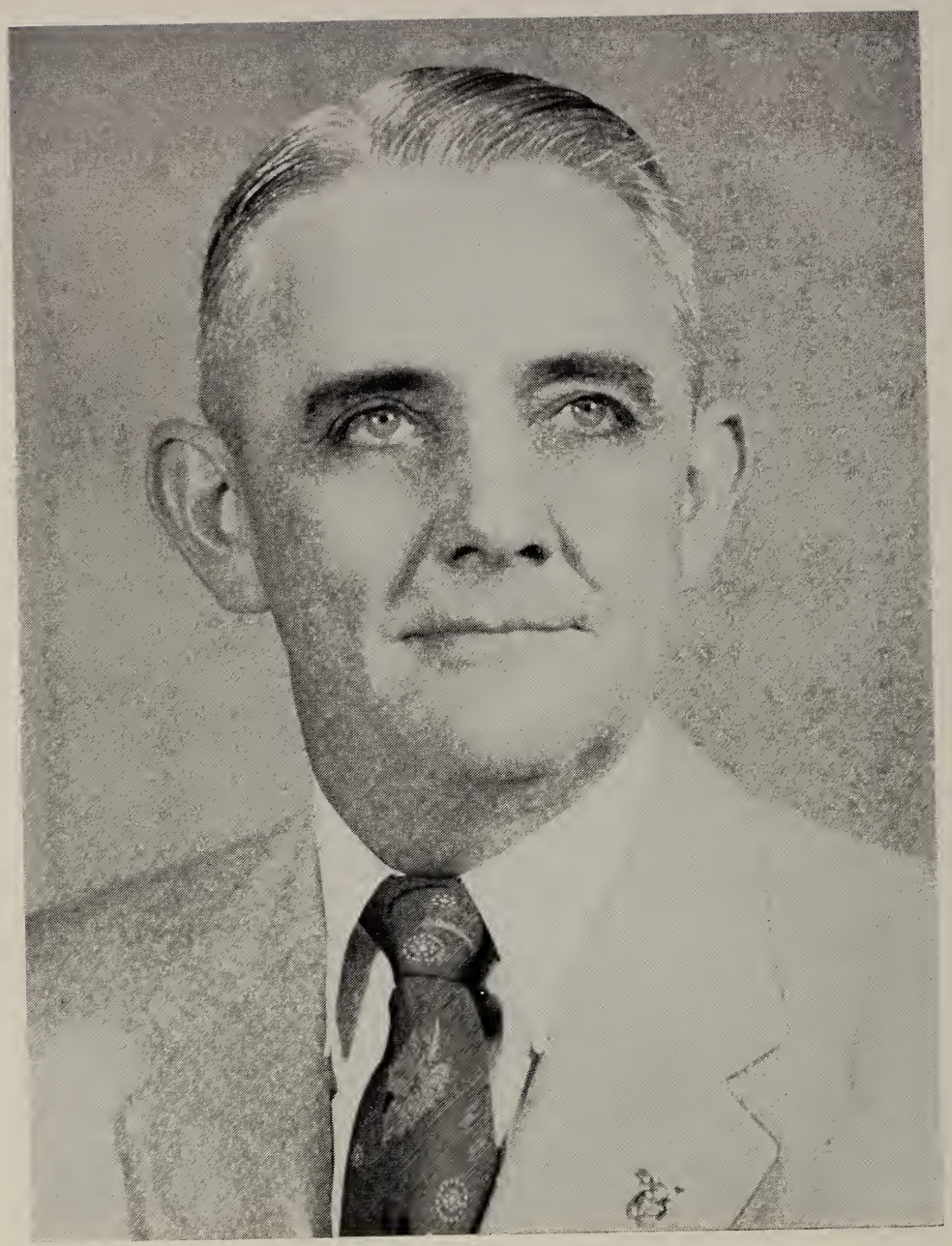


BRISTOL LABORATORIES, SYRACUSE, NEW YORK

BRISTOL™

SUPPLY: TETREX Capsules—tetracycline phosphate complex—each equivalent to 250 mg. tetracycline HCl activity. Bottles of 16 and 100.

TETREX Syrup—tetracycline (ammonium polyphosphate buffered) syrup—equivalent to 125 mg. tetracycline HCl activity per 5 ml. teaspoonful. Bottles of 2 fl. oz. and 1 pint.



Guy A. Owsley, M.D.
President
Indiana State Medical Association
1960-61

Dr. Guy Owsley of Hartford City succeeded to the office of president of the Indiana State Medical Association at the Annual Convention dinner, French Lick, Oct. 4.

Dr. Owsley was born in Indianapolis, Feb. 18, 1904. He received his early education in Thorntown, where his father, Dr. Guy M. Owsley, was engaged in the general practice of medicine. His grandfather, Dr. William J. Owsley, practiced in Montgomery and Boone counties.

Dr. Owsley attended Indiana University and received the B.S. degree in 1926 and the M.D. degree in 1928. He interned in the Letterman Army Hospital, San Francisco, Calif., and practiced for four years with his father in Thorntown.

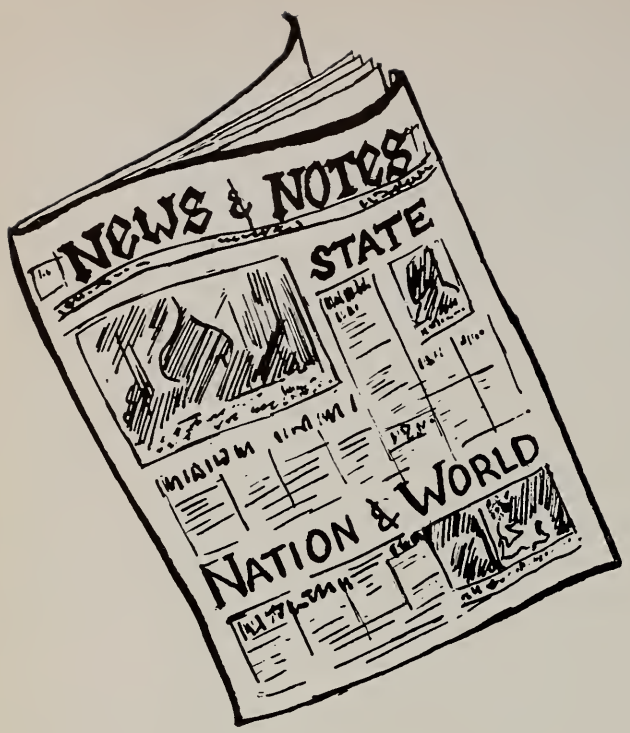
He then re-entered the Army Medical Service and was assigned to the Eye, Ear, Nose and Throat Section of the Station Hospital at Fort Benjamin Harrison. Following post-graduate work at Indiana University, the University of Southern California and Harvard University, he entered the practice of his specialty in Hartford City.

He has served as president of the Delaware-Blackford County Medical Society, has been his society's delegate to the State Association, secretary and councilor for the Ninth Councilor District. He had just completed three years as Chairman of the Council when he was chosen as president-elect a year ago.

During World War II he served successively as Chief of the Eye, Ear, Nose and Throat Section of Billings General Hospital, Executive Officer of Billings General, Commander of the Hospital Ship "Emily H. M. Weder," Commanding Officer of the Los Angeles Port Hospital, Chief of the Eye, Ear, Nose and Throat Section of the Borden General Hospital, and before returning to private practice, he supervised the opening of the Hearing Center of Walter Reed General Hospital.

Dr. Owsley is a Fellow of the American College of Surgeons, Fellow of the International College of Surgeons, Associate Fellow of the American College of Allergists, Fellow of the American Society of Eye, Ear, Nose and Throat Allergists, Diplomate of the American Board of Otolaryngology, Fellow of the American Academy of Ophthalmology and Otolaryngology, and a member of the Pan-American Association of Ophthalmology.

Dr. Owsley has always been active in the civic affairs of the state and in his home community. He enters the high office of president after an extremely busy year as president-elect.



New Medical Supplement Appears In Current National Magazine

"The Crisis in American Medicine," a 48-page special supplement, appears in the October issue of Harper's Magazine, which went on sale Sept. 27.

The issue carries articles by Edward T. Chase, "The Politics of Medicine;" Selig Greenberg "The Decline of the Healing Art;" Joseph Fletcher, Episcopal Theological School, "The Patient's Right to Die."

Also Dr. David Rutstien of the Harvard Medical School, "Do You Really Want a Family Doctor?" Dr. Lindsay E. Beaton, President of the Arizona State Medical Association, "A Doctor Prescribes for His Profession;" John Russell, "The Hidden Bottleneck in Medical Research."

Also Dr. Martin Cherkasky and Maya Pines, "Tomorrow's Hospitals;" and Dr. Rene J. Dubos, "Beyond Traditional Medicine."

The Editors of Harpers, writing in the introduction to the supplement, believe that "the articles will offer a basis for informed debate on questions which the country will have to settle before long, because they affect the health, and perhaps the lives, of all of us."

Indiana Flying Physicians Honored As 'Most Active; Well-Rounded Program'

The Indiana Chapter of the National Flying Physicians Association has been selected as the state group having the most active and well-rounded program, according to a recent announcement.

The chapter, with a membership of some 100 Indiana physicians, has organized a statewide disaster project, in cooperation with Indiana Civil Defense, which will enable the FPA to fly large numbers of medical personnel into any disaster area on short notice.

Dr. Frank Coble, Richmond, took office as President of the Hoosier chapter at the recent ISMA convention.

The group is attempting to contact all Indiana physicians interested in private flying and any such ISMA members not yet on the mailing list. Such persons should contact Dr. Dan Urschel, Mentone or Dr. Norbert Welch, Vincennes.

AEC Renews Purdue Contract

The Atomic Energy Commission has renewed a contract with Purdue Research Foundation in the amount of $5,000 on work to develop new principles and technics for moisture determination in pharmaceuticals.

DOCTORS TO GET MEDICAL NEWS OVER LOCAL T.V. CHANNELS

A weekly review of medical news for physicians, using regular commercial television channels, will go on the air Oct. 30 over a nationwide network, it was announced by Medical News Inc. of New York.

The 15-minute program, "This Week in Medicine," will be broadcast on Sunday afternoons. Selection of the broadcast time was based on preferences expressed by physicians in cities where the program was tested with the cooperation of county medical societies.

Tests in four cities—Dallas, Kansas City, Miami and Binghamton—showed that even though "This Week in Medicine" could be seen by the public over regular channels, the technical language and subject matter limited the audience to physicians and members of allied health professions.

Using video tape and film, each program will include a world-wide summary of medical news and a filmed feature on some aspect of research,



To the relief of musculoskeletal pain, new MEDAPRIN* adds restoration of function

Analgesics offer temporary relief of musculoskeletal pain, but they merely *mask* pain rather than getting at its *cause*. New Medaprin, in addition to bringing about prompt subjective improvement, promotes the *restoration of normal function* by suppressing the inflammation that *causes* the pain.

Medaprin, Upjohn's new analgesic-steroid combination, contains aspirin plus Medrol,** the corticosteroid with *the best therapeutic ratio in the steroid field.*† Instead of suffering recurrent discomfort because of the "wearing off" of analgesics, the patient on Medaprin experiences a smooth, *extended* relief and more normal mobility.

Indications: Medaprin is indicated in mild-to-moderate rheumatic and musculoskeletal conditions, including rheumatoid arthritis, deltoid bursitis, low back pain, neuralgia, synovitis, fibromyositis, osteoarthritis, low back sprain, traumatic wrist, sciatica, and "tennis elbow."

Dosage: The recommended dosage is 1 tablet q.i.d. The usual cautions and contraindications of corticotherapy should be observed.

Supplied: In bottles of 100 and 500.

Formula: Each Medaprin tablet contains

- 300 mg. acetylsalicylic acid, for prompt relief of pain
- 1 mg. Medrol, to suppress the causative inflammation
- 200 mg. calcium carbonate, as buffer

*TRADEMARK **TRADEMARK, REG. U. S. PAT. OFF.— METHYLPREDNISOLONE, UPJOHN
†RATIO OF DESIRED EFFECTS TO UNDESIRED EFFECTS

The Upjohn Company, Kalamazoo, Michigan

Upjohn

Continued

clinical medicine or surgery. It will mark the first use of regular television channels to reach a nationwide medical audience on a professional level.

The series will be sponsored by Ciba Pharmaceutical Products Inc. and produced by the editorial staff and medical consultants of *Medical News*. News will be gathered by the *Medical News* network of contributing editors and correspondents in this country and abroad. As in the biweekly newspaper, also sponsored by Ciba, the news and features content will be controlled by the editorial staff and medical consultants independently of the pharmaceutical company.

The program will also give highlights of major scientific meetings and call the attention of physicians to important editorial content of scientific journals.

Information on prescription pharmaceutical products will be given in scientific terms and will be confined to pharmacological properties. Clinical indications for use of Ciba drugs will not be cited, but will be made available to physicians through normal channels. Nonprescription drugs will not be mentioned.

"A layman who happens to tune in will find the product information incomprehensible," according to T. F. Davies Haines, president of Ciba.

Mr. Haines said that the use of open circuit television to reach a medical audience "is intended to add substantially to the physician's resources for keeping abreast of his swift-moving field."

"It will give physicians an up-to-date report on new medical developments with a minimum drain on their crowded schedules," he added.

Medical societies will be furnished information on stations and broadcast time and specialized organizations and societies will be given advance information on scheduling of filmed features of special interest to their members.

Dr. Ivan F. Bennett, of the Eli Lilly & Co. laboratory for Clinical Research was chairman for the 1960 meeting of the Indiana Association for Mental Health, which met in Indianapolis Sept. 15 and 16.

Hoosiers With Health Insurance Increase 4.9% in One Year

Number of Hoosiers with health insurance reached a new high of 3,630,000 at the end of 1959, the Health Insurance Institute reported in August. This was an increase of 4.9% over the 1958 year-end total.

The report was based on the 14th annual Health Insurance Council survey of health insurance coverage in the U. S., which revealed that nearly 128 million Americans, or 72% of the total civilian population, were protected by health insurance as of Dec. 31, 1959.

The survey of reports from insurance companies, Blue Cross-Blue Shield and other health care plans, disclosed that the number of persons in the state with hospital expense insurance increased by 170,000 during the year to reach a total of 3,630,000 at the end of 1959.

The number of persons with surgical expense insurance climbed from 3,282,000 at the end of 1958 to 3,456,000 at the end of last year. Persons protected by regular medical expense insurance, which helps pay for doctor visits for non-surgical care, increased from 2,141,000 to 2,313,000.

I.U. to Expand Nerve Cell Research Through Hartford Grant

An expanded program of nerve cell research at Riley Hospital, I.U. Medical Center, will be made possible by a grant from the John A. Hartford Foundation, New York City, of $239,000 to the I.U. Foundation for experimental and clinical studies of degeneration and regeneration in the central nervous system.

Announcement of the grant was made jointly by Ralph W. Burger, president of the Hartford Foundation, and Herman B Wells, president of Indiana University.

Under the direction of Dr. Leslie W. Freeman, research will be aimed at establishing all the factors that are involved in nerve cell degeneration and regeneration.

Dr. Freeman's studies of the repair of spinal nerve damage have attracted wide attention. Refuting former medical beliefs, he has established that axons, which act like "electric wires" in nerve cells can regrow after damage, if conditions are right.

Continued

Continued

This finding has brought some success in treatment of paraplegia, the paralysis caused by damage to spinal nerves.

The grant will cover the first three years of a projected ten-year program in which Dr. Freeman hopes to learn more about the right conditions for axon regeneration, and what factors prevent regeneration. The grant will provide for expansion of laboratory facilities at Riley Hospital, and will make possible the hiring of specialists in several branches of neurology.

Hill-Burton Grant Approved For Evansville Samaritan Home

The Department of Health, Education and Welfare reports that as of July 31, Hill-Burton grants for Indiana include one project approved at Good Samaritan Home, Evansville, at an estimated total cost of $782,284, with an approved $228,678 federal share and supplying 90 additional beds.

Also as of July 31, 68 projects, costing $72,-711,277, with a $23,828,304 federal contribution and supplying 3,166 additional beds were completed and in operation.

Still under construction were 26 projects at a total cost of $30,970,600, including a $8,328,915 federal share and designed to supply 1,094 additional beds.

Two projects were approved but not yet under construction. They will cost $1,801,809, including a $561,011 federal share, and supply 43 additional beds.

DR. YOUMANS NAMED TO AMA POST

Dr. John B. Youmans, Technical Director of Research for the U. S. Army Medical Research and Development Command, has been named Director of the American Medical Association's Division of Scientific Activities.

Since August, he served in his new position on a consulting basis, and will assume full time duties at the American Medical Association office in Chicago this month.

As new head of a Division that was created in 1959, Dr. Youmans will coordinate all scientific activities of the American Medical Association. He succeeds the late Dr. Edward L. Turner.

I.U. Physiology Researchers Study Arterioles' Regulating Ability

The mechanism by which arterioles regulate the blood flow through the vital organs is being studied by a physiology research team at the Indiana University School of Medicine.

Directed by Paul C. Johnson, assistant professor of physiology, the study is supported by grants totalling $22,066 from the American Heart Association and the U. S. Public Health Association. Preliminary work was started two years ago under a grant from the Indiana Heart Foundation.

Each vital organ possesses a mechanism which, automatically and independently of the heart's pumping action, regulates the flow of the blood through the organ.

"We have found," Prof. Johnson said, "that this autoregulation is due to the unusual properties of the arterioles which govern the flow of blood in the organ.

"Our studies indicate that the arterioles are extremely sensitive to change in the arterial pressure, contracting when the internal pressure increases and expanding when it decreases. The arterioles differ in this from all other blood vessels and the reason for this behavior is not known. The purpose of our research is to learn more about autoregulation and the mechanism of this unique behavior of the arterioles."

Hahn Memorial Award Established For Student Essay Winner

The Indiana Neuropsychiatric Association has announced the establishment of a Dr. E. Vernon Hahn Memorial Award to be presented to a member of the junior or senior class at Indiana University School of Medicine. The award will consist of $250 and will be given to the author of a prize-winning essay on any subject in the fields of psychiatry, neurology or neurosurgery.

Members of the association will be available to serve as advisors to the students who write for the award, and four members, Dr. Dwight W. Schuster, Dr. John Nurnberger, Dr. Philip T. White and Dr. Paul Merrell will serve as judges. Entries are due prior to Dec. 1, 1960. The award will be made at the January, 1961, meeting of the association.

Continued

AMA Urges Physicians to Give Blue Shield Plans All-Out Support

All-out support of Blue Shield Plans by the medical profession "as a necessary step in preserving the voluntary approach to the problem of financing medical care" is urged in a report adopted by the American Medical Association at its 190th annual meeting in June.

The precedent-setting action came when the AMA House of Delegates approved a report by the Council on Medical Service which sets forth specific proposals for closer relationships between the AMA and Blue Shield both locally and at the national level.

In addition to urging an extension of doctor participation in Blue Shield Plans, the AMA resolution stated a basis for strengthening liaison with Blue Shield and defined a positive basis for extending the effectiveness of Blue Shield, which was described as ". . . a proper economic arm of the medical profession and . . . a major component of the nation's voluntary health insurance system."

The Council's report included these recommendations:

1. AMA urges physician participation in Blue Shield Plans.

2. The AMA encourages direct liaison between medical societies and the Blue Shield Plans . . . to maintain the best possible physician-plan relationship.

3. The AMA encourage Plans in experimentation directed toward continued improvement in our voluntary prepayment and health insurance system.

4. Liaison between the AMA and Blue Shield Plans should be strengthened.

The adopted resolution also contained "certain principles" which should be embodied in the term, "Blue Shield concept." These include sponsorship of Blue Shield by the medical profession, doctor participation, medical society representation on the governing board of Plans, medical society cooperation in preventing abuses of the patient, physician or Plan and freedom of choice of physician for each patient.

"Blue Shield was an outgrowth of AMA activities," states the concluding paragraph of the Council's report. "The growth in Plans and enrollment and the contribution of the Plans toward more and more effective prepayment programs and insurance coverages have been far beyond original expectations. They have been an important factor in making the voluntary system a bulwark against compulsory Federal encroachment.

"The goal of physicians, medical societies, Blue Shield Plans and the AMA is to provide continuing proof that the voluntary system is the better system. To this end all should strive."

Surgeons Hear Dr. DeVault, Several Hoosier Physicians

Dr. Virgil T. DeVault, native of White County and chief medical officer of the U. S. State Department since 1950, was keynote speaker at a meeting of the Indiana division of the International College of Surgeons, Sept. 14 in Indianapolis. Having recently returned from an over two months' tour of Africa, Dr. DeVault discussed medical problems of that country.

Hoosier physicians who took part in the program were Dean John D. VanNuys of I. U. Medical Center; Drs. Hunter A. Soper, Clyde G. Culbertson, John A. Campbell, A. D. Dennison, Jr., Joseph C. Finneran, and Edward B. Smith, all of Indianapolis.

Editors President Sends AMA Booklet To Aid Members' Writing on Insurance

Dean W. Detweiler of the Perfect Circle Corporation, Hagerstown, Ind., President of the International Council of Industrial Editors, recently mailed a copy of the AMA booklet "Let's Use, Not Abuse Health Insurance" to the members of his organization, together with the suggestion that its contents might be helpful to them in preparing articles on how to make the best use of group insurance plans. The Council of Industrial Editors is composed of members of the editorial staffs of the employee publications and house organs of most of the business and industrial firms of United States and Canada.

Dr. Carl A. Bunde, former Vice-president of Medical Affairs for Pitman-Moore, Indianapolis, has been appointed Medical Research Director of the Wm. S. Merrell Company of Cincinnati.

DR. MERICLE NAMED PRESIDENT OF INDIANA REHABILITATION CHAPTER

ISMA president Dr. Earl W. Mericle has been elected president of the newly formed Indiana Chapter of the National Rehabilitation Association.

Other ISMA members who hold offices in the group are Drs. Glenn Gardiner, East Chicago, president-elect; Neal Baxter, Bloomington; Maurice Glock, Fort Wayne, and Stewart T. Ginsburg, Indianapolis, board of directors.

New Travel Immunization Booklet Out

"Immunization Information for International Travel," a booklet periodically revised and published by the U. S. Public Health Service, has just been issued in its latest form. All previous issues of the booklet are superseded. Copies may be obtained from the Superintendent of Documents, Government Printing Office, Washington 25, D. C. The price is 25c per booklet, with a discount of 25% for 100 or more.

Several Hoosiers Elected to A.P.A. Offices

In news from the American Pharmaceutical Association annual convention, P. F. Belcastro, Lafayette, was elected secretary-treasurer, and G. J. Sperandio, Lafayette was named delegate of the Section on Practical Pharmacy.

Cecil P. Headlee, Indianapolis, was chosen as secretary of the Section on Education and Legislation; Benjamin A. Smith, Indianapolis, was named chairman-elect of the Section on Pharmaceutical Economics and Robert Evanson, Lafayette was elected secretary of this section.

Other Hoosiers named to section offices include J. Richard Zapapas, Indianapolis, vice-chairman of the Industrial Pharmacy Section and Robert C. Anderson, also of Indianapolis, secretary-treasurer of the Scientific Section.

Mrs. Gloria F. Francke, a pharmacy graduate of Purdue University, recently resigned as Executive Secretary of the American Society of Hospital Pharmacists, a post she has held for more than 10 years.

INDIANA STATE BOARD OF HEALTH

Monthly Report—August, 1960

Disease	Aug. 1960	July 1960	June 1960	Aug. 1959	Aug. 1958
Animal Bites	795	626	918	618	653
Chickenpox	29	56	335	7	22
Conjunctivitis	65	59	155	59	38
Diphtheria	0	1	0	0	1
Dysentery, Unspecified	11	9	10	15	15
Impetigo	176	82	86	99	159
Infectious Hepatitis	54	25	28	20	12
Infectious Mononucleosis	10	16	16	4	14
Influenza	366	287	393	150	248
Measles (Rubeola-Rubella)	222	411	1,514	64	81
Meningitis, Meningococcal	5	3	6	2	3
Meningitis, Other	11	5	13	25	27
Mumps	67	111	473	11	70
Pertussis	11	36	21	56	109
Pneumonia	86	131	189	61	62
Poliomyelitis	32	11	2	40	33
Streptococcal Infections	385	267	429	150	179
Tinea Capitis	0	1	33	3	11

FUTURE MEETINGS, SEMINARS, COURSES

College of Chest Physicians' Courses

Two postgraduate courses on diseases of the chest are scheduled for October and November by the American College of Chest Physicians, according to Dr. J. Winthrop Peabody, Sr., Chairman of the College's Council on Postgraduate Medical Education.

The first course, Clinical Cardiopulmonary Physiology, is arranged under the co-chairmanship of Dr. Albert H. Andrews, Associate Clinical Professor of Bronchoesophagology, University of Illinois College of Medicine, and Dr. Edwin R. Levine, Assistant Professor of Clinical Medicine, Chicago Medical School. It will be held at the Sheraton Towers Hotel, Chicago, Oct. 24-28.

The second, Recent Advances in the Diagnosis and Treatment of Diseases of the Heart and Lungs, is arranged under the co-chairmanship of Dr. Edgar Mayer, Clinical Professor of Medicine, New York University Postgraduate Medical Center; Dr. Alfred S. Doneief, Lecturer in Medicine, Columbia University College of Physicians and Surgeons; and Dr. Emil A. Naclerio, Chief, Thoracic Surgical Services, Harlem and Columbus Hospitals, New York. It will take place at the Park Sheraton Hotel, New York City, Nov. 14-18.

Tuition for each five-day course will be $100 including round-table luncheon discussions.

Additional information may be obtained from The Executive Director American College of Chest Physicians, 112 E. Chestnut St., Chicago. Ill.

Maternity Institute at Lafayette

"Challenge of Change—Tomorrow's Concept of Maternity Care" will set the theme for various panels, speakers and discussion groups at a maternity institute to be held at the Purdue University Memorial Union Building, Nov. 3 and 4.

The session is sponsored by St. Elizabeth Hospital, Lafayette, Lafayette Home Hospital, Inc., District 8 of the Indiana State Nurses Association and the Tippecanoe County Medical Society, in cooperation with the Indiana League for Nursing, Indiana Hospital Association, Indiana State Board of Health and Indiana Obstetrical and Gynecological Society.

Dr. Harry B. Benaron, Associate Professor of Obstetrics and Gynecology at Northwestern University, will deliver the keynote address, Nov. 3. Another featured speaker is Miss Aileen Hogan, of Maternity Center, New York City.

Hoosiers participating in the program include Drs. James E. Simmons and Martha O'Malley Indianapolis; Dr. J. J. Stefaniak, C. H. Lawshe and Robert G. Brunger, Lafayette.

Chicago Diabetes Symposium

The Chicago Diabetes Association will conduct its FOURTH ANNUAL SYMPOSIUM ON DIABETES at the Offield Auditorium, Passavant Memorial Hospital, Friday, Nov. 11, beginning at 9:00 a.m.

Speakers will include Prof. W. H. J. Butterfield and Dr. Peter H. Wright of Guy's Hospital Medical School, London; Dr. Sidney Goldenberg, St. Louis University School of Medicine; Drs. Ralph A. Reis, James B. Hurd, Marvin Cornblath, Henry T. Ricketts, Frank W. Newell and Benjamin Spargo of the faculties of Northwestern University Medical School and the University of Chicago.

There will be a round-table discussion at the luncheon recess at Abbott Hall, led by various members of the Diabetes Association from the faculties of medical schools in Chicago.

Registration is free for members of the Chicago Diabetes Association or the American Diabetes Association and for medical students and resident house staff members. The fee for nonmembers is $25.00.

Members of the Academy of General Practice may claim hour for hour credit in Category II.

Inquiries may be addressed to the Association, 620 North Michigan Avenue, Chicago 11.

Continued

FUTURE MEETINGS Continued

I.U. Postgraduate Courses

Tentative schedules for 1960-61 postgraduate medical courses to be given by the Indiana University School of Medicine in Indianapolis and other Hoosier cities have been announced as follows:

1960		
Oct. 5, 12, 19, 26, (7:00-10:00 p.m.)	Psychiatry (Logansport & Columbus)	Dr. Nurnberger
Dec. 7	Pediatrics	Dr. Meiks
Dec. 8	Urology	Dr. Garrett
1961		
Jan. 11	Non-Tuberculis Pulmonary Disease	Dr. Behnke
Jan. 12	Recent Advances in Physical Diagnosis	Dr. Behnke
Jan. 25	Treatment of Arteriosclerosis Disease	Dr. Close
Jan. 26	Weight Reduction and General Dietary Therapy	Dr. Lukemeyer
Feb. 22	Orthopedics	Dr. Garceau
Mar. 1, 2	Anesthesia for Full and Part-time Anesthetists	Dr. Stoelting
Mar. 8, 9	Obstetrics and Gynecology	Dr. Huber
Apr. 6, 7, 8, 9	Radiology of the Chest	Dr. Campbell
Mar. 13-24	Anatomical and Clinical Otolaryngology	Dr. Manion
Mar. 29	Cancer Symposium	
Apr. 5, 12, 19, 26 (7:00-10:00 p.m.)	Psychiatry (Ft. Wayne & Evansville)	Dr. Nurnberger
Apr. 26	Treatment of Common Disorders of the Blood	Dr. Rohn
Apr. 27	Gastroenterology	Dr. Rosenak
May 17, 24, 31 and June 7 (7:00-10:00 p.m.)	Psychiatry (Indianapolis)	Dr. Nurnberger

Ob-Gyn Conference for Nurses

District V—Indiana Michigan, Ohio and Kentucky—of the American College of Obstetricians and Gynecologists will sponsor a two-day conference for maternity and gynecological nurses in Columbus, Ohio, Nov. 3 and 4.

Nurses of the district who are interested in maternity, newborn and gynecological nursing are eligible to attend.

Applications for pre-registration and hotel reservations may be obtained from "Ob-Gyn Nurses' District Conference," P.O. Box 95, Columbus 16.

11th Annual Animal Care Panel

Unusual new technics for handling animals used in scientific research will highlight the 11th annual meeting of the Animal Care Panel to be held in St. Louis, Oct. 26-28. The success with hypnotism of small animal subjects will be one of the newer innovations to be reviewed. The project has aroused great interest among other panel members. It is based on the medical use of hypnotism for human patients.

Assistants to Meet in Dallas

Some 800 medical assistants are expected to attend the fourth annual national convention of the American Association of Medical Assistants in Dallas, Texas, Oct. 14-16. The AAMA, an organization whose aims and goals have been commended by the American Medical Association, has a membership of approximately 9000 in 29 chapter states.

Two major segments of the convention program will deal with current problems and future challenges of medical practice. One, an educational seminar, scheduled for Saturday, Oct. 15, will feature talks on "Waiting Room Atmosphere," "The Hospital, the Doctor and You" and "The Problem of Medical Care Cost in the 60's."

The Challenge of the 60's is the theme of the Second Annual Leadership Seminar, sponsored by Lakeside Laboratories, Inc., also scheduled for Oct. 15. This seminar will feature lectures on credit and office management plus a round-table discussion of physician-assistant-patient re-

FUTURE MEETINGS

Continued

lationships. Participants in the round-table will include two physicians and two medical assistants.

Among the noted physician-speakers scheduled to play a part in this convention will be E. Vincent Askey, M.D., president of the AMA.

Arizona Cancer Seminar in January

The Ninth Annual Cancer Seminar of the Arizona Division of the American Cancer Society will be held Jan. 12, 13 and 14, at the Tidelands Motor Inn, in Tucson. Topics will include chemotherapy, virology, endocrinology and environmental factors as related to tumor formation and tumor therapy.

The faculty will consist of nationally known authorities in the various subjects. Members of the ISMA are invited to attend.

San Diego Postgraduate Assembly

Members of the ISMA are invited to attend the 14th annual Postgraduate Assembly of the San Diego County General Hospital, Wednesday and Thursday, Nov. 2 and 3, San Diego, Calif. Seven guest speakers will conduct the two-day meeting. Dr. Harris Schumacker, Jr., of Indianapolis, will speak on surgical subjects.

Nuclear Medical Society Plans '61 Meeting

The Society of Nuclear Medicine met in Estes Park, Colorado, in August. Over 500 physicians and scientists from this and other countries were in attendance. Seventy scientific papers were presented. The society will hold its next annual meeting at the Sheraton Hotel, Pittsburgh, June 14 to 17, 1961. Further information may be obtained by addressing Society of Nuclear Medicine, 430 N. Michigan Ave., Chicago, 11.

Wanted: Locations Physicians

Following is a list of physicians who made inquiry at our office during the months of July and August 1960 concerning openings in our state for practice.

General Practice

Joseph F. Wethington, M.D., St. Mary's Hospital, 2414 S. 7th St., Minneapolis 6, Minn.

Evan Constan, M.D., 142 S. 8th St., Reading, Pa.

S. T. Gettelman, M.D., 3609 N. 97th St., Milwaukee 22, Wis.

General Practice and /or Internal Medicine

Abraham Scheinbaum, M.D., 955 S. Elm St., Kankakee, Ill.

Clarence R. Woodbury, M.D., 8801 So. Keeler, Oak Lawn, Ill.

Richard Schultheis, M.D., Doctor's Home, Philadelphia General Hospital, 34th and Curie Ave., Philadelphia, Pa.

Fred W. Thomas, M.D., 7454-B O'Reilly St., El Paso, Tex.—available July 1961.

M. Keith Baird, M.D., Broadlawns Hospital, Des Moines, Ia.—available July 1961.

Andrew Thomas, M.D., 3445 Broadway, Indianapolis 5, Ind.—available July 1961.

Dale King, M.D., 614 Nectarine, Oxnard, Calif.

Specialists

Claire E. Cotton, M.D., 5035 Edsal Dr., Lyndhurst, Ohio —*internal medicine.*

Vincent J. Gallant, M.D., 53 Chicago Blvd., Detroit 2, Mich.—*general surgery.*

Marshall J. Blondy, M.D., 20480 Meyers, Detroit 35, Mich.—*pediatrics.*

Andrew Pentz, M.D., 1649 Franklin Ave., Columbus 5, Ohio—*pediatrics and pediatric cardiology.*

Anthony H. Axiotis, M.D., P.O. Box 1016, Galesburg, Ill.—*psychiatry.*

Nicholas H. Gomez, M.D., 6044 Ingleside Avenue, Chicago 37, Ill.—*anesthesiology.*

Arthur J. Johnson, M.D., University Hospital, 410 W. 10th Ave., Columbus, Ohio—*urology.*

Locations

Allen County—FORT WAYNE—Opening for a physician, preferably one who has completed internship rather recently, to become associated with group in internal medicine, with the possibility of becoming a specialist in allergy. Contact A. N. Ferguson, M.D., 2902 Fairfield Ave., Fort Wayne.

Decatur County—GREENSBURG—pop. between 7,000-8,000. County seat town. Opening for associate with Robert Acher, M.D. Office, equipment available. Contact Dr. Acher, 221 E. Washington St., Greensburg.

Lawrence County—OOLITIC—pop. 2,000, one mile from Bedford where hospital facilities are available and 18 miles from Bloomington, home of Indiana University. Fully equipped office, x-ray, diathermy available. Opening for associate with Claude Dollens, M.D., only physician in the community, with option to buy. Contact Mr. Wilbur C. Dollens, 4226 N. Meridian Street, Indianapolis.

St. Joseph County — SOUTH BEND — pop. 216,000. Residence-office of physician who is retiring because of health reasons. Prefer to sell but will rent to responsible party. Good schools, churches, recreational facilities. Located 30 miles from Lake Michigan; many small lakes in the vicinity. Industrial community. Home of Notre Dame University. Contact Mr. Harry C. Davis, Executive Secretary, St. Joseph County Medical Society, 106 W. Monroe St., South Bend 1.

Deaths . . .

Theodore R. Borders, M.D.

Dr. Theodore R. Borders, 58, Fort Wayne general practioner, passed away Aug. 14.

A graduate of Howard University Medical School, class of 1930, Dr. Borders had practiced in Fort Wayne for 30 years.

Andrew M. Brenner, M.D.

Dr. Andrew M. Brenner, partner in a clinic at Winchester, Ind., passed away June 28 at his home.

A 1936 graduate of the Indiana University School of Medicine, Dr. Brenner served as flight surgeon in World War II; he was a member of the American Legion and Phi Chi.

John E. Dalton, M.D.

Dr. John E. Dalton, head of staff of the dermatology department at Marion County General Hospital, passed away Aug. 5 in Indianapolis. He was 59.

Dr. Dalton had retired from private practice Jan. 1, 1960, to accept the dermatological post. He was a former staff member at St. Vincent's Hospital, Indianapolis, and a fellow and former president of the American Dermatological Society.

A graduate of the Indiana University School of Medicine, Dr. Dalton was associated with Massachusetts General Hospital, Cleveland General Hospital and the University of Breslau, Germany, before opening private practice in Indianapolis in 1931.

Charles R. Dancer, M.D.

Dr. Charles R. Dancer, 87, who practiced in Fort Wayne 51 years before retiring in 1950, passed away July 26 at Marion, Ind.

Dr. Dancer was graduated from Fort Wayne Medical College in 1900; he served in the Army Medical Corps from 1917-1919.

He was a former member of the board of managers of Irene Byron Hospital, served as city school physician at one time, and was also on the staff of Fort Wayne State School.

Lloyd A. Elliott, M.D.

Dr. Lloyd A. Elliott, Elkhart physician and founder and president of the Elkhart Foundation for Medical Education and Research, passed away June 24 at Elkhart. He was 75.

A 1911 graduate of the University of Illinois Medical School, Dr. Elliott moved to Elkhart and began practice in 1913. He served overseas in the Medical Reserve Corps during World War I.

Dr. Elliott was the first Elkhart County physician to become a member of the American College of Surgeons. He was active in the establishment of the Elkhart Clinic in 1943. A medical library in his honor was established in 1947 at Elkhart General Hospital.

Nathaniel J. Fine, M.D.

Dr. Nathaniel J. Fine, regional medical officer for the Pennsylvania Railroad for 15 years, passed away Aug. 5 at Indianapolis, where he had resided for five years.

Dr. Fine was a 1942 graduate of Laval University Medical School, Quebec, Canada. He served in the Air Force Medical Corps during World War II, and at the time of his death, was on the staff of Community Hospital, Indianapolis.

La Mar Knepple, M.D.

An 88-year-old Kokomo physician, Dr. La Mar Knepple, passed away June 24. He began his medical practice in Wakarusa in 1894, and had been retired since 1953.

A 50-Year Club member of ISMA, Dr. Knepple was a charter member of Kokomo Kiwanis and belonged to Elks Lodge.

J. F. Michaels, M.D.

An 84-year-old Edinburg physician, Dr. J. F. Michaels, passed away Aug. 25. He practiced in Edinburg 41 years, until retiring four years ago due to ill health.

A senior and 50-Year-Club member of ISMA, Dr. Michaels was a 1899 graduate of Marion-Sims College. He had practiced in Montgomery and Loogootee, Ind., before coming to Edinburg.

Harold Nisenbaum, M.D.

Dr. Harold Nisenbaum, 47-year-old Evansville general practitioner, passed away July 14 at an Evansville golf course.

A 1935 graduate of the Indiana University School of Medicine, Dr. Nisenbaum had practiced in Evansville since 1936, with exception of the time he served in the Army Medical Corps during World War II.

Lyman T. Rawles, M.D.

A former member of the ISMA *Journal* Editorial Board, Past-president of the Allen County Medical Society, several ISMA committees, Dr. Lyman T. Rawles, passed away July 18 at South Whitley. He practiced in Fort Wayne until his retirement in 1943, and was elected to the ISMA 50-Year-Club in 1955.

Dr. Rawles, an orthopedic surgeon, who at one time headed the medical staff at St. Joseph's Hospital, was a graduate of Northwestern School of Medicine. He was an orthopedic instructor at St. Joseph's School of Nursing and a member of the Scottish Rite and Shrine.

Hans A. Schulze, M.D.

Dr. Hans A. Schulze, 55, former medical director at the Indiana State Reformatory at Pendleton, died July 19, a week after he left his Pendleton post and opened a new office in Indianapolis.

Dr. Schulze, who came to the U. S. from Germany in 1926, was a graduate of the University of Cincinnati School of Medicine.

Aubrey H. Williams, M.D.

Dr. Aubrey H. Williams, Fort Wayne internist and allergist, passed away July 5 after a long illness. He was 51.

A graduate of the Indiana University School of Medicine, Dr. Williams was on the staff of Lutheran Parkview and St. Joseph Hospitals, Fort Wayne. He had served as a medical officer in the Navy during World War II.

District, County News

Thirteenth District

Three widely-known out-of-state speakers were featured on the program at the annual meeting of the Thirteenth District Medical Society, Sept. 28 at Elkhart.

Dr. Paul Dudley White, world-reknown cardiologist, spoke on the topic, "The Health of the Physician Himself." Dr. White received an honorarium from the Elliott Foundation for Medical Education and Research.

Dr. I. Phillips Frohman, Washington, D.C., discussed "Research by the General Physician in his Practice."

Also on the program was Dr. Felix Wroblewski, New York, N. Y., speaking on "Enzymes in Clinical Diagnosis."

Clay

Dr. Donald Garvin, Brazil, spoke to members of the Clay County Medical Society at their July 19 meeting in Brazil on "Evaluation of Externship in Smaller Hospitals." Ten members attended.

The group met on two other occasions during the summer, June 21 and Aug. 16, for business sessions.

Floyd

Members of the Floyd County Medical Society held business meetings on July 8 and Aug. 12. Included on the Aug. 12 program was a film on radiology. Over twenty members attended the meetings.

Association News

EXECUTIVE COMMITTEE

August 12, 1960

Roll call showed the following present: Don E. Wood, M.D., chairman; Wendell E. Covalt, M.D.; Earl W. Mericle, M.D.; Guy A. Owsley, M.D.; Maurice E. Glock, M.D.; Okla W. Sicks, M.D.

Ralph Hamill, attorney; James A. Waggener, executive secretary; Robert J. Amick, field secretary.

Guests: C. Joseph Stetler, director, Legal Department, AMA, Chicago; George M. Fister, M.D., Council on Legislative Activities of the AMA, Ogden, Utah; Mrs. Edward L. Rigley, president, Woman's Auxiliary, South Bend; Mrs. Burton Kintner, first vice-president, Woman's Auxiliary, Elkhart.

The system of communication on legislative matters between the Woman's Auxiliary and the Association was discussed, and upon motion of Drs. Glock and Covalt, the president, president-elect and legislative chairman of the Woman's Auxiliary are to be placed on the mailing list to receive copies of all matters concerning legislation.

The statement of income and balances as of July 31, 1960 and the Treasurer's report were approved on motion of Drs. Mericle and Covalt.

Membership Report

Number of members as of Aug. 12, 1959		4,222
1960 members as of Aug. 12, 1960:		
Full dues paying	3,601	
Interns	30	
Residents	171	
Council remitted	40	
Senior	389	
Military	35	
Honorary	1	
Total 1960 members as of Aug. 12, 1960		4,267
Gain over last year		45
Number of members Dec. 31, 1959		4,256
Number of AMA members as of Aug. 12, 1959		4,096
1960 AMA members: Dues paying	3,459	
Exempt, but active	671	
Total 1960 AMA members as of Aug. 12, 1960		4,130
Gain over last year		34
Number of AMA members as of Dec. 31, 1959		4,210
Number who have paid state dues but not AMA dues in 1960		123

Headquarters Office

The secretary reported on his conversation with Senator Hardtke concerning the survey on Social Security coverage of physicians.

Unfinished Business

Dr. Wood reported that he had made an investigation of interest rates at which the Association could borrow money for construction of the headquarters building and that the lowest figure he had received so far was 5½%, and one insurance company had indicated that it might be possible for it to lend money at less than 5½%.

The secretary reported that he had received a guide for release of information from hospital medical records as prepared and proposed for release by the Indiana Hospital Association and this had been referred to the attorneys for review. Judge Hamill stated that Mr. Hollowell had not completed his review of this material.

President Mericle reported that in accordance with the action of the Council, taken at its meeting on July 10, he had appointed the following Interim Committee on Aging:

Nathan L. Salon, Fort Wayne, chairman
Andrew C. Offutt, Indianapolis
Walter U. Kennedy, New Castle
Frank M. Hall, Indianapolis
Okla W. Sicks, Indianapolis

Legislation

Dr. Wood, chairman of the Commission on Legislation, reported on physicians and Social Security and old-age legislation pending before Congress at this time.

Annual Convention, French Lick, Oct. 2, 3, 4 and 5, 1960

The secretary went over the arrangements as currently laid out for the fall meeting, and upon motion of Drs. Mericle and Covalt it was decided to change the time of the Executive Committee meeting to 10:00 a.m., Sunday, Oct. 2, and the Council to meet at 12:30 p.m.

Annual Convention, Indianapolis, 1961

The secretary reported that he had been able to clear the dates of Tuesday, Wednesday and Thursday, Oct. 24, 25 and 26, 1961, for the 1961 annual convention, to be held in Indianapolis. This was approved on motion of Drs. Glock and Mericle. The motion also included instructions to the secretary to attempt to secure similar dates at French Lick for 1961 in case the Indianapolis convention site is not available in 1961.

Organization Matters

The request for $25.00 from the Indiana Farm-City Committee was approved on motion of Drs. Owsley and Glock.

Upon motion of Drs. Glock and Owsley, permission was granted for the Indianapolis General Hospital to take nasal swabs at the State Fair Indiana State Medical Association exhibit.

A letter requesting the appointment of a physician to be considered to receive the Physician's Award from the President's Committee on Employment of the Physically Handicapped was referred to the Commission on Public Health.

A letter from the Judicial Council of the American Medical Association, addressed to Dr. Cleon Nafe, concerning Blue Shield payments to surgeons and to assist-

ing surgeons was read for the information of the Committee.

By consent a letter to Dr. A. C. Offutt from Sen. J. Russell Townsend, Jr., was referred to the Indiana Academy of Ophthalmology and Otolaryngology for its opinion.

A letter from the Governor concerning the Indiana Sesquicentennial celebration was read and by consent it was agreed that this letter should be referred to the Commission on Special Activities.

A letter from the Delaware-Blackford County Medical Society was discussed by Dr. Owsley and was referred to the Council.

Report on the Indiana Medical Education Foundation was presented to the Committee for its information.

Letter from Morris Fishbein, M.D., dated July 13, 1960, concerning his plan to write up medical notables of Indiana in POSTGRADUATE MEDICINE was discussed. By consent it was suggested that we write Dr. Fishbein concerning the following Indiana physicians:

Frank B. Wynn
John Newell Hurty
Williams Niles Wishard
John H. Oliver
Charles P. Emerson

A letter from Dr. Joe Davis concerning the Joint Council on the Health Care of the Aged and the Joint Committee for the Improvement of Patient Care was read for the information of the Committee.

Correspondence from Dr. Kenneth L. Olson concerning Blue Cross taking over the payments for radioactive isotope therapy was reported to the Committee for their information due to the fact that this had been referred by the Council Liaison Committee with Blue Shield.

Future Meetings

AMA National Conference on Health Mobilization, Chicago, Nov. 4 to 6, 1960. Upon motion of Drs. Mericle and Glock, the chairman of the appropriate Commission, or a member selected by him, was authorized to represent the Association at this conference.

AMA Medical Disciplinary Committee meeting, Sept. 12, 1960. On motion of Drs. Covalt and Glock, the chairman of the Grievance Committee and the secretary were authorized to attend this meeting.

AMA Interim meeting, Washington, D. C., Nov. 27-Dec. 1, 1960.

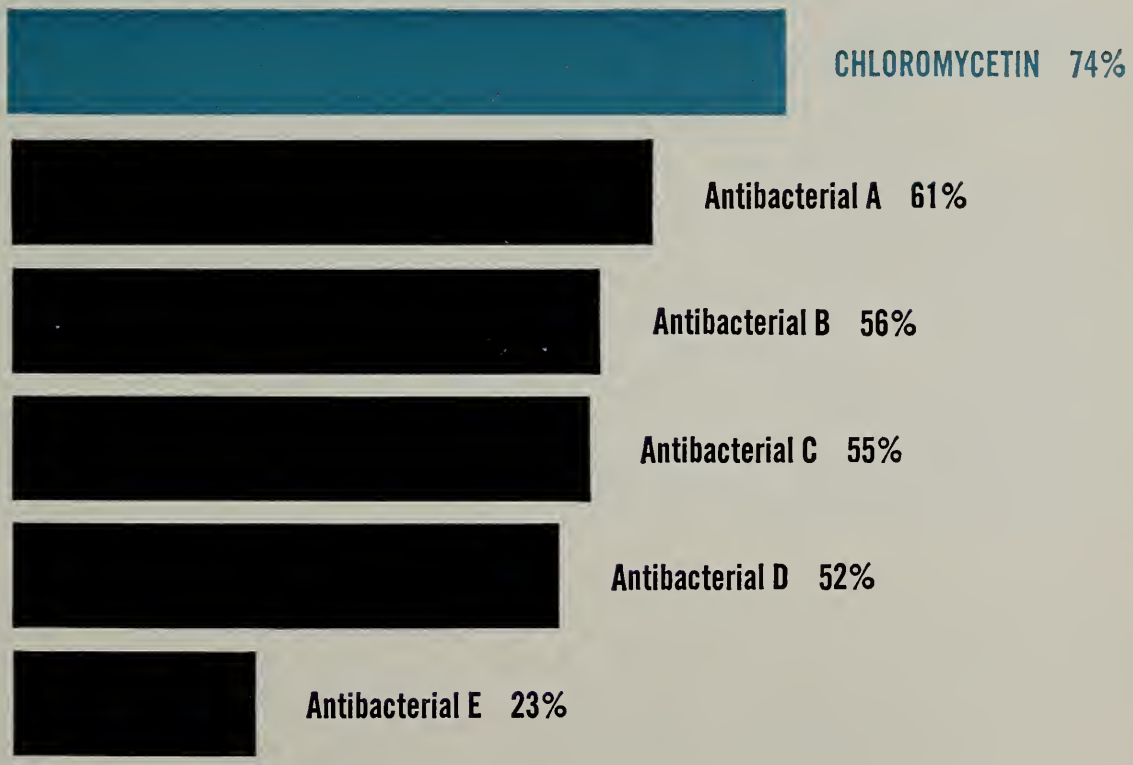
International College of Surgeons, Indiana Division, I. U. Medical Center, Indianapolis, Sept. 14, 1960.

There being no further business the Committee adjourned to meet again at 10:00 a.m., Sunday, Sept. 11, 1960, at the Columbia Club, Indianapolis.

MYCETIN®

(chloramphenicol, Parke-Davis)

IN VITRO SENSITIVITY OF 4,860 GRAM-POSITIVE AND GRAM-NEGATIVE PATHOGENS TO CHLOROMYCETIN AND TO FIVE OTHER ANTIBACTERIALS*



*Adapted from Goodier & Parry[1]

The Journal of the INDIANA STATE MEDICAL ASSOCIATION

November 1960

Office of Publication:
1019 Hume Mansur Building, Indianapolis, Indiana

$1.00 per copy
except Yearbook
$5.00 per year

Contents

SCIENTIFIC

Multiple Jejunal Diverticula: Report of Three Cases, Richard J. Noveroske, M.D., Roscoe E. Miller, M.D., Indianapolis 2009
Immediate Cholangiography, Harold D. Caylor, M.D., Bluffton 2014
The Shirodkar Procedure and the Habitual Aborter, John N. Lein, M.D., Richard W. Stander, M.D., Charles A. Hunter, M.D., Indianapolis 2017
Older Versus Newer Preanaesthetic Drugs, Douglas Layman, M.D., V. K. Stoelting, M.D., Indianapolis 2023
Mental Health and the Transplanted School Child, Esther J. Swenson, Ph.D., University, Alabama 2028
Electrocardiogram of the Month: Myocardial Infarction, Charles Fisch, M.D., Indianapolis 2036

EDITORIALS

What Defeated MD Social Security? 2042
Seat Belts Can Control Death, Injury 2043
Socialized Medicine Fails to Keep Promises 2043
Don't Relax Yet 2044
Interprofessional Strength (Guest Editorial) 2044
Editorial Notes 2045

SPECIAL FEATURES

One of the Finest, E. Vincent Askey, M.D., AMA President 2056
AMA Clinical Meeting, Nov. 28-Dec. 1 2057
First Albert Stump Memorial Lecture: Medicine and the Law: A Socially Necessary Alliance, Robert B. Murphy, Madison, Wisc. 2066
Medicine-At-Law: Decisions and Opinions from "The Citation," American Medical Assn. 2108

REGULAR FEATURES

Month in Washington 1976
Fourth Estate 1984
Journal Medical Essay Contest 2022, 2135
President's Page 2048
Woman's Auxiliary Reports to ISMA 2052
Abstracts, Book Reviews 2118
New Preferred Blue Shield Certificates Made Available to Direct Pay Members (One of a series) 2125
Board of Health Report 2126
Letters to the Editor 2127
News Notes 2128
Eli Lilly Announces Promotion of Four 2129
Wyeth Laboratories Fellowship Applications 2130
Deaths 2132

BUSINESS

County Society and District News 2133
Association News: Executive Committee, September 11, 1960 2134

EDITORIAL AND ADVERTISING INFORMATION

All articles must be typewritten, double-spaced with margins of one inch.

Photographs should be printed on glossy paper. Negatives cannot be used.

Illustrations are desirable. Selection of illustrations submitted at discretion of editor and editorial board members. Cost of color illustrations must be shared by the author.

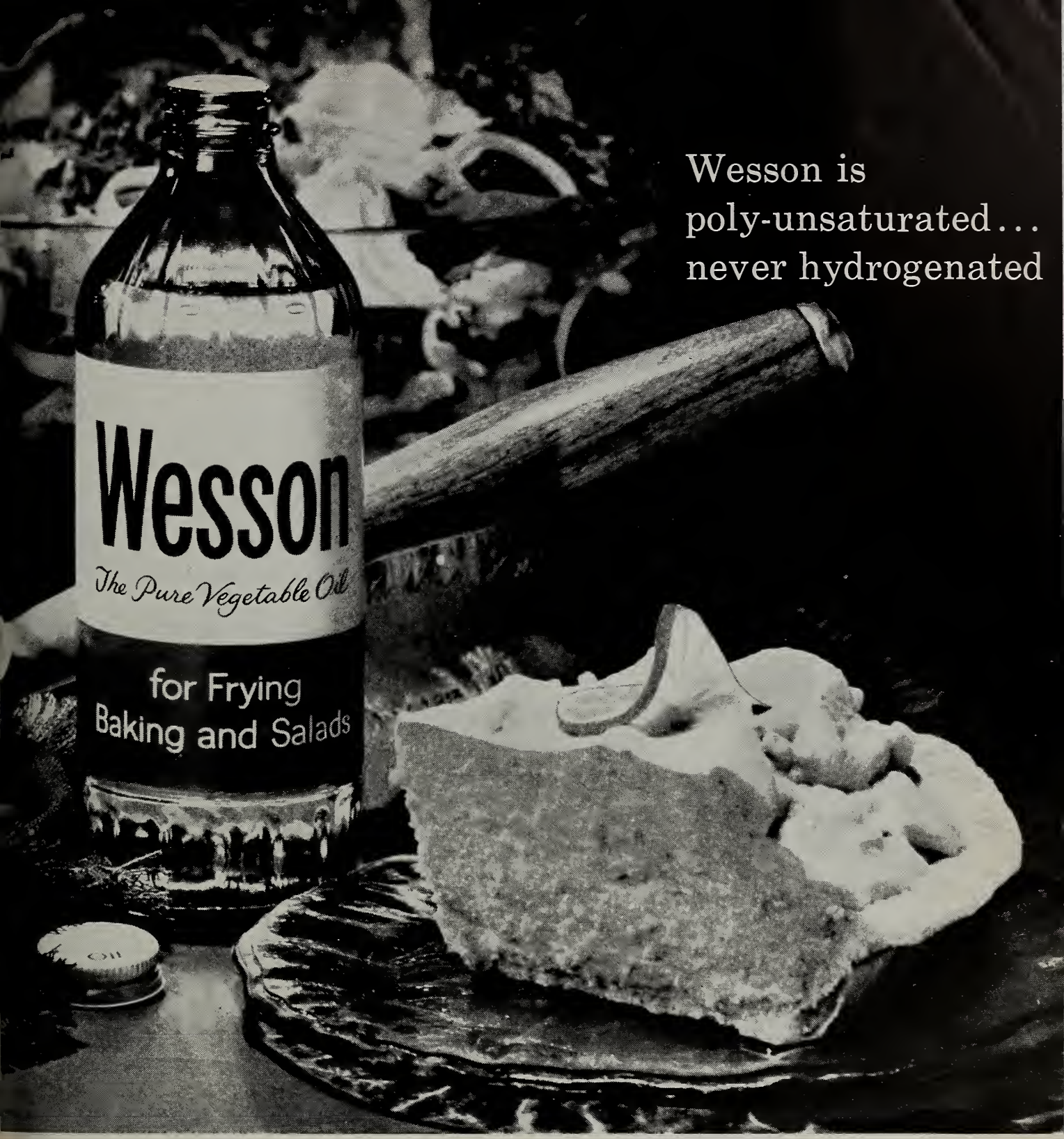
Contributors are responsible for all statements made in their articles. The editors and editorial board members may not be in agreement with all views expressed by authors, but it is desired to give all authors as great latitude as possible. However, the right is reserved to reduce in length or reject any article.

Articles are accepted for publication with the understanding that they are submitted for exclusive publication in THE JOURNAL of the Indiana State Medical Association.

Communications dealing with editorial matter should be sent to Frank B. Ramsey, M.D., Editor, 1802 North Illinois Street, Indianapolis 2, Indiana. All other communications should be sent to THE JOURNAL of the Indiana State Medical Association, 1019 Hume Mansur Building, Indianapolis 4, Indiana.

Advertising rates will be furnished on request. Copy must be received by the 5th of the month preceding month of issue. (Scientific manuscripts must be received at least two weeks earlier if geared for a specific issue.)

Entered as second class matter January 25, 1933, at the Postoffice at Indianapolis, Indiana. Copyright, 1960, by the Indiana State Medical Association. Published monthly at 1019 Hume Mansur Bldg., Indianapolis 4, Indiana.



The majority of housewives prefer Wesson particularly by the criteria of odor, flavor (blandness) and lightness of color. (Substantiated by sales leadership for 59 years and reconfirmed by recent tests against the next leading brand with brand identification removed, among a national probability sample.)

Poly-unsaturated Wesson is unsurpassed by any readily available brand, where a vegetable (salad) oil is medically recommended for a cholesterol depressant regimen.

WESSON'S IMPORTANT CONSTITUENTS

Wesson is 100% cottonseed oil . . . winterized and of selected quality	
Linoleic acid glycerides (poly-unsaturated)	50-55%
Oleic acid glycerides (mono-unsaturated)	16-20%
Total unsaturated	70-75%
Palmitic, stearic and myristic glycerides (saturated)	25-30%
Phytosterol (Predominantly beta sitosterol)	0.3-0.5%
Total tocopherols	0.09-0.12%
Never hydrogenated—completely salt free	

Free Wesson recipes for delicious main dishes, desserts and salad dressings are available for your patients. Request quantity needed from The Wesson People, Dept. N, 210 Baronne St., New Orleans 12, La.



This summary of what is happening in Washington is prepared by AMA's Capital office and airmailed to *The Journal* on the ninth of each month preceding month of issue.

MONTH IN WASHINGTON

Washington, D. C.—Representatives of the medical and health professions, the federal government and national civic groups are cooperating in development of a program for starting the general use of the Sabin live-virus poliomyelitis vaccine next year.

Shortly after clearing the Sabin vaccine for general use, Leroy E. Burney, M.D., Surgeon General of the Public Health Service, asked 23 non-government organizations to designate members to serve on a Surgeon General's Committee on Poliomyelitis Control.

An Agenda Committee met with PHS officials in Atlanta Oct. 11 and 12 and drafted a basic agenda for a meeting of the Control committee in mid-winter. At the Atlanta meeting, preliminary consideration also was given to administrative and technical problems involved in use of the live-virus vaccine developed by Albert B. Sabin, M.D., of Cincinnati.

The Agenda committee was made up of representatives of the American Medical Association, American Academy of General Practice, American Academy of Pediatrics, Association of State and Territorial Health Officers, Children's Bureau and the National Foundation.

The Sabin vaccine is not expected to be available in substantial quantities before mid-1961.

The chief question is whether the vaccine—which is given orally in the form of pills, liquid or candy—will be administered on individual or mass community basis. The PHS special committee that recommended approval of the oral vaccine said that the community basis would be better.

"Because of the unique nature of live poliovirus vaccine, with its capacity to spread the virus in a limited manner to non-vaccinated persons, the committee cannot make recommendations for manufacture without expressing concern about the manner in which it may be used," the special committee said.

RESPONSIBILITY IS SERIOUS

"The seriousness of this responsibility can be illustrated, for example, by the known potentiality of reversion to virulence of live poliovirus vaccine strains, and the possibile importance of this feature in the community if the vaccine is improperly used.

"For example, the vaccine has been employed largely in mass administrations where most of the susceptibles were simultaneously given the vaccine, thus permitting little opportunity for serial human transmis-

inner protection



Tain

(Triacetyloleandomycin, Triaminic® and Calurin®)

to contain the bacteria-prone cold

safe antibiosis

Triacetyloleandomycin, equivalent to oleandomycin 125 mg. This is the URI antibiotic, clinically effective against certain antibiotic-resistant organisms.

fast decongestion

Triaminic®, 25 mg., three active components stop running noses. Relief starts in minutes, lasts for hours.

well-tolerated analgesia

Calurin®, calcium acetylsalicylate carbamide equivalent to aspirin 300 mg. This is the freely-soluble calcium aspirin that minimizes local irritation, chemical erosion, gastric damage. High, fast blood levels.

TAIN brings quick, symptomatic relief of the common cold (malaise, headache, muscular cramps, aches and pains) especially when susceptible organisms are likely to cause secondary infection. Usual adult dose is 2 Inlay-Tabs, q.i.d. In bottles of 50. ℞ only. Remember, to contain the bacteria-prone cold...TAIN.

SMITH-DORSEY · LINCOLN, NEBRASKA

a division of The Wander Company

sion; or, it has been administered during a season of the year when wild strains have usually shown limited capacity for spread. This experience should provide the basis for developing useable practices for the U.S.A."

The special committee also said attention should be given to administration to special groups, such as very young children, pregnant women, and susceptible adults.

"Even more important is the planned continuation of this program as long as necessary to achieve and maintain the required results," the committee said.

The committee was headed by Roderick Murray, M.D., of the National Institutes of Health. Its other members were four M.D.'s and one Ph.D., all of whom were connected with universities except for one M.D. from the PHS's Communicable Disease Center at Atlanta.

ANTICIPATE IT WON'T REPLACE SALK VACCINE

Neither the committee nor Dr. Burney anticipated that the live-virus vaccine would replace the killed-virus Salk vaccine used since April, 1955.

"It appears probable that only a unified national program which utilizes each of the available types of vaccine to its best advantage can accomplish the total prevention of outbreaks," the committee said.

Dr. Julian P. Price of Florence, S. C., Chairman of the AMA's Board of Trustees, predicted the live-virus vaccine "will be one more powerful weapon against an ancient and crippling disease." He said that physicians "have conscientiously pushed immunization with the Salk vaccine and now, with this new vaccine, the profession is hopeful that even better results can be achieved."

STATES PREPARE TO PARTICIPATE IN NEW PROGRAM

Five states were ready soon after the effective date of Oct. 1 to submit plans for participation in the federal-state program of health care for the needy and near-needy aged persons which recently was enacted into law. The states were Arkansas, Michigan, New Mexico, Oklahoma and Washington.

As of early October, another 25 states were preparing to consider legislation to set up such a program or had indicated a willingness to proceed without new legislation. They were Alabama, California, Colorado, Delaware, Florida, Georgia, Hawaii, Idaho, Illinois, Indiana, Kentucky, Louisiana, Massachusetts, Montana, Nevada, New Jersey, North Dakota, North Carolina, Ohio, Pennsylvania, Rhode Island, Utah, West Virginia, Virginia and Wyoming.

Arthur S. Flemming, Secretary of Health, Education and Welfare, urged all states to take part in the program as soon as possible. But he also said he hopes that Congress in the next session will approve a Republican plan for a supplementary federal-state program to help provide private health insurance for elderly persons who cannot meet their medical expenses.

It appears that the issue probably will arise in Congress next year because some Democrats also have said they will again sponsor legislation that would provide health care for aged persons through the Social Security system.

"I'm sending this urine specimen from the patient with pyelitis to the lab. What'll I order while I'm waiting for the findings?"

"I'd use AZOTREX. *The azo dye will give her quick symptomatic relief. The sulfa-tetracycline combination is likely to hit the common urinary pathogens. If she doesn't respond, then switch to something else when you get the sensitivity data."*



Continued

NEW AMA STUDY AND ACTION PROGRAM

The AMA has launched a "comprehensive study and action program" to guide Americans in spending their health-care dollars more wisely.

The AMA's new Commission on Medical Care Costs has set out "to find answers to the many questions being raised about medical care costs and to present the findings frankly and forthrightly to the medical profession and to the public."

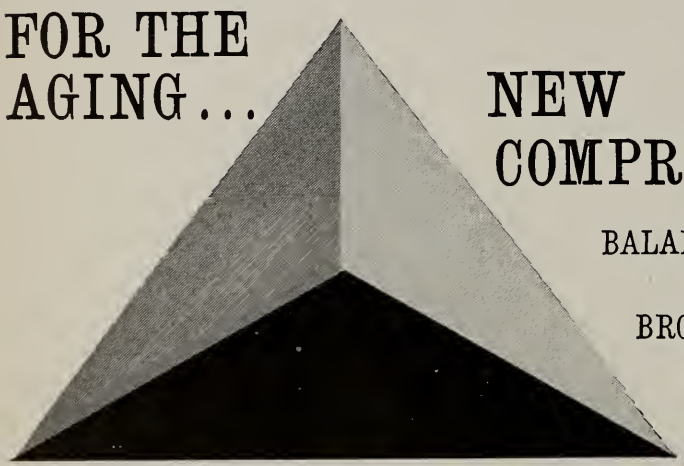
The program is "dedicated to promoting the highest quality health care at the lowest cost." Louis M. Orr, M.D., of Orlando, Fla., chairman of the commission, said that "any barrier that stands in the way of this objective should be removed—immediately."

One of these barriers is money wasted on ineffective non-prescription or over-the-counter drug products, such as vitamins, food fads, and rheumatism and arthritis remedies. AMA's Council on Foods and Nutrition has estimated that much of the estimated $350 million spent annually on self-prescribed vitamins is wasted.

The AMA is urging physicians to alert their patients and the public to the latent dangers involved in self-prescribing and to the folly of throwing their health-care dollars away on quackeries.

On another front in the war against quackery, Food and Drug Commissioner George P. Larrick reported that during the past 12 months the FDA had seized falsely promoted vitamins, minerals and other so-called "health foods" valued in excess of $1.5 million. He said that the amount of misinformation, pseudo-science and plain "hokum" on health care reaching the public through books and magazine articles is increasing. ◄

FOR THE AGING...



NEW COMPREHENSIVE SUPPORT

BALANCED HORMONE SUPPLEMENTATION

▲

BROAD NUTRITIONAL REINFORCEMENT

▲

MOOD ELEVATION

NEW

1 small capsule every morning

GEVRESTIN®

Geriatric Vitamins-Minerals-Hormones-d-Amphetamine Lederle

Each capsule contains: Ethinyl Estradiol 0.01 mg. • Methyl Testosterone 2.5 mg. • d-Amphetamine Sulfate 2.5 mg. • Vitamin A (Acetate) 5,000 U.S.P. Units • Vitamin D 500 U.S.P. Units • Vitamin B_{12} with AUTRINIC® Intrinsic Factor Concentrate 1/15 U.S.P. Unit (Oral) • Thiamine Mononitrate (B_1) 5 mg. • Riboflavin (B_2) 5 mg. • Niacinamide 15 mg. • Pyridoxine HCl (B_6) 0.5 mg. • Calcium Pantothenate 5 mg. • Choline Bitartrate 25 mg. • Inositol 25 mg. • Ascorbic Acid (C) as Calcium Ascorbate 50 mg. • l-Lysine Monohydrochloride 25 mg. • Vitamin E (Tocopherol Acid Succinate) 10 Int. Units • Rutin 12.5 mg. • Ferrous Fumarate (Elemental iron, 10 mg.) 30.4 mg. • Iodine (as KI) 0.1 mg. • Calcium (as $CaHPO_4$) 35 mg. • Phosphorus (as $CaHPO_4$) 27 mg. • Fluorine (as CaF_2) 0.1 mg. • Copper (as CuO) 1 mg. • Potassium (as K_2SO_4) 5 mg. • Manganese (as MnO_2) 1 mg. • Zinc (as ZnO) 0.5 mg. • Magnesium (MgO) 1 mg. • Boron (as $Na_2B_4O_7.10H_2O$) 0.1 mg. Bottles of 100, 1000.

LEDERLE LABORATORIES, a Division of AMERICAN CYANAMID COMPANY, Pearl River, New York Lederle

a broad spectrum non-narcotic analgesic

Trancoprin, a new analgesic, not only raises the pain perception threshold but, through its chlormezanone component, also relaxes skeletal muscle spasm[1-6] and quiets the psyche.[2,3-5,7]

The effectiveness of Trancoprin has been demonstrated clinically[8] in a number of patients with a wide variety of painful disorders ranging from headache, dysmenorrhea and lumbago to arthritis and sciatica. In a series of 862 patients,[8] Trancoprin brought excellent or good relief of pain to 88 per cent of the group. In another series,[9] Trancoprin was administered in an industrial dispensary to 61 patients with headache, bursitis, neuritis or arthritis. The excellent results obtained prompted the prediction that Trancoprin "... will prove a valuable and safe drug for the industrial physician."[9]

Exceptionally Safe

No serious side effects have been encountered with Trancoprin. Of 923 patients treated with Trancoprin, only 22 (2.4 per cent) experienced any side effects.[8,9] In every instance, these reactions, which included temporary gastric distress, weakness or sedation, were mild and easily reversed.

Indications

Trancoprin is recommended for more comprehensive control of the pain complex (pain → tension → spasm) in those disorders in which tension and spasm are complicating factors, such as: headaches, including tension headaches / premenstrual tension and dysmenorrhea / low back pain, sciatica, lumbago / musculoskeletal pain associated with strains or sprains, myositis, fibrositis, bursitis, trauma, disc syndrome and myalgia / arthritis (rheumatoid or hypertrophic) / torticollis / neuralgia.

Dosage

The usual adult dosage is 2 Trancoprin tablets three or four times daily. The dosage for children from 5 to 12 years of age is 1 tablet three or four times daily. Trancoprin is so well tolerated that it may be taken on an empty stomach for quickest effect. The relief of symptoms is apparent in from fifteen to thirty minutes after administration and may last up to six hours or longer.

How Supplied

Each Trancoprin tablet contains 300 mg. (5 grains) of acetylsalicylic acid and 50 mg. of chlormezanone [Trancopal® brand]. Bottles of 100 and 1000.

Trancoprin Tablets / non-narcotic analgesic

References: 1. DeNyse, D. L.: *M. Times* 87:1512, Nov., 1959. 2. Ganz, S. E.: *J. Indiana M. A.* 52:1134, July, 1959. 3. Gruenberg, Friedrich: *Current Therap. Res.* 2:1, Jan., 1960. 4. Kearney, R. D.: *Current Therap. Res.* 2:127, April, 1960. 5. Lichtman, A. L.: *Kentucky Acad. Gen. Pract. J.* 4:28, Oct., 1958. 6. Mullin, W. G., and Epifano, Leonard: *Am. Pract. & Digest Treat.* 10:1743, Oct., 1959. 7. Shanaphy, J. F.: *Current Therap. Res.* 1:59, Oct., 1959. 8. Collective Study, Department of Medical Research, Winthrop Laboratories. 9. Hergesheimer, L. H.: An evaluation of a muscle relaxant (Trancopal) alone and with aspirin (Trancoprin) in an industrial medical practice, to be submitted.

Winthrop LABORATORIES, New York 18, N. Y.

Trancoprin and Trancopal (brand of chlormezanone) trademarks reg. U.S. Pat. Off.



LOOKS AT MEDICINE

This section of THE JOURNAL is devoted to the presentation of opinions which appear on the editorial pages of the public press, and which are of interest to the medical profession. Its function is to review comments which may be favorable or unfavorable to medicine. Members are invited to submit editorial clippings for this column.

Charity is a Dirty Word

In the days of our childhood there were three things to abide in men forever, and the greatest of these was charity.

For charity, in those days, meant a divine love for man, the benevolence of all men of good will toward their brothers. It was kind. It envied not. It vaunted not itself. It was not puffed up. It was not gained simply by bestowing all one's goods to feed the poor, because it was a thing of the heart without which man was nothing.

So it was a word such men as Thomas Jefferson could use with dignity, deeming it the duty of each man by himself and all men joined together to show it toward their neighbors. It was an honorable word with which to bespeak the responsibility of the whole community for those among it who were old, sick or otherwise unfortunate.

But not any longer. First the word itself lost its meaning, and those who would translate the message of St. Paul were constrained to speak only of love, a word of so many meanings as to have no meaning at all.

And now finally charity has become a dirty word. In newspaper advertisements all across the land, paid from the rich coffers of the AFL-CIO, the word is spat out: Is medical care to be available for the needy as a handout—as public charity? It is a word from which good men shy as they arise to speak on the floor of the United States Senate.

There they have been speaking about a simple objective, to see that no old person goes without proper medical care because he lacks the means to provide it for himself. The question is, how?

Now this problem, be it noted, is only how to care for a small minority; among the blessings Providence has bestowed on this country is that those among us who are needy are the few, not the many. So it would not be too costly or too difficult to set up a system—even one run by the federal government, if that is insisted upon—under which those in need might have a formal and orderly way to receive aid from the whole community.

But to set a standard of need, we are told, would be public charity, and charity is an evil thing. It demeans a man to have to state that he is in need. So to care for this minority some people tell us we must put the medical care of every old person, fortunate and unfortunate alike, in the hands of the federal government.

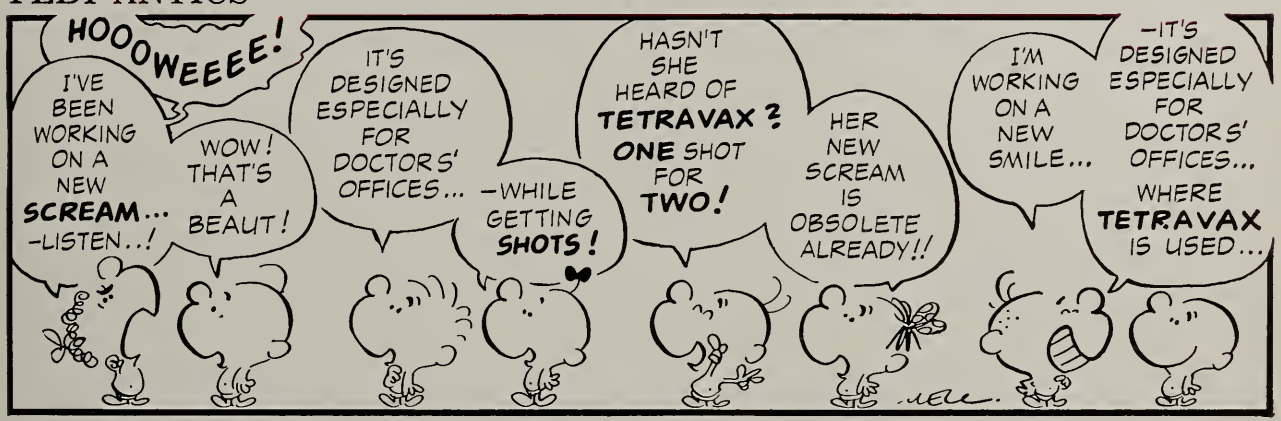
Well, it's true that men of pride and dignity do not welcome a situation in which they must turn to others for succor. Indeed, it is the desire not to be "beholden" that makes free men labor and save to provide for themselves and their own. But surely it is not "demeaning" for a man struck down by what he cannot help, to be helped by his fellow human beings. There is no shame for the blind in being led by those who can see.

What is truly demeaning is for the hale man, the free and self-reliant man, to be beholden to the federal government for his food or his shelter or his care in sickness. For then he lives not by the charity of his fellow men in his

FOR SIMULTANEOUS IMMUNIZATION AGAINST 4 DISEASES:

Poliomyelitis-Diphtheria-Pertussis-Tetanus

PEDI-ANTICS



TETRAVAX®

DIPHTHERIA AND TETANUS TOXOIDS WITH PERTUSSIS AND POLIOMYELITIS VACCINES

now you can immunize against more *diseases...with* fewer *injections*

Dose: 1 cc.
Supplied: 9 cc. vials in *clear plastic* cartons. Package circular and material in vial can be examined without damaging carton. Expiration date is on vial for checking even if carton is discarded.



For additional information, write Professional Services, Merck Sharp & Dohme, West Point, Pa.

TETRAVAX IS A TRADEMARK OF MERCK & CO., INC.

MERCK SHARP & DOHME, DIVISION OF MERCK & CO., INC., PHILADELPHIA 1, PA.

distress but simply by taking from them. It is thus that men of good will are shamed.

Yet that is precisely what is proposed by those who treat charity as a dirty word. If all they really sought were succor for the unfortunate, charity would provide it. What they really seek is not succor for the needy, but a way to put all men upon the same level. If they can achieve a system where the government provides all men with their needs, then no man shall have more than another. We will all, in time, take what government provides.

We do not know the word for this new spirit. But whatever it is, it has no kindness. It rests on envy and it vaunts itself, puffed up in the belief that it can do for all men better than all men can do for themselves. It is the same spirit that already walks across wide areas of the world, where men are but numbers to be fed, clothed and nursed for other purposes than humanity. Whatever it calls itself, it is not a thing of the heart.

And we are so old-fashioned as to wonder, if charity is to be lost to this new spirit, then how long there will abide faith in every man's dignity and the hope that here we will preserve it?

Wall Street Journal
Aug. 24, 1960

The Aging and the Aged

The Senate Subcommittee on the Problems of the Aged and the Aging is busy right now taking testimony on the Forand bill and other measures that would provide free medical care for people over 65.

The issue is the political phenomenon of 1960. The idea of increasing Social Security taxes has been introduced by Rep. Forand two or three times before, and it has always died in committee or elsewhere because of a lack of backers. But this year is different; this is an election year and those who seek the votes they think are found in this appeal to elderly people are pressing the issue hard.

And those, like spokesmen for the Administration, who are opposed to compulsory increase

Continued on page 1990

Annual Clinical Conference

CHICAGO MEDICAL SOCIETY

FEBRUARY 28, MARCH 1, 2 and 3, 1961

Palmer House, Chicago

Daily Half-Hour Lectures by Outstanding Teachers and Speakers on subjects of interest to both general practitioner and specialist.

Panels on Timely Topics
Medical Color Telecasts
Teaching Demonstrations
Instructional Courses

Scientific Exhibits worthy of real study and helpful and time-saving Technical Exhibits.

The Chicago Medical Society Annual Clinical Conference should be a MUST on the calendar of every physician. Plan now to attend and make your reservations at the Palmer House.

-pain due to or associated with -spasm of skeletal muscle

a new muscle relaxant-analgesic

Robaxisal®

ROBAXIN® WITH ASPIRIN

Many conditions, painful in themselves, often give rise to spasm of skeletal muscles. ROBAXISAL, the new dual-acting muscle relaxant-analgesic, treats both the pain and the spasm with marked success: In clinical studies on 311 patients, 12 investigators[1] reported satisfactory results in 86.5%. Each ROBAXISAL Tablet contains:

- A relaxant component—Robaxin*—widely recognized for its prompt, long-lasting relief of painful skeletal muscle spasm, with unusual freedom from undesired side effects.....400 mg.

*Methocarbamol Robins U.S. Pat. No. 2770649

- An analgesic component—aspirin—whose pain relieving effect is markedly enhanced by Robaxin, and which has added value as an anti-inflammatory and anti-rheumatic agent.... (5 gr.) 325 mg.

SUPPLY: ROBAXISAL Tablets (pink-and-white, laminated) in bottles of 100 and 500.

Also available: ROBAXIN Injectable, 1.0 Gm. in 10-cc. ampul; ROBAXIN Tablets, 0.5 Gm. (white, scored) in bottles of 50 and 500.

...or when anxiety accompanies pain and spasm: **ROBAXISAL®-PH** (Robaxin® with Phenaphen®). Sedative-enhanced analgesic and skeletal muscle relaxant. Each two white-and-green laminated ROBAXISAL-PH tablets contain: methocarbamol 800 mg., plus the equivalent of one Phenaphen capsule (phenacetin 194 mg., acetylsalicylic acid 162 mg., hyoscyamine sulfate 0.031 mg., and ¼ gr. phenobarbital 16.2 mg.). Bottles of 100 and 500.

[1]Clinical reports in files of A. H. Robins Co., Inc., from: J. Allen, Madison, Wisc., B. Billow, New York, N. Y., B. Decker, Richmond, Va., C. Freeman, Jr., Augusta, Ga., R. B. Gerdon, New York, N. Y., J. E. Holmblad, Schenectady, N. Y., L. Levy, New York, N. Y., N. LoBue, Chicago Heights, Ill., H. Nachman, Richmond, Va., A. Poindexter, Los Angeles, Cal., E. Rogers, Brooklyn, N. Y., K. H. Strong, Fairfield, Ia.

Additional information available upon request.

A. H. ROBINS CO., INC., Richmond 20, Virginia

Making today's medicines with integrity . . . seeking tomorrow's with persistence

FOURTH ESTATE

Continued from page 1986

in taxes find the going increasingly difficult. By its very nature, the proposal to care for elderly people marks those who oppose it on grounds that it is an unwarranted and unnecessary growth of Federal responsibility and power as coldhearted, unsympathetic people.

Yet there is sound reason to question the idea of Federal responsibility on grounds of morality and justice. Who, one may fairly ask, in the context of a society taught to honor one's mother and father has first responsibilty for the aged if not the sons and daughters? Who next, if not the community—or neighbors, the village, the town, the city, the state? These are the people and the institutions that have the first moral responsibility.

So far as justice is concerned, it would be well for the Senators on the subcommittee to remember, too, that while they are concerned with the problems of the aged they are also concerned with the problems of the aging.

All of us, whether 65 or 16, are among the aging. And it is the aging rather than the aged who will carry the burden of this load from the day they begin to work until the time comes for the federal government to guarantee their medical aid. As Dr. Dickinson, the American Medical Association's chief of medical economic research, points out, "A man of 50 will pay into Social Security for only 15 years, (but) his son for 40." The youth who begins his life's work at age 20 will pay for 45 years.

Those who consider this an unjust exploitation of the nation's youth can well ask the elderly people who have been persuaded to join the clamor for federal aid whether their demands are as unselfish as they will be burdensome on those who follow them.

And the politicians, too, who see in this issue not really the problem of the aged or the injustice to the younger but only votes, might do well to pause.

For once the aging voter realizes upon whose backs the full burden of this vote-getting scheme will be placed, the votes might fall into a different pattern than they think. Even on the crassest level of wardheel politics, politicians know there are vastly more aging voters than aged.

Wall Street Journal
April 4, 1960

A Better Chance to Survive

Don't get excited about it, but Army researchers in nuclear medicine believe they are on the track of something that would enable man to survive in twice the radiation he could take today in an H-bomb attack.

These researchers believe they will have pills making this possible. One dose of the pills would give this 50% protection for at least five hours. The pills would be made of cheap chemicals, therefore could be made in huge quantities and within everyone's price reach.

Dr. David Jacobus and Dr. Michael Dacquisto, working on this project at Walter Reed Hospital in Washington, talk cautiously. They say there's "a reasonable chance" they'll have the anti-radiation pills by mid-1962.

One reason for the optimism among these Army research men is this:

Crude forerunners of the radiation-protection medicine already are being used cautiously in at least one Army hospital to reduce the destruction of good flesh, in some cases, that normally takes place when radiation is used on a man or woman to destroy cancer.

It is then already theoretically possible to pour in heavier doses of radiation to more effectively kill the cancers without causing too much destruction of good tissues.

What's the secret of these new chemicals?

Scientists have known for 10 years that some sulfur-containing chemicals given to mice would double their ability to live through heavy radiation. But these chemicals were poisonous. Give enough to a man to survive atomic radiation attack and the chemicals would kill him.

A few years ago, Dr. Jacobus discovered that if he took a little of one chemical, a little of another and perhaps a little of a third—each poisonous in itself—you would get the same radiation protection with less of a poisonous effect . A large animal, like a dog, would get sick but it wouldn't die. That was the first major breakthrough.

Then the medical men went on a widespread search for less toxic chemicals. Chemists throughout the U. S. were urged to make synthetic chemicals with certain theoretical structures, and to turn in any other new chemicals that seemed to have anti-radiation qualities. The Army men received 600 likely prospects. They've tested 300, found half promising.

Continued



in infectious disease[17,22,30,36]
in arthritis[18,19,20,29]
in hepatic disease[2,3,4,5,38]
in malabsorption syndrome[1,2,6,27]
in degenerative disease[6,7,19,20,40]
in cardiac disease[23,26,29,38,41]
in dermatitis[24,39]
in peptic ulcer[6,21,38]
in neuroses & psychiatric disorders[25,26]
in diabetes mellitus[31,32,33,38]
in alcoholism[9,11,35,37,38]
in ulcerative colitis[10,14,16]
in osteoporosis[13,19,20]
in pancreatitis[15]
in female climacteric[12,34]

Patients with chronic disease deserve the nutritional support provided by

Theragran-M

Squibb Vitamin-Minerals for Therapy

11 vitamins, 8 minerals clinically-formulated and potency protected to provide

enough nutritional support to do some good

with vitamins only

Theragran
also available:

Theragran Liquid
Theragran Junior

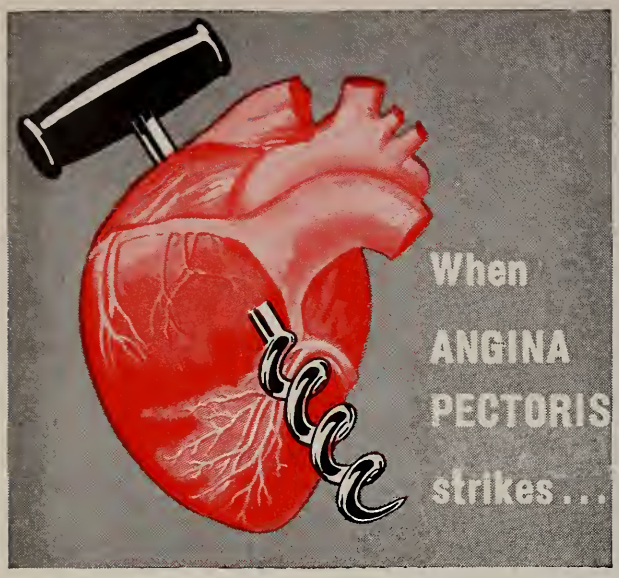
Theragran products do not contain folic acid.

1-41 a list of the above references will be supplied on request.

SQUIBB

'THERACRAN'® IS A SQUIBB TRADEMARK

Squibb Quality—the Priceless Ingredient



prescribe

NIPHYLLINE

the unique specific

This exclusive development is neutral in action, and ***specific in prophylaxis and treatment of angina pectoris.*** It is effective orally in about thirty minutes, for periods of 7 to 8 hours . . . and, even when given routinely, does not cause nausea or gastric upset. Niphylline is an efficient vasodilator and diuretic combining the effectiveness of Neothylline (soluble, neutral, stable derivative of theophylline) and pentaerythritol tetranitrate, substantially more effective than mannitol hexanitrate. Thus, the patient receives the benefits of both drugs without any annoying side effects.

Niphylline is safe, and well tolerated . . . exerts strengthening effect on heart muscles, and acts synergistically, remarkably reducing severity and frequency of cardiac attacks.

Indications: Relief and control of angina pectoris, cardiovascular symptoms, asthenia, coronary spasm with myocardial pain, prophylaxis and treatment of left ventricular insufficiency, cardiac dyspnea and oliguresis.

Dosage: One or two tablets, 3 or 4 times daily, or as directed by physician.

Supplied: Bottles of 100 and 1000 tablets.

Each tablet contains: Pentaerythritol tetranitrate, 10 mg., and Neothylline (dihydroxypropyl theophylline), 100 mg.

PM **PAUL MANEY**
LABORATORIES, INC.
Cedar Rapids, Iowa

FOURTH ESTATE

Continued

Ten look extremely good. They seem to have more than double the usual radiation protection. They seem a lot less toxic.

The researchers would like to find chemicals that are not toxic at all. But they figure it's better to make a man sick than to let him die.

Preliminary tests with the 10 chemicals on mice and dogs look good. After further work with dogs, the Army men will try the "new 10" on men in a limited way this fall.

Dr. Jacobus has another idea. He and his colleagues now know that some chemicals with little apparent anti-radiation power in themselves do have the power to help other chemicals do a better job.

The nuclear medical men are going to test the effects of chemical mixtures including these activators.

So in the end they expect to have "pills" containing from three to five chemicals which last for five hours that will almost double your natural resistance to radiation.

When they say "double your protection," they mean you will be able to live through twice the amount of radiation that would ordinarily kill you, and stay well under twice the amount of radiation that would ordinarily make you sick.

But if such pills do become available, you would still need fallout shelters. The fallout in major bombing areas, in case of an attack, would still be deadly unless you went to a shelter. What the pills would do would give you life-saving time to get to a shelter. They would also—theoretically—allow you to emerge from your shelter for emergencies with less danger.

Medical people always caution the public against expecting too much from research, and rightly so. But in this case, the news that there is a possibility that pills of this kind can be developed and made widely available, is news of the highest interest.

Kokomo Tribune
Aug. 28, 1960

Care That's Really Free

It hasn't been planned that way, but Congress is debating several "free" hospital and health care schemes at a time when the nation is observing National Hospital Week, May 8 through 14.

Perhaps this is the time to evaluate the honest



SALUTENSIN™

Hydroflumethiazide • Reserpine • Protoveratrine A

An integrated multi-therapeutic antihypertensive, that combines in balanced proportions three clinically proven antihypertensives.

In each **SALUTENSIN** Tablet:

Saluron® (hydroflumethiazide)— a saluretic-antihypertensive	50 mg.
Reserpine—a tranquilizing drug with peripheral vasorelaxant effects	0.125 mg.
Protoveratrine A—a centrally mediated vasorelaxant	0.2 mg.

Comprehensive information on dosage and precautions in official package circular or available on request.

BRISTOL LABORATORIES • Syracuse, New York

merit of these "free" plans of government-directed medicine against the record of charitable health care which Americans have received and will continue receiving. A good example of what has been done through private hospitals and the medical profession is the National Jewish Hospital at Denver. For more than 61 years, this medical institution has given treatment to old folks, young folks, middle-aged folks—people of all ages—who are unable to pay. The motto is, "None may enter who can pay . . . none can pay who enter."

The "free" government plans limit care according to age and they deny treatment to those whose income happens to be above a politically computed minimum.

There are hundreds of hospitals all over the United States rendering service to needy people of all ages without levying a charge in the form of a general social security tax. There are thousands of members of the medical profession who offer their time and talent in the same service.

This is medical care that is genuinely free. This is the story that should be told to America instead of the propaganda being pushed by the socialists of both parties, in and out of government, who can hardly wait to install socialized medicine.

Indianapolis Star
May 10, 1960

Good Example May Cut Deaths

Why is it that so many of us hold life so cheap? Last year 91,500 of us were killed by accident in the continental United States. Of these fatalities, 37,500 were vehicular, 13,000 were industrial and 27,000 occurred in the home.

Add to these the uncounted number of non-fatal accidents that must have occurred to each one in which there was actual loss of life, and you get some idea of the dreadful toll of what is, in a great part, a careless and thoughtless disregard for the sanctity of human life. A disregard of "the reverence for life," to use the words of Dr. Albert Schweitzer.

Even more appalling is the loss of life due to deliberate self-destruction. Addressing the National Association for Mental Health recently, Dr. Joseph Hirsh placed at 50 to 60 thousand the number of Americans who die by suicide each year.

He expressed the opinion that, for each successful suicide effort, there were no fewer than five, and perhaps as many as 60, unsuccessful tries.

Although many public agencies address themselves to the humanitarian task of reducing the numbers of these accidental and suicidal deaths, individual efforts score greater accomplishments.

In all probability, the boy whose father is a careful driver is apt to follow the example he's become familiar with all of his life.

The girl whose mother is an orderly housewife is apt to run her own home in an equally orderly fashion.

And the recently employed worker is apt to heed the safety regulations of his shop or industry if he sees these regulations honored by his seniors.

Much, too, can be done to prevent suicide attempts. In Dr. Hirsh's study, he noted an increase incidence of attempts at self-destruction on dull days in the fall and winter, during prolonged hot spells in the summer and following recent marital separation or divorce.

The incidence was also notably higher in persons who lacked any formal religious affiliation.

Alerted by these observations and recognizing the emotional affects of purely personal conditionings, the considerate friend, relative, clergyman or physician may provide just the right word, deed or counsel to tide the depressed person over a period of climax.

Surely we who dwell in this free and prosperous land cannot look with indifference on an annual holocaust of 150,000 or more accidental and suicidal deaths.

Kokomo Tribune
Aug. 23, 1960

Do-It-Yourself Health Program

A great deal of attention is being given to the health problems of the growing elderly proportion of our population. Out of this, it is to be hoped, will come programs and policies that will meet the needs without imposing on us the costly regimentation that some proposed legislation would make inevitable.

One point deserves to be much more widely understood than it is—the problems involved are not, by any means, confined to medical care,

Continued on page 2000

as it calms anxiety!

Smooth, balanced action lifts depression as it calms anxiety... rapidly and safely

Balances the mood — no "seesaw" effect of amphetamine-barbiturates and energizers. While amphetamines and energizers may stimulate the patient —*they often aggravate anxiety and tension.*

And although amphetamine-barbiturate combinations may counteract excessive stimulation—*they often deepen depression.*

In contrast to such "seesaw" effects, Deprol's smooth, *balanced* action lifts depression as it calms anxiety—both at the same time.

Acts swiftly — the patient often feels better, sleeps better, within a few days. Unlike the delayed action of most other antidepressant drugs, which may take two to six weeks to bring results, Deprol relieves the patient quickly — often within a few days. Thus, the expense to the patient of long-term drug therapy can be avoided.

Acts safely — no danger of liver damage. Deprol does not produce liver damage, hypotension, psychotic reactions or changes in sexual function—frequently reported with other antidepressant drugs.

Bibliography *(13 clinical studies, 858 patients)*: **1.** Alexander, L. (35 patients): Chemotherapy of depression – Use of meprobomote combined with benoctyzine (2-diethylaminoethyl benzilate) hydrochloride. J.A.M.A. *166*:1019, March 1, 1958. **2.** Bateman, J. C. ond Carlton, H. N. (50 patients): Meprobamote and benactyzine hydrochloride (Deprol) as adjunctive theropy for patients with advanced cancer. Antibiotic Med. & Clin. Therapy 6:648, Nov. 1959. **3.** Beerman, H. M. (44 patients): The treatment of depression with meprobamate and benactyzine hydrochloride. Western Med. *1*:10, March 1960. **4.** Bell, J. L., Tauber, H., Santy, A. and Pulito, F. (77 patients): Treatment of depressive states in office practice. Dis. Nerv. System 20:263, June 1959. **5.** Breitner, C. (31 patients): On mental depressions. Dis. Nerv. System 20:142, (Section Two), May 1959. **6.** Gordon, P. E. (50 patients): Deprol in the treatment of depression. Dis. Nerv. System *21*:215, April 1960. **7.** Landman, M. E. (50 patients): Clinical trial of a new antidepressive agent. J. M. Soc. New Jersey. In press, 1960. **8.** McClure, C. W., Popas, P. N., Speare, G. S., Palmer, E., Slattery, J. J., Konefol, S. H., Henken, B. S., Wood, C. A. and Ceresio, G. B. (128 patients): Treatment of depression – New technics and therapy. Am. Pract. & Digest Treat. *10*:1525, Sept. 1959. **9.** Pennington, V. M. (135 patients): Meprobamate-benactyzine (Deprol) in the treatment of chronic brain syndrome, schizophrenia and senility. J. Am. Geriatrics Soc. 7:656, Aug. 1959. **10.** Rickels, K. and Ewing, J. H. (35 patients): Deprol in depressive conditions. Dis. Nerv. System 20:364, (Section One), Aug. 1959. **11.** Ruchwarger, A. (87 patients): Use of Deprol (meprobamate combined with benactyzine hydrochloride) in the office treatment of depression. M. Ann. District of Columbia 28:438, Aug. 1959. **12.** Settel, E. (52 patients): Treatment of depression in the elderly with o meprobamate-benactyzine hydrochloride combination. Antibiotic Med. & Clin. Therapy 7:28, Jan. 1960. **13.** Splitter, S. R. (84 patients): Treatment of the onxious patient in general practice. J. Clin. & Exper. Psychopoth. In press, April-June 1960.

Dosage: Usual starting dose is 1 tablet q.i.d. When necessary, this dose may be gradually increased up to 3 tablets q.i.d.

Composition: 1 mg. 2-diethylaminoethyl benzilate hydrochloride (benactyzine HCl) and 400 mg. meprobamate. **Supplied:** Bottles of 50 light-pink, scored tablets. Write for literature and samples.

Deprol®

WALLACE LABORATORIES / *Cranbury, N. J.*

CD-2843

FOURTH ESTATE

Continued from page 1994

and hospital and nursing home service. Dr. Edward L. Bortz, a past president of the American Medical Association, has made that clear. As he puts it, major afflictions of older citizens today can be traced to faulty diet, flabby bodies, excessive fatigue and aimless living. He adds, a do-it-yourself health program designed to cure or alleviate these afflictions can be the greatest insurance policy for a longer, healthier life.

In his words, our society is "immature and youth-oriented." So this is the time to cease "worshipping the glamor and romance of youth" and concentrate on the contributions that the mature older citizen makes to our society.

One of the most urgent needs is to abandon the custom of compulsory retirement at age 65 or any arbitrary figure. Great numbers of people now attain their period of top performance at 65 or older. To consign them to the ranks of the idle is to do them a grave injustice—and to deprive the nation of energies, abilities, and experience it can use to vast advantage.

Muncie Press
July 20, 1960

To Prevent Accidents

Thanks to the automobile safety-check programs now being made in Kokomo and all over the United States, the public will be alerted to the fact that such programs are going on and thousands of defects in cars will be discovered.

Correction of these defects can and will result in the prevention of many accidents, and hence the program here and those in the thousands of communities over the nation will be well worth while.

Check lanes were set up in Kokomo Monday and will be maintained at different locations through June 4. City police are being assisted in making the checks by members of the Howard County Civil Defense auxiliary police unit.

These inspections should not be regarded by motorists as something to avoid, but rather as an opportunity for car and truck owners to have a free check-up. Stickers are being issued to all motorists whose vehicles pass the 10-point inspection, and they can be affixed on the windshield with pride.

An idea of how important such inspections are can be gained from Police Chief Luellen's statement that one out of every eight vehicles



checked in Indiana last year had defects. The cars that showed something wrong were truly vehicles "enroute to an accident."

Cooperating in the program is the department of Howard County Sheriff Tom Leap, who has check lanes at points throughout the county. In the state, the program is being conducted by the Indiana Office of Traffic Safety, the Indiana Sheriffs Assn., the Indiana Assn. of Police Chiefs, the Automobile Dealers of Indiana, and the Indiana State Police.

Let's cooperate with it cheerfully.

Kokomo Tribune
May 5, 1960

Let's Keep It Voluntary

The Forand bill has been bottled up, at least for a time, in the House Ways and Means Committee in Washington. This is the bill introduced by a Rhode Island congressman which would amend the Social Security Act to provide 120 days a year of medical care for retired people over 65.

The bill calls for hospitalization up to 60 days, time in nursing homes, drugs and surgical fees. It would be financed by raising the Social Security Tax (now set at a maximum of $144 a year from each employe and another $144 a year from each employer), another one-half of one percent, or a maximum of $24 more a year from each employe and another $24 a year from each employer.

The bill is endorsed by a number of politicians, the AFL-CIO and similar groups and some other organizations. It is opposed by the American Medical Assn., private health insurance groups, the National Chamber of Commerce and others.

Those favoring the bill point out that more medical and hospital care is needed as people grow older, but that large numbers of people in their retired years must depend on relatively small social security and other pensions to meet these costs as well as to live.

Those against the Forand bill see it as the opening wedge in a drive for "socialized medicine," with all its implications of bureaucracy and red tape. They cite many types of care available to aging persons already, and cite statistics proving health insurance coverage for persons over 65 has mushroomed in the last few years.

* * *

As of Jan. 1, 1960, according to the Health

push-button control in

skin inflammation, itching, allergy



PANTHO-FOAM

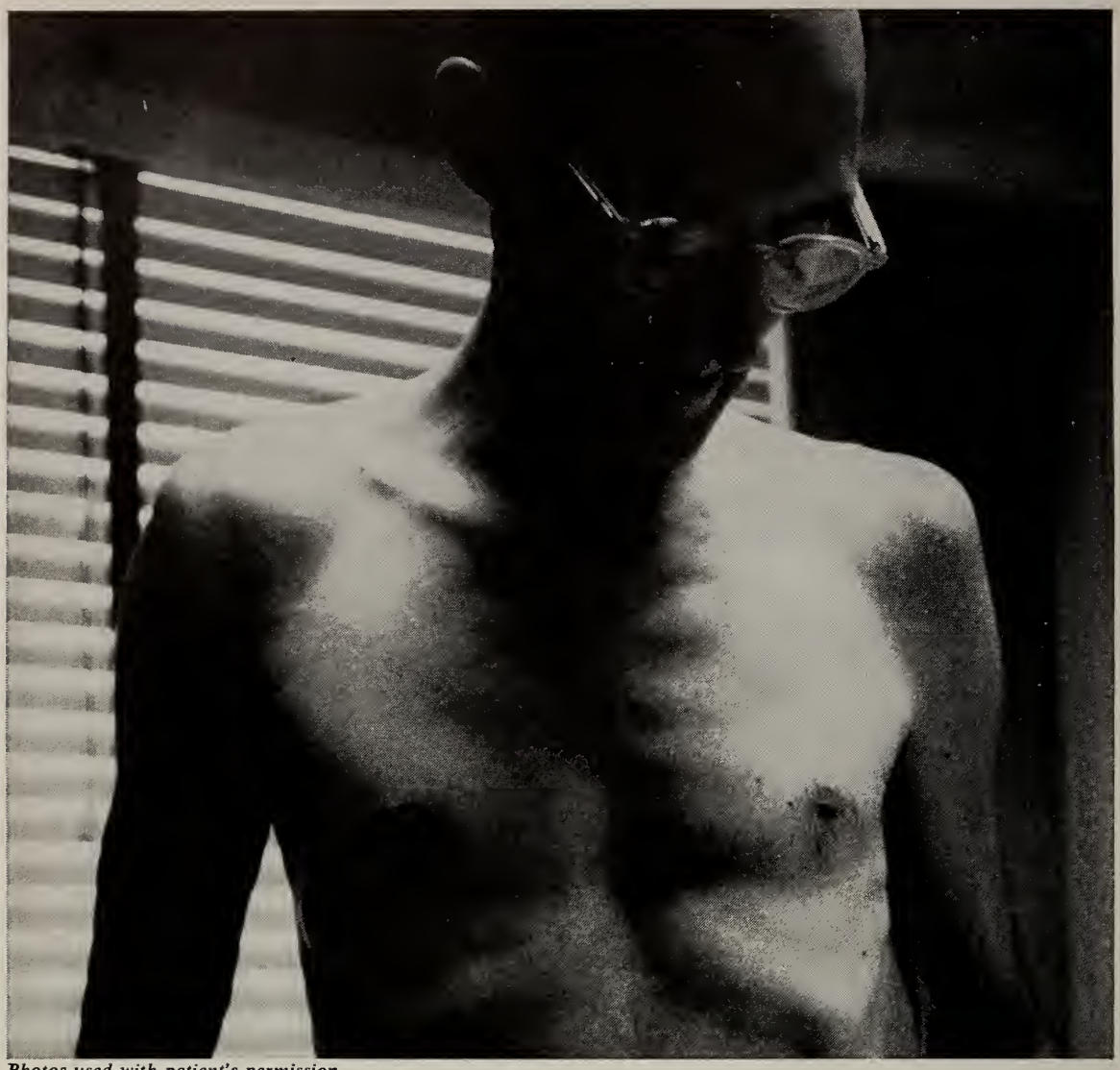
This non-occlusive foam lets the skin "breathe" as it "puts out the fire" of inflammation — unlike ordinary ointments.

Applied directly on affected area, **pantho-Foam** is today's non-traumatizing way to provide prompt relief and healing in . . .

burns
eczemas (infantile, lichenified, etc.)
dermatitis (atopic, contact, eczematoid)
neurodermatitis
pruritus ani et vulvae
stasis dermatitis

supplied: aerosol container of 2 oz.

u. s. vitamin & pharmaceutical corp.
Arlington-Funk Laboratories, division • 250 East 43rd Street, New York 17, N. Y.

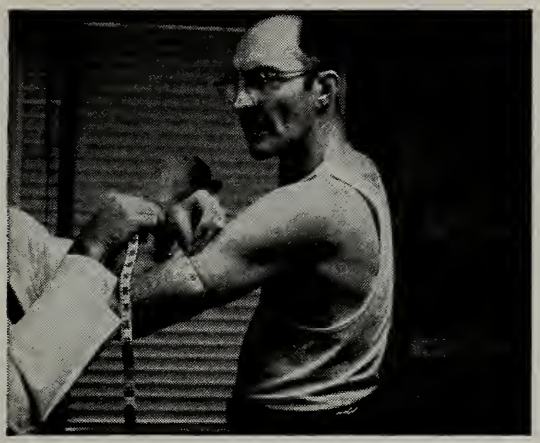


Photos used with patient's permission.

How new **Dianabol** rebuilt muscle tissue in this underweight, debilitated patient

Patient was weak and emaciated before Dianabol. R. C., age 51, weighed 160 pounds following surgery to close a perforated duodenal ulcer. His convalescence was slow and stormy, complicated by pneumonia of both lower lobes. Weak and washed out, he was considered a poor risk for further necessary surgery (cholecystectomy). Because a conventional low-fat diet and multiple-vitamin therapy failed to build up R. C. sufficiently, his physician prescribed Dianabol 5 mg. b.i.d.

Patient regains strength on Dianabol. In just two weeks R. C.'s appetite increased substantially; he had gained 9½ pounds of lean weight. His muscle tone was improved, he felt much stronger. After 4 weeks, he weighed 176 pounds. Biceps measurement increased from 10″ to 11½″. For the first time since onset of postoperative pneumonia, his chest was clear. Mr. C.'s physician reports: "He tolerated cholecystectomy very well and one week postop felt better than he has in the past 2 years."



Dianabol: new, low-cost anabolic agent

By promoting protein anabolism, Dianabol builds lean tissue and restores vigor in underweight, debilitated, and dispirited patients. In patients with osteoporosis Dianabol often relieves pain and increases mobility.

As an anabolic agent, Dianabol has been proved 10 times as effective as methyltestosterone. Yet it has far less androgenicity than testosterone propionate, methyltestosterone, or norethandrolone.

Because Dianabol is an oral preparation, it spares patients the inconvenience and discomfort of parenteral drugs.

And because Dianabol is low in cost, it is particularly suitable for the aged or chronically ill patient who may require long-term anabolic therapy.

Supplied: *Tablets,* 5 mg. (pink, scored); bottles of 100.

Complete information sent on request.

Dianabol®
(methandrostenolone CIBA)

converts protein to working weight in wasting or debilitated patients

8/2829MD

CIBA
SUMMIT, NEW JERSEY

Continued

Insurance Institute, 49% of all Americans 65 and older had health insurance protection, or about 7,700,000 out of 15,700,000 persons in this age group. This is coverage of about one out of every two in this age group, compared to one out of four covered in 1952. By 1970, they estimate that 90% of those who need and want health insurance will have it in this age group through private plans.

Opponents of the Forand bill also feel it is unfair to the great majority of Americans to force them to contribute, through social security payments by employer and employe, to the cost of caring for ailments of the older citizens, some of whom are able to take care of themselves through voluntary plans. The bill would encourage hospitalization, rather than treatment at home or in physicians' offices, they feel.

At the same time, this is a potent political issue, as we pointed out several months ago. Thanks to the advances of modern medicine, American life expectancy is rising, more people are living beyond the age of retirement and consequently they are able to form a voting "interest group" in our society. Both parties recognize the situation as a real issue.

While disagreeing with the Forand approach, many politicians still wish to be on record as doing something to meet the issue. Sen. Jacob Javits, (R-NY), for instance, is working up a plan to combine federal and state subsidies with voluntary contributions from the income of the aged themselves, to handle insurance programs issued through both non-profit and commercial hospitalization and medical care insurance companies. The states would have to put up some money before the plan would take effect.

Examining both these approaches, such a conservative publication as *Business Week* magazine throws up its hands at the problem of putting through such a plan as proposed by Sen. Javits.

"The problem basically is that the aged are high-cost, high-risk, low-income customers," states *Business Week* in a recent editorial. "Their health needs can be met only by themselves when they are young, or by other younger people who are still working. The only way to handle their health problem, therefore, is to spread the risks and costs widely. And that can best be done

through the Social Security System to which employers and employes contribute regularly. By comparison with the heavily subsidized schemes, this approach has the advantage of keeping old people from feeling that they are beggars living off society's handouts."

That may be the only answer. Yet it must be remembered that once the state enters into a field such as medical care, the individual automatically surrenders some of his liberty, his freedom of action.

We earnestly hope that Congress will bend every effort to solving this problem in a manner that allows the voluntary, freedom-of-choice, features of our way of life to remain.

Hammond Times
May 6, 1960

Little Sir Echo

Secretary of Health, Education and Welfare Arthur S. Flemming has presented the Eisenhower administration plan for step-by-step socialized medicine. He has offered to Congress and the American people a compound of political opportunism, fiscal irresponsibility and centralized government.

This plan is said to be the administration answer to Democratic proposals to increase social security taxes and add hospital care to payments now made to America's older citizens. It isn't an answer, it's an echo. The voice may be that of a Republican Cabinet officer, but the words and philosophy belong to Walter Reuther and the "liberals" who believe that nothing is quite so good as bigger Federal government.

Let there be no mistake about the ultimate goal which the "liberals" hope to reach. The final goal is a scheme for socialized medicine paid for through national taxation and offered to the public by production-line practitioners of something that won't even resemble modern medical care.

The medical aid program for older citizens is merely the opening wedge. The flat prediction is made here that by 1965 Congress will be giving serious consideration to a "health program for youth," if this Flemming-Forand-Reuther scheme is adopted.

This proposal will not provide health care for all of the aged citizens of the nation. Exemptions will shunt aside an estimated 3,500,000 persons who have gross income above certain minimum figures. Another 2,500,000 now on public relief are receiving hospital and medical treatment through state sources and the charitable work of the medical profession. Since there are an estimated 16,000,000 Americans over 65, the plan would in reality affect only 10,000,000 persons. Even these would have to pay the first $250 each year of any treatment.

The Eisenhower administration is in the contradictory position of advocating a balanced budget one day, and greater expenses on another. Adding $600,000,000 annually to Federal expenditures is hardly the way to achieve fiscal stability.

Every state in the union will have its fiscal machinery strained if not wrecked if this Federal program goes into effect. Each state will be called on to match Federal appropriations, bringing the total national cost to $1,200,000,000 which must be dredged up each year from the pockets of the taxpayer. As a passing note, this figure is merely the first, low "estimate" designed not to frighten the citizenry.

This is no voluntary program. Every state will be forced, willy-nilly, into the health insurance business, and if a state doesn't like the idea, the Federal government will pay the total cost of this plan for citizens in the recalcitrant state for two years. Presumably, two years will be long enough to browbeat any state government into conformity.

Rich states, such as Indiana, must subsidize poor states, such as Alabama. Richer states must pay two-thirds of the cost of their health insurance program even though they haven't approved or requested it, while poorer states will have to pay only one-third of their cost.

These are the facts. They aren't the fanciful statments of a politician who is concerned with nothing beyond his own ambition and election.

Congress should reject this administration plan and the various Democratic proposals. All of them are nothing but political creations with no sincere regard for the real problems of America's older citizens.

The medical profession and the insurance industry should be permitted to continue meeting the real requirements of health care for those who want and need it. They should not be slowly strangled by bureaucratic regulation. Greater strides in coping with the physical prob-

in arthritis and allied disorders

Butazolidin®

brand of phenylbutazone

Geigy

Proved by a Decade of Experience
Confirmed by 1700 Published Reports
Attested by World-Wide Usage

Since its anti-inflammatory properties were first noted in Geigy laboratories 10 years ago, time and experience have steadily fortified the position of Butazolidin as a leading nonhormonal anti-arthritic agent. Indicated in both chronic and acute forms of arthritis, Butazolidin is noted for its striking effectiveness in relieving pain, increasing mobility and halting inflammatory change.



Butazolidin®, brand of phenylbutazone:
Red, sugar-coated tablets of 100 mg.
Butazolidin® Alka: Orange and white capsules containing Butazolidin 100 mg.; dried aluminum hydroxide gel 100 mg.; magnesium trisilicate 150 mg.; homatropine methylbromide 1.25 mg.

Geigy, Ardsley, New York

162-60

November 1960 2005

lems and financial difficulties of ill-health have come from these sources than from any bureaucracy.

Indianapolis Star
May 5, 1960

Meeting the Aged Care Issue

One of the toughest single jobs facing the Republican party, at the Chicago convention and throughout the campaign, is to put before the public a satisfactory program of health insurance for the aged. This nation is not now doing anything approaching a proper job of insuring the elderly against financially ruinous medical costs, and 16,000,000 65-and-over voters can provide for either party the margin for victory—or defeat—in November.

The Democrats at present hold a psychological advantage. They were first into Congress with a proposal to provide disaster insurance for a large bloc of over-65 citizens by increasing the social security tax. This put the Republicans in the position of having to produce a counterproposal, and the counterproposal, while avoiding some of the errors of the Democratic bill, committed some major ones on its own. Among other things, it offered a vague and jerry-built scheme of financing that predictably would prove costlier and more unwieldy than the Democratic plan. The Republican position was not helped when two such prominent figures as Gov. Rockefeller and Walter Lippmann endorsed, in effect, the Democratic plan.

It remains true that the Democratic proposal has glaring and dangerous faults. It freezes out of the program all those millions of older persons not covered by social security. It imposes upon younger people the double burden of financing the care of those now over 65 and paying for their own insurance as well. It would require millions to participate who are now amply covered by private health plans. It would deprive private insurance companies of legitimate business. It would impose the impersonal mechanism of government bureaucracy upon the traditional and invaluable personal relationship between patient and doctor. It would reduce still further the right of citizens to spend their own money at their own discretion. They have already forfeited spending control of one-third of their dollars.

The Republican platform committee, the convention and the men it nominates can take the initiative on this issue in a way that will be of valuable service to the party and to the American people.

The platform should, at least, make amply clear that the GOP recognizes the federal government's obligation to assure against disaster every older citizen who cannot provide such assurance for himself without undue burden. This is a basic duty of a government committed to the principle of human dignity.

During the campaign, exposure of the weaknesses of the Democratic program will be immensely more effective if the Republicans have a clear-cut program of their own to advance, and we hope the preparation of such a program is at this moment being carried out by the most competent minds in the party.

We are confident that a program can be drafted that fully meets both the humanitarian need and the requirements of basic American principle. We believe, as a matter of fact, that the voters, young and old, will respond favorably to the doctrine that encourages self-reliance while caring for all who need care. As we see it, this is the main line of demarcation between the two parties, and there will never be a better time to make its meaning clear.

Chicago Sun-Times
July 10, 1960

The Name's The Thing

One of the nation's leading spokesmen for "social legislation" defined its chief points recently. He said that the goals of any social security system should provide for adequate retirement; protection against loss of work; medical care for disabled workers; care of dependent children and wives, and burial and death benefits to survivors.

That's odd. The South had the same system at one time, except that it was called slavery and the nation fought a war to abolish its evils.

Shakespeare was right when he asked, "What's in a name?"

The Indianapolis Star
April 30, 1960

◄

The Journal of the INDIANA STATE MEDICAL ASSOCIATION

Supervised by THE COUNCIL

Volume 53 — November 1960 — Number 11

Multiple Jejunal Diverticula: Report of Three Cases

RICHARD J. NOVEROSKE, M.D.
ROSCOE E. MILLER, M.D.
*Indianapolis**

THREE NEW CASES of multiple jejunal diverticula were seen recently within a two-month period. The bizarre appearance of radiographs directed the authors' attention to this entity; in each case multiple chronic complaints had existed for some time.

Probably the first description of small bowel diverticula was recorded by Sir Astley Cooper in 1844. He described numerous pouches in the upper jejunum of a 65-year-old man.

Incidence of non-Meckelian diverticula has been reported at rates varying from one per 25,000[8] to one per 200 routine upper gastrointestinal examinations.[9] By 1948, 322 cases had been recorded in the literature.[12] While congenital diverticula occur, they are rare, usually single, and on the antimesenteric side. The vast majority of jejunal diverticula are acquired and are seen in elderly patients. The average age in one series of 25 cases was 65 years. In one series of 122 cases there were twice as many males as females.[1]

These diverticula may develop in any portion of the small bowel, from the ligament of Treitz to the ileo-cecal valve. The upper and middle portions of the jejunum are the commonest locations. The diverticula may be exceedingly numerous; Hansemann found a case with over 400 in the jejunum at autopsy. Such acquired diverticula are almost always on the mesenteric border, with the orifice of each diverticulum at the point where a mesenteric vessel perforates the muscular coat of the intestine. From observations Edwards concluded that the diverticula are acquired. He also concluded that they are due to persistent irregular contractions forcing the mucosa through the areas of the intestinal wall weakened by the perforating mesenteric vessels. Subsequent observations have tended to confirm these theories.

Many patients with small bowel diverticula have no symptoms. Patients with symptoms generally have one or more of the following: cramping, vague abdominal pain, flatulence, anorexia, nausea, vomiting, a sensation of fullness or localized tenderness. Vague abdominal pain and flatulence are the most common symptoms.

Partial Obstruction Frequent

The most frequent and the most interesting complication of these diverticula is a chronic partial obstruction which is neuromuscular in

* From the Department of Radiology, Indiana University Medical Center.

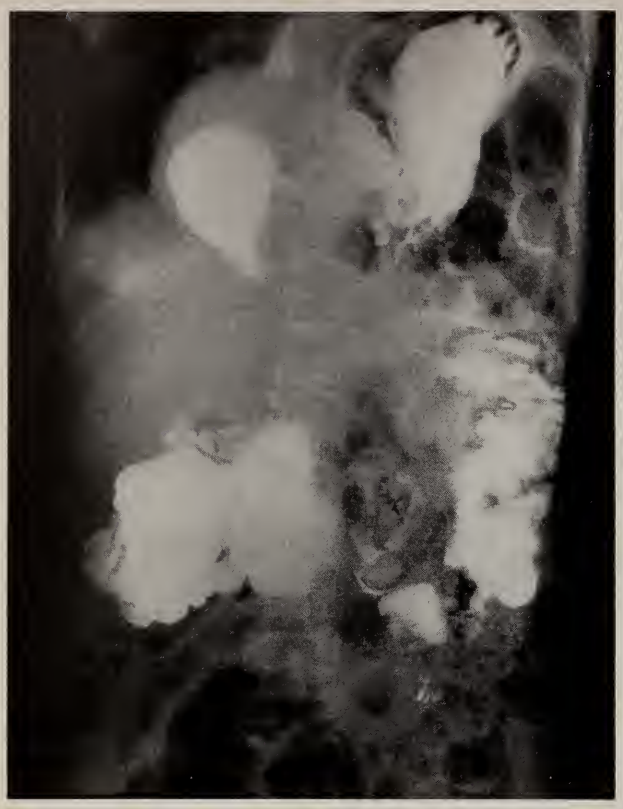


FIGURE 1-A

EVENTRATION of the diaphragm, obstruction of the duodenum, dilatation of the jejunum and several diverticula are apparent.

origin and not due to tumor or adhesions. The diverticula, which are initiated by a dyskinesia, aggravate the already poorly functioning segment of the intestine. With each contraction of the intestine, some of the fluid is forced into the diverticula instead of moving through the intestine. When the diverticula empty, their contents move both proximally and distally. Because of this inefficiency, chronic partial obstruction results in varying degrees.[1, 6] At surgery the involved segment is usually dilated and hypertrophied. These phenomena are analogous to chronic retention in diverticula of the bladder.[6]

An acute abdomen may result from the following reported complications of the diverticula: acute obstruction, inflammation, hemorrhage, perforation, foreign body retention, volvulus and intussusception. Adenocarcinoma which developed in a jejunal diverticulum has also been reported.[1]

Diagnosis of small bowel diverticulosis is most often made from the roentgenogram, for the symptoms are not specific and the diverticula are sometimes difficult to demonstrate at surgery.

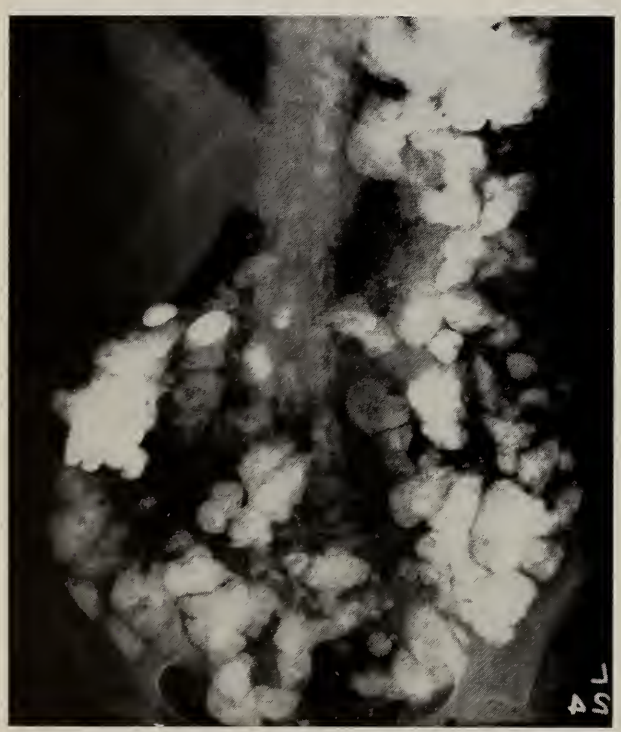


FIGURE 1-B

24 HOURS after the ingestion of the barium meal there is retained barium in the stomach and puddling of barium in the many small bowel diverticula.

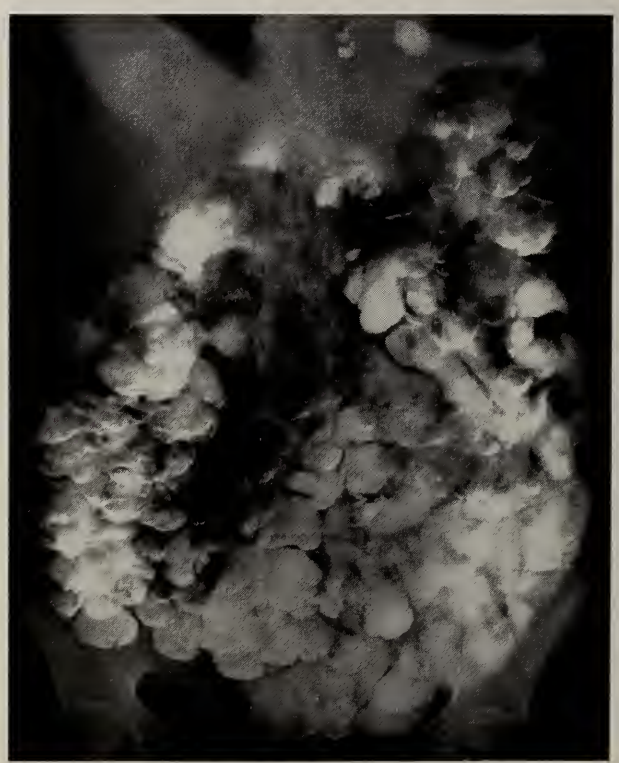


FIGURE 1-C

THIS POST-OPERATIVE FILM shows barium outlining the numerous pouches in the small bowel. Less obstruction is now present.

Case indicated in 1920 that the diagnosis was based on finding a collection of barium or liquid intestinal content with a rounded gas cap on an erect film of the abdomen. (Figure 2) Diverticula can also be diagnosed with recumbent films which demonstrate spherical collections of barium along the course of the intestine. (Figure 1-C)

Treatment of multiple jejunal diverticulosis usually consists of symptomatic medical management including low residue diet, sedation, and parasympatholytic drugs. This treatment does not reduce the diverticula which tend to increase in size and number with time. For the complications, surgery is usually necessary. It may also be necessary for very painful uncomplicated diverticulosis.[4]

If the involvement is extensive, the complication is treated and an entero-enterostomy (side-tracking the involved segments) is usually performed.[1] If the portion of bowel involved by diverticula is small, the affected portion may be resected. Railton felt that an average of five feet or slightly more of small intestine should be the maximum resected. Rarely, massive small bowel resection requiring removal of more than 200 cm (almost 7 feet) of intestine has been done for other indications. These resections are usually followed by a severe watery diarrhea with anorexia, nausea and adominal cramps. Fat absorption is severely impaired and protein absorption is moderately decreased.[11] Resection is also limited by the fact that new diverticula may appear later in non-involved segments.[4]

Case Presentations

A 42-year-old housewife was admitted to the Indiana University Medical Center 11-22-59, with complaints of "tissue breaking down," gas and burning sensation in the abdomen which were partially relieved by frequent small feedings and sitting upright a great deal. She also had vomiting one to two hours after meals, weight loss, diarrhea and peripheral edema. The gastro-intestinal symptoms were thought to be due to a hiatus hernia which had been demonstrated by a previous upper gastro-intestinal series.

Past history and review of systems revealed urticarial reaction to certain foods for many years, no pregnancies, right oophorectomy and appendectomy at 16 years of age and bilateral inguinal and ventral herniorrhaphies with recurrences.



FIGURE 2

MULTIPLE "GAS CAPS" over collections of barium in the jejunum and the large hiatus hernia are prominent.

Physical examination revealed an emaciated, 85-pound woman who looked much older than her stated age. Bowel sounds were heard over the lower half of the left hemithorax. Examination of the abdomen was negative except for bilateral inguinal hernias and a ventral hernia with scars in these areas. The skin was atrophic and loosely attached. Edema was present below the knees.

A gastroduodenal examination and small bowel series on 11-25-59, revealed findings interpreted as eventration of the left hemidiaphragm with malrotation of both small and large bowel, volvulus of the stomach, herniation of the first portion of the duodenum into a paraduodenal internal hernia sac and malabsorption syndrome, possibly sprue, of the small bowel with segmentation, dilatation and puddling of barium in grossly abnormal segments of the small bowel—most likely due to protein deficiency. (Figure 1-A) The colon examination was postponed several times because of gross barium retention in the small bowel. (Figure 1-B) These films were examined by several radiologists and a number of clinicians prior to surgery.

At surgery on 12-2-59, numerous diverticula of the entire small bowel were found, along with a failure of attachment of the mesentery of

the small bowel. This inadequate attachment permitted rotation of the small bowel about the superior mesenteric artery and contributed to the functional obstruction of the duodenum at the ligament of Treitz. The stomach was located high in the left hemithorax.

Diverticula were on the mesenteric side of the small bowel. They began in the duodenum and involved the entire small bowel to within 12 inches of the ileo-cecal valve; their size varied from one to four centimeters in diameter. The bowel was derotated and a duodeno-jejunostomy anterior to the superior mesenteric artery was performed in an effort to prevent recurrence of duodenal obstruction. Involvement of the small bowel was too extensive to permit any definitive surgical procedure for the diverticula.

In spite of the patient's general debility her convalescence was uncomplicated. Progress gastroduodenal examination and small bowel series demonstrated some improvement in intestinal function, and the patient was symptomatically improved.

In retrospect, it is easy to see the spectacular involvement of the small bowel by the numerous diverticula. (Figure 1-C)

Case 2

A 69-year-old housewife was admitted to the Indiana University Medical Center on 12-18-59 with the complaints, "I'm anemic, have an ulcer, and want some blood." She had been anemic for 11 years. Three months prior to admission she developed an aching epigastric pain and had an upper gastrointestinal series which revealed an ulcer. She took ulcer medication with improvement, but she still had some pain after "heavy food." Because of the anemia she was admitted to the hospital.

Past history was noncontributory. The review of systems revealed anorexia of unknown duration; the patient ate mostly soups. She also had long-standing constipation. The patient's weight was 125 pounds at admission; three months prior to admission she had weighed 204 pounds.

Physical examination revealed a hematocrit of 39% ; the hemoglobin was 14 gms %. Repeated stool hematest examinations were negative. On 12-22-59 the patient had a gastroduodenal examination and a small bowel series which revealed a large esophageal hiatus hernia with a diverticulum of the stomach arising from the region of the hiatus hernia. There were also

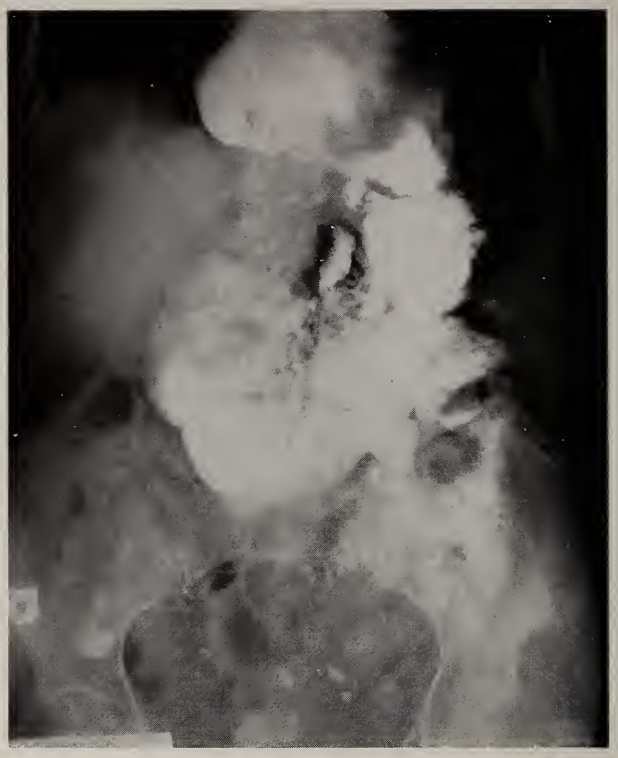


FIGURE 3-A

THIS 30-minute film demonstrates segmental dilatation of the jejunum and a hiatus hernia.

multiple diverticula of the small bowel from the duodenum through the jejunum. (Figure 2)

On 12-24-59 the patient's husband signed her out of the hospital against medical advice.

Complains of Abdominal Pain

An 84-year-old widow was admitted to the Marion County General Hospital on 12-17-59 with the chief complaint of upper abdominal pain of two weeks duration.

She had been in a chronically poor state of health until the day after Thanksgiving when she developed upper abdominal pain of a colicky nature which radiated into the lower chest. This pain was not relieved by belching, vomiting or sitting upright. There was an 18 pound weight loss during the two weeks prior to admission.

Past history revealed that the patient had a transthoracic repair of a hiatus hernia in 1947. She also had a cervical transection of the left phrenic nerve in 1947. In 1952 a benign rectal polyp was excised. An epidermoid carcinoma of the cervix was treated with radiation in 1954.

Physical examination revealed a thin, elderly woman who was not in acute distress. There was some distention of the abdomen with high pitched bowel sounds. No masses were palpable in the abdomen.

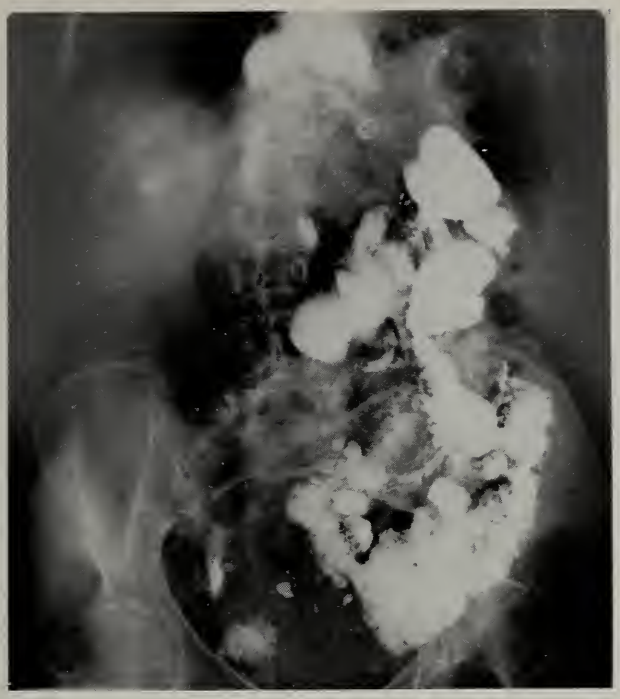


FIGURE 3-B

THIS DELAYED film demonstrates residual jejunal dilatation and multiple diverticula.

A barium enema showed multiple diverticula in the recto-sigmoid and splenic flexture portions of the colon. Two upper gastrointestinal series demonstrated a large esophageal hiatus hernia. About two-thirds of the stomach was above the diaphragm and twisted somewhat to the left. Deformity of the esophagogastric junction, probably due to previous surgery, was also seen. The duodenal bulb was in a vertical plane in the left upper quadrant, and it appeared to be normal. Probable calcification of the splenic artery was also noted.

A small bowel series was done in January, 1960. Fifteen and 30 minute films demonstrated a dilated loop of the proximal jejunum in the center of the abdomen. (Figure 3-A) Barium passed through this segment, but it was still dilated at the end of three and one-half hours. This delayed film demonstrated multiple large diverticula of the small bowel. (Figure 3-B)

A request for re-examination was met with refusal by the patient and her family. No further diagnostic procedures were desired. She was discharged on 1-18-60 and died four days later. There was no autopsy.

Summary

In cases of multiple jejunal diverticula presented, each patient had malnutrition, severe weight loss, a hiatus hernia and vague abdominal complaints. Two of the cases had a partial small bowel obstruction, which is the most common complication of jejunal diverticulosis. Older patients with persistent vague abdominal complaints, and especially with weight loss unexplained by upper and lower gastrointestinal x-ray studies, should have further small bowel radiological investigation.

It should be noted that of the two patients who had been to surgery, one patient received no lasting benefit from the operations for the hiatal hernia alone; the other received benefit from an operation that did not involve the hiatal hernia. While treatment usually consists of symptomatic medical management, early surgery for severe pain or correction of the complications should result in better patient care.

ACKNOWLEDGEMENTS

Grateful acknowledgement is made to Drs. J. Stanley Battersby, Glenn W. Irwin, Will F. Ungemacht, Edward R. Gabovitch and Henry R. Black for permission to present these cases. We are also indebted to Mrs. Gordon T. Brown for review of the manuscript.

BIBLIOGRAPHY

1. Benson, R. E., Dixon, C. F., Waugh, J. M.: Non-Meckelian Diverticula of the Jejunum and Ileum. *Ann. Surg.* 118:377-393, Sept., 1943.
2. Case, J. T.: Diverticula of Small Intestine Other Than Meckel's Diverticulum. *J.A.M.A.* 75:1463-1470, Nov. 27, 1920.
3. Dixon, C. F., Deuterman, J. L., Weber, H. M.: Diverticula of Intestine. *Surg., Gyn., & Obst.* 66:314-321, (No. 2-A), Feb., 1938.
4. Edwards, H. C.: *Diverticula and Diverticulitis of the Intestine.* Baltimore: Williams and Wilkins Company, 1939.
5. Orr, I. M., Russell, J. Y. W.: Diverticulosis of the Jejunum—a Clinical Entity. *Brit. J. Surg.* 39:139-147, Sept., 1951.
6. Phillips, J. H. C.: Jejunal Diverticulosis, Some Clinical Aspects. *Brit. J. Surg.* 40:350-354, Jan., 1953.
7. Railton, S. V.: Diverticula of Small Bowel and Their Surgical Significance. *Canadian Med. Assn. J.* 64:55-58, Jan., 1951.
8. Rankin, F. W., Martin, W. J.: Diverticula of the Small Bowel. *Ann. Surg.* 100:1123-1135, Dec., 1934.
9. Ritvo, M., Votta, P. J.: Diverticulosis of the Jejunum and Ileum. *Radiology* 46:342-350, Apr., 1946.
10. Van Ravenswaay, A. C., Winn, G. W.: Jejunal Diverticula: Consideration of Clinical Symptomatology and Case Report. *Am. J. Digestive Diseases* 10:108-111, Mar., 1943.
11. Welch, C. E.: *Intestinal Obstruction.* Chicago: The Year Book Publishers, Inc., 1958.
12. Wilkerson, J. H., Coffman, R.: Multiple Diverticula of the Jejunum. *Am. J. Surg.* 75:733-738, May, 1948. ◄

Elimination of pitfalls makes operative cholangiography a useful procedure.

Immediate Cholangiography

HAROLD D. CAYLOR, M.D.
Bluffton

FOR ABOUT 10 years we have used immediate cholangiography as an aid in our biliary tract surgery, and for the last nine it has been routine procedure whenever possible during cholecystectomy and choledochostomy. With the passage of time and increased experience we have gradually evolved a method which in our hands almost always yields satisfactory roentgenograms. Since success in operating room or immediate cholangiography depends on meticulous attention to details and close cooperation among the anesthesiologist, roentgenologist and surgeon, we propose in this study to dwell at length on the details that have proved to be necessary in our experience.

Historical Data

P. L. Mirizzi,[1, 2] an Argentine surgeon, was apparently the first to introduce cholangiography, in 1931. Cholangiography has usually been classified as (1) immediate, that done in the operating room in the course of biliary tract surgery, and (2) delayed, roentgenographic study of the biliary tract performed after an operation by injection of radiopaque media through a T-tube, catheter or some other device which has previously been inserted in the biliary tract. The latter study is usually made in the x-ray department of a clinic or hospital.

Our interest in this useful adjunct to biliary tract surgery was stimulated in 1950 by two cases of congenital anomalies of the biliary tract. We could have avoided at least one biliary tract operation if we had had immediate cholangiography available at this time. Reports of these cases have been published.[3, 4]

Early workers in this field included MacDonald,[5] Mixter,[6] and Zierold,[7] along with ourselves.[8, 9] In the intervening years many authors including Baker,[10, 11] Glenn,[12] and Ferris,[13, 14, 15, 16] have presented their experiences, endorsed this procedure and published their technics and results.

Indications for Exploration

Early in this presentation we want to emphasize that in our opinion cholangiography should be used only as a screening test. If a patient presents a situation indicating need for exploration of the common bile duct, the duct should be explored and a cholangiogram made after the T-tube has been inserted. Presently our indications for opening and exploring the common bile duct are:

1. History of jaundice with or without chills and fever.
2. Palpable common duct stones.
3. Enlarged common and/or cystic duct.
4. Many small stones in the gallbladder and/or the cystic duct.
5. X-ray evidence of common duct stones. Intravenous cholangiography (cholografin Methylglucamine).
6. Suspected congenital anomaly of the biliary tract.
7. Persistent biliary symptoms after cholecystectomy.

Whenever we have inserted a T-tube in a common duct we routinely do a cholangiogram while the patient is still on the table. This practice on many occasions has indicated over-

looked stones that may most easily be removed at this, the first operative procedure on the biliary tract.

From these statements you have already surmised that in our hands operative or immediate cholangiography is a screening mechanism by which we hope to discover the common bile ducts that should be explored that have not met the criteria mentioned above. That is those cases with silent pathological findings. Glenn in 1952[17] observed that "in all patients with stones in the gallbladder one in 10 will have stones in the common duct." Ferris[15] quotes Hickens and his associates who found 12% of overlooked stones in a series of 100 cases and Glenn, again quoted by Ferris,[15] found 12% in a series of 56 cases. Immediate cholangiography is the most logical method we know to find these silent symptomless stones. In our experience the best, safest and easiest time to perform adequate biliary tract surgery is during the first exploration and surgical procedure on this extra hepatic biliary system. Each subsequent operation in this region becomes increasingly difficult and dangerous.

Technic for Immediate Cholangiography

1. Patient is tested for sensitivity to the dye prior to surgery by having him hold a dram or two in his mouth for three minutes and then if no sign of allergic reaction is obtained the dye is swallowed. The patient is observed for another three minutes for allergic reactions.

2. A Bantam Bucky diaphragm electrically activated by the portable x-ray switch is on the operating table. The patient is placed on the operating table and a scout film is taken to check the position technic and functioning of the apparatus before the anesthesia is begun.

3. We presently are using plastic drapes which adhere to the patient's skin with a plastic spray adhesive—if these are not used it is better to sew on the drapes.

4. Make any type of surgical incision which seems feasible for the surgeon.

5. Isolate the cystic duct and ligate close to the gallbladder to avoid forcing stones or sandy material out of the organ.

6. Pass another ligature around the cystic duct close to the common duct. This is not tied until a catheter is inserted. By pulling on these two ligatures the duct is stretched and this is an aid in inserting the catheter in the duct.

7. Incise the duct.

8. Probe the cystic duct to break up the valves of Heister and expedite passage of a catheter into the common duct.

9. Insert catheter into cystic duct and down into the common duct and tie the ligature already in place. To avoid bubbles a warm, sterile, saline solution is kept dripping from the end of the catheter until it is tied in place. We presently are using clear polyethylene catheters for cholangiograms. Through this clear tubing we can see bubbles and dispose of them. We also have found that aspiration of bile with a syringe through the catheter demonstrates that the catheter is properly placed. When the syringe containing the saline is detached and another containing the dye attached to the catheter we hold the free end of the catheter below the level of the table and at the side of the patient to let bile and/or saline drip from this end by siphonage. The syringe containing the dye is attached and the injection is started.

10. We presently are using 50% Miokon Sodium (Brand of Sodium Dipiotrigoate) although 35% Diodrast works well. This warmed solution is alternately injected and aspirated so as to mix with the bile in the common duct and the biliary tract, three to five cc is injected. Then a series of three radiographs are taken injecting more solution between each exposure so finally a total of 10 to 15 cc is injected.

11. X-ray procedure: Portable x-ray machine 100 K.V.P.; 100 M.A.; 30-inch distance; 1/10 to 3/10 second (depending on patient's size starting with 18 cm patient at 1/10 second). Three exposures are made. If the patient is small the x-ray tube should be tilted (angled) about five degrees—to offset the common duct from the spine.

12. Leave the catheter or tube in place and proceed with the cholecystectomy.

13. When films are developed and if they are not satisfactory, repeat cholangiograms can be made because the catheter is still in the duct.

14. If the films are adequate and there is no reason for further procedure on the common duct, the catheter is removed and the cystic duct ligated or suture ligated.

Discussion

The chief artifacts we have had to contend with in operative cholangiography are bubbles. These are inadvertently introduced during the

insertion of the catheter or injection of the dye. Let me reiterate the importance of having no bubbles in the catheter when the saline solution is going through the tube and when the syringes are switched from the saline to the dye. We have found that the siphoning effect obtained by lowering the external end of the catheter is valuable in avoiding bubbles at this stage of the technic.

A second source of difficulty is inserting the catheter too far down the common duct so that the intrahepatic biliary system is not visualized as well as the region of the ampulla.

The proper positioning of the patient is also important and the scout film before the anesthetic is an aid in this regard. Mixing of the dye and bile has been mentioned and is important. We still feel three films should be taken in each case if possible.

Respiratory movements can be avoided if spinal anesthesia is being used by simply asking the patient to hold his breath for the fraction of a second required for the exposure. With general anesthesia an anesthesiologist can render the patient almost apnoeic. Then someone in surgery can count out the cadence of the respiratory movements so that the exposure can be made at the proper time for minimal motion.

For the procedure to be valuable adequate roentgenograms must be obtained and only by teamwork among the anesthesiologist, surgeon and roentgenologist can this aim be adequately accomplished. Several years ago we tried Polaroid films for cholangiography but we never were able to produce roentgenograms of adequate quality for interpretation.

If a space-filling defect is found in the cholangiogram the common duct is incised and explored using the cholangiogram as a guide. If a T-tube is inserted in the common duct we do a cholangiogram through the T-tube in the operating room.

Bubbles frequently plague one with a T-tube. Ferris has suggested allowing an I.V. solution to drip into the tube as it is inserted in the duct to avoid bubbles. We have found a Russell Best type of tube, a double lumen T-tube, useful in avoiding bubbles. One lumen is left open while the dye is injected down the other. When the dye merges from the open end this can be clamped and roentgenograms taken.

Solutions too hot or cool, too rapid injection, or too much pressure, or over distension of the biliary tract may cause spasm of the sphincter. All of these are to be avoided.

After the technic had been properly developed so that adequate roentgenograms of diagnostic qualities can be routinely expected, we have found the procedure a useful addition to our armamentarium for biliary tract surgery.

BIBLIOGRAPHY

1. Mirizzi, P. L.: La colangiografia durante las operaciones des las vias biliares. *Bol. y trab. de la Soc. de cir. de Buenos Aires* 16:1133, 1266, 1413, 1466, 1932.
2. Mirizzi, P. L.: Operative cholangiography. *Surg., Gynec., & Obst.* 65:702-710, Nov. 1937.
3. Collett, H. S., Caylor, H. D., Tirman, W. S., Choledocholithiasis. *Am. J. Surg.* 80:514-522, Nov. 1950.
4. Collett, H. S., Tirman, W. S., Caylor, H.D.: Roentgen demonstration of the common duct entering duodenal diverticulum. *Radiology* 55:72-76, 1950.
5. MacDonald, D.: Further observations on clinical value of cholangiography. *Am. J. Surg.* 80:349-355, 1950.
6. Mixter, C. G., Hermanson, L., Segel, A. L.: Operative cholangiography; evaluation of 406 cases. *Ann. Surg.* 134:346-350, 1951.
7. Zierold, A.: Operating room cholangiograms. *Minn. Med.* 34:439-441, 1951.
8. Caylor, H. D.: Immediate cholangiography in surgery. *Minn. Med.*, 36:761-762, 1953.
9. Caylor, H. D.: Cholangiography in surgery. *Am. J. Surg.*, 87:516-519, 1954.
10. Baker, J. W., Lawrence, G. H.: Preoperative and operative decisions in gallbladder and bile duct surgery. *Surg. Clin. N. Am.* 38:1263-1277, 1958.
11. Baker, J. W.: Cholecystectomy and operative cholangiography. *A. M. A. Arch. Surg.* 79:853-856, 1959.
12. Kanter, H. G., Evans, J. A., Glenn, F.: Cholangiography, critical analysis. *A.M.A. Arch. Surg.* 70: 237-252, 1955.
13. Ferris, D. O., Weber, H. M.: Evaluation of routine operative cholangiography. *A.M.A. Arch. Surg.* 73:197-203, 1956.
14. Ferris, D. O.: Technic of operative cholangiography. *Surg. Clin. N. Am.* 37:933-937, 1957.
15. Ferris, D. O.: Operative cholangiography—An aid in reducing the incidence of residual common duct stones. *Postgrad.* 26:301, 1959.
16. Ferris, D. O., Hodgson, J. R.: Operative cholangiography. *Am. Arch. Surg.* 79:857-860, 1959.
17. Glenn, F.: Common duct exploration for stones. *Surg., Gynec. & Obst.* 95:431-438, 1952. ◄

Incompetent cervix may be improved by "purse-string" maneuver.

The Shirodkar Procedure and the Habitual Aborter

JOHN N. LEIN, M.D.
RICHARD W. STANDER, M.D.
CHARLES A. HUNTER JR., M.D.
*Indianapolis**

DURING THE PAST 10 years, habitual abortion due to an incompetent cervical os has received increasing attention in the medical literature. In 1950, Lash & Lash[1] reported on their experience in closing the incompetent cervical os in the non-pregnant state. The authors felt that by "wedging" the cervix, the os would be made competent, thereby enabling the woman to carry a fetus to term in subsequent pregnancies. During the next five years, the correction of this defect in the non-pregnant state became a fairly common procedure.

It remained for Shirodkar[2] in 1955 to describe a simple operation for the correction of the incompetent cervical os during pregnancy. Shirodkar in his original paper stated, "I am publishing this report in order that hundreds of women in our country who suffer from this unfortunate handicap may benefit by this operation which will enable them to fulfill their cherished desire of having live children." In this short article, he briefly described his method of closing the os using fascia lata. Following this report, many articles have appeared modifying his procedure.

Important Factor in Habitual Abortion

All authors now agree that the incompetent cervical os is a most important factor in habitual abortion occurring in the middle trimester of pregnancy. Shirodkar himself felt that women with repeated fetal losses between the fourth and seventh month, in 95% of cases had a weak cervical sphincter. In 1957, Baden & Baden[3] attempted to classify the types of incompetency that might be encountered. They felt that the defect could be described as either incomplete or complete. Complete incompetence involves the entire cervical structure. Incomplete involves either the external or the internal os. The authors felt external os incompetence was most common and that incomplete incompetency was more common than complete. They found cervical incompetence of a surgical degree occurring once in every 300 consecutive pregnancies.

The most important point in the evaluation of these patients is the history. Barter *et al.*[4] point out that "sudden loss of the amniotic fluid

* From the Department of Obstetrics and Gynecology, Indiana University Medical Center and the Marion County General Hospital.

between the 16th and 20th week of pregnancy, not preceded by painful contractions, is the most striking feature in the history of such pregnancies." There is uniform agreement that the most common cause of the incompetence is preceding cervical trauma in the form of deep lacerations, overzealous dilatation and curettage, traumatic forceps delivery, vaginal hysterotomy, extensive conization or cautery, subtotal amputation of the cervix, surgical revision of the cervix and so forth.

It has been our experience that these patients are usually multiparous with a history of cervical trauma and have repeatedly and painlessly lost a normal appearing fetus between the 16th and 20th week of pregnancy.

Between Oct. 1, 1958, and Sept. 30, 1959, nine modified Shirodkar procedures were carried out at the Indiana University Medical Center and the Marion County General Hospital. A brief summary of these case histories is as follows:

Case Histories

Case No. 1—A 36-year-old white female, gravida five, with no living children. Past history revealed the patient had four previous abortions, one at 12 weeks, two at 20 weeks, and one at eight weeks. She had been observed closely by her local physician with repeated vaginal examinations, and at 17 weeks gestation, the cervix was 4 cm dilated with membranes bulging through the external os. The patient was admitted to the hospital and a Shirodkar procedure done shortly after admission. Postoperatively the patient received progesterone, antibiotics and was at bed rest.

Following the procedure the pregnancy was uneventful until 38 weeks gestation when there was spontaneous rupture of the membranes. The patient was delivered by cesarean section of a 5 lbs. 7 oz. living male.

Case No. 2—A 32-year-old white female, gravida three, with no living children. Past history revealed a dilatation and curettage had been done in 1947 for unknown reasons. Following this, the patient had one abortion at 16 weeks and one immature delivery at 26 weeks.

She was seen at the Indiana University Medical Center early in her pregnancy and followed carefully with repeated vaginal examinations. At 28 weeks, the cervix was found to be 4 cm dilated and 60% effaced with membranes bulging through the external os; a modified Shirodkar procedure was performed. Postoperatively, the patient received progesterone, antibiotics and bed rest. Following the procedure, the pregnancy was uneventful until 38 weeks gestation at which time she was admitted to the hospital for elective cesarean section. The patient was delivered by cesarean section of a 6 lbs. 13 oz. living male.

Case No. 3—A 22-year-old white female, gravida three, with no living children. Past history revealed two immature deliveries, one at 22 weeks, the other at 26 weeks gestation. She was admitted to the hospital at 32 weeks gestation, the os being 3 cm dilated with membranes easily visible. A modified Shirodkar procedure was performed and the patient postoperatively placed on progesterone, antibiotics and bed rest. At 38 weeks gestation, she was admitted to the hospital and an elective transverse cervical cesarean section performed, resulting in delivery of a 4 lbs. 4 oz. living male.

Case No. 4—A 31-year-old white female, gravida five, with no living children. Past history revealed a 16-week spontaneous abortion in 1946 followed by dilatation and curettage on two occasions. The patient then had a 22-week spontaneous immature delivery, a 24-week gestation with spontaneous labor and the loss of twins, and a 28-week stillborn in 1958.

At 24 weeks gestation, she was admitted to the hospital when the cervix was found to be 4 cm dilated and a modified Shirodkar procedure was done. The patient was not placed on progesterone or antibiotics postoperatively. On the second postoperative day, she developed a severe pyelonephritis with a temperature of 104°. This was treated successfully with antibiotics.

Suture Tears

At 28 weeks, she was admitted to the hospital with vaginal bleeding. Vaginal examination revealed the suture to have torn loose. The patient went into spontaneous labor, the suture was cut, and she was delivered of a 2 lbs. 7½ oz. male which died two days postpartum. The patient suffered a neurotic depressive reaction during her early postpartum period.

Case No. 5—A 21-year-old white female, gravida two, with no living children. The past history revealed a 24-week immature delivery in 1955. She was seen early in her pregnancy, fol-

lowed carefully, and at 28 weeks gestation, the cervix was found to be 3 cm dilated with membranes bulging through the external os. She was admitted to the hospital and a modified Shirodkar procedure performed. After the operation, the patient was placed on progesterone, antibiotics and bed rest. The pregnancy then continued until 32 weeks gestation at which time she went into spontaneous labor. The suture material surrounding the cervical os was cut and the patient was delivered of a 3 lbs. 8 oz. living male. The infant survived.

Case No. 6—A 33-year-old white female, gravida six, with no living children. Past history revealed that a dilatation and curettage had been done in 1948 for dysfunctional bleeding. Following this, there was a 20-week immature delivery, a 18-week late abortion, and three consecutive spontaneous abortions at 16 weeks gestation. Between her fourth and fifth late abortions, a Lash procedure had been carried out. At 17 weeks gestation, she was found to be 3 cm dilated.

A modified Shirodkar procedure was performed. She was placed on a progestational agent, antibiotics and bed rest postoperatively. In spite of this, the patient bled vaginally and had a very stormy postoperative course. She was examined one week postoperatively, the suture was found to have torn through the cervix. The suture was cut, and the patient delivered a stillborn six ounce infant.

Case No. 7—A 24-year-old Negro female, gravida four, with one living child. Past history revealed an immature delivery at 24 weeks gestation in 1957 and a six-week abortion in 1957. In 1958, she delivered a 7 lbs. 8 oz. living male infant and at that time was found to have a bicornuate uterus with a septum. A portion of the uterine septum was removed at the time of the delivery. She was first seen in the prenatal clinic at 26 weeks gestation and at that time was found to be 4 cm dilated with membranes bulging through the os. A modified Shirodkar procedure was performed. The patient was postoperatively placed on progesterone, antibiotics and bed rest. At 34 weeks, she was re-admitted to the hospital. At that time, the suture was found to have torn loose and it was cut. The patient, shortly thereafter, went into spontaneous labor and was delivered of a 3 lbs. 4½ oz. living female. The infant survived.

Case No. 8—A 28-year-old white female, gravida six, with three living children. Past history revealed a full-term infant had been delivered without complications in 1952. Delivery of a term hydrocephalic was accomplished in 1954; the baby died shortly after delivery. A six-week spontaneous abortion had occurred in 1954. In 1955, the patient was spontaneously delivered of a living infant at 32 weeks gestation. In 1957, there was a 20-week immature delivery; the baby died shortly after it was born.

In 1954, following the six-week spontaneous abortion, a dilatation and curettage had been performed. The patient was followed in the prenatal clinic carefully and at 29 weeks gestation, was found to be 2 cm dilated with the membranes visible through the external os. She was admitted to the hospital and a modified Shirodkar procedure performed. Following this, the patient had a rocky course with numerous admissions to the hospital because of false labor. At 34 weeks gestation, she went into spontaneous labor. The suture was cut, and after pitocin stimulation the patient delivered a 4 lbs. 8 oz. living male infant. The infant survived.

Case No. 9—A 29-year-old female, gravida seven, with two living children. The past history revealed a full term infant in 1951. A full term 10 lbs. baby had been delivered in 1953 and a three-week spontaneous abortion occurred in 1954. Between 1954 and 1959, the patient had one 22-week immature delivery with loss of the child, and two 16-week late abortions. She was seen at 14 weeks gestation for the first time and the cervical os was found to be two cm dilated. She was admitted to the hospital and a modified Shirodkar procedure performed. Postoperatively, the patient was placed on progesterone and bed rest. This patient is currently at 32 weeks gestation; the prenatal course since the operation has been entirely uneventful.

Technic

When the diagnosis is established, the patient is immediately admitted to the hospital and the surgical procedure carried out as soon as possible. The opportune time for the operation appears to be between the 14th and 18th week. As noted by Barter,[4] when the operation is done in the face of excessive effacement, the procedure is technically more difficult. Our experience agrees with this.

The surgical procedure is simple and should result in very little blood loss. The patient is

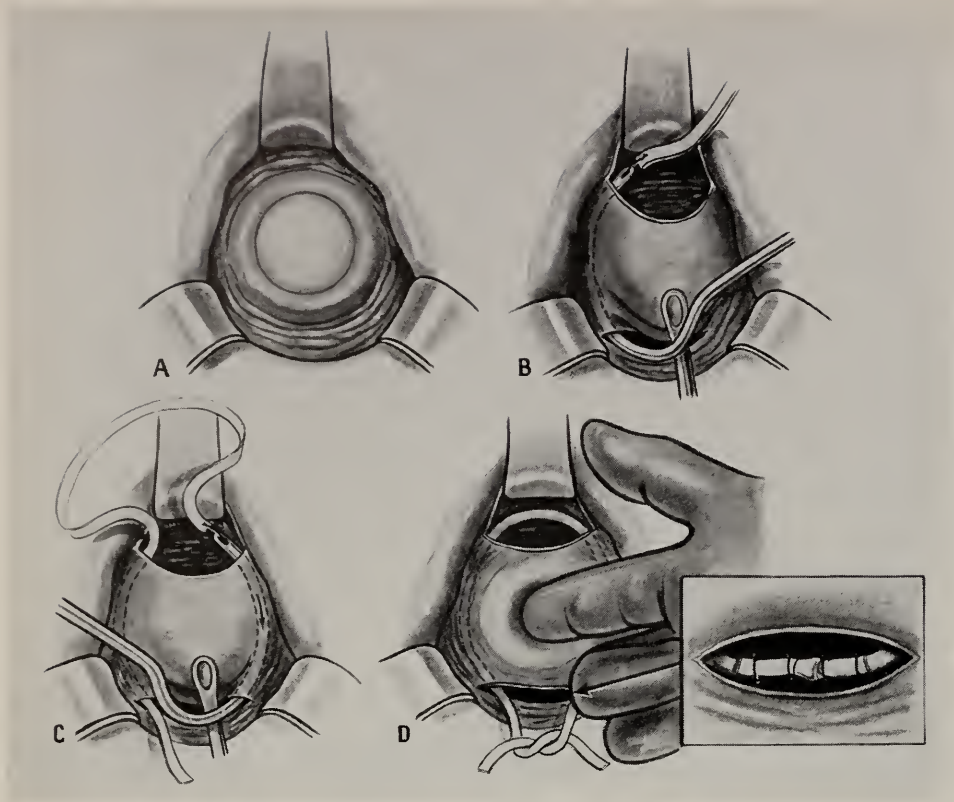


FIGURE 1

A. Dilated cervix with membranes easily visible through the external os.

B., C. Transverse incisions have been made anteriorly and posteriorly at the level of the internal os. Cotton umbilical tape is being placed at the level of the internal os utilizing modified[12] aneurysm needles.

D. Ligature is tied while assistant's finger is held in the canal.

INSERT—Cotton tape is anchored.

placed in the lithotomy position and given general anesthetic. The perineum and vagina are cleansed with surgical soap. In cleansing the vagina, care must be taken to avoid rupturing of the membranes. With vaginal retractors in place, the anterior and posterior lips of the cervix are grasped with sponge forceps and the membranes carefully replaced. The procedure is contraindicated if the membranes are ruptured.

Next, small transverse incisions are made at the level of the internal os anteriorly and posteriorly. The bladder is dissected free anteriorly and the vaginal mucosa reflected posteriorly. Then using long aneurysm needles, which greatly facilitate the placing of the suture, umbilical tape is placed around the cervix. It is most important that the suture be at the level of the internal os. The suture material utilized in our procedure is 5/8" cotton twill tape. The first portion of the procedure is diagramatically shown in A, B and C of Figure 1.

With the finger of an assistant in the cervical canal, the suture is pulled tight and tied posteriorly as shown in D of Figure 1. It is most important that a finger be placed in the canal at the time the ligature is tied so that the os is not completely closed. After tying the tape, it is anchored with interrupted 000 silk (C, insert, Figure 1) and the vaginal mucosa is closed with interrupted 00 chromic suture. Postoperatively, the patient is placed on bed rest, progesterone and prophylactic antibiotics. In our series we have used 100 mg of progesterone daily for seven days and 600,000 units of procaine penicillin with 0.5 gm streptomycin every 12 hours for the first week.

During the first seven days, the patient is not permitted to get out of bed. It is emphasized to the patient when she leaves the hospital that she may carry on her normal daily activities, but should refrain from intercourse and any activities which will increase intra-abdominal pressure. Cesarean section is the method of choice for deliveries since cutting the ligature necessitates repeat repair with each subsequent pregnancy. In those patients delivered vaginally either the suture had torn loose or the fetus was considered to be of non-viable size.

Discussion

The procedure described is popularly known as the Shirodkar operation in spite of the fact that McDonald initiated it four years before Shirodkar reported his cases. In 1957, McDonald[5] published a report of 70 cases, the first of which he had done in 1951.

As noted in the case histories, five of the nine patients had a history of some form of cervical

trauma, with dilatation and curettage most frequently incriminated. It is possible that the four other patients may have had a traumatic episode of which we were not aware. The most striking feature in the analysis of these cases is the fact that these women, prior to the Shirodkar procedure, had 26 pregnancies which ended either in late abortion or premature delivery at such a date that the fetus had little chance to survive. This represents a high degree of fetal wastage. Out of a total of 32 pregnancies prior to the patients having the Shirodkar procedure, these women had produced six living children, a fetal salvage of 19%.

When one then notes that following the procedure in the eight women who have delivered, we have a total of six living infants, the fetal salvage rises to 75%. Other authors report success rates of 79%,[4] 72%,[6] and 80%.[7] With these percentages, the efficacy of this procedure becomes apparent. In all but two cases, the suture material was plain cotton umbilical tape. It was our feeling that by utilizing this material, a reaction would be set up which would possibly result in a permanent correction of the incompetent os.

We are in agreement with most authors, that postoperatively the patient should be placed on progesterone, antibiotics and bed rest. In spite of the majority opinion, Durfee[8] has an excellent fetal salvage without using uterine relaxing hormones, bed rest, progesterone or estrogen. With proper aseptic technic, the procedure is simple and the morbidity low. In order to be complete, mention should be made that one maternal death following the suture of the incompetent os has recently been reported. The death in this case was due to an E. coli. septicemia.[9]

We have noted that the suture material in our cases was cotton umbilical tape. In reviewing the literature, we found that various authors have used the following materials: Fascia lata,[2] chromic catgut,[5] preserved fascia,[4] tantalum wire,[10] braided silk[5] and Mercilene.[7] All of these materials appear to be adequate.

History Important in Evaluation

It should be emphasized that the history is the most important single factor in the evaluation of these patients. Many other methods of diagnosis have been devised. Most workers will agree that if one is able to pass a seven millimeter Hegar dilater without difficulty through the nonpregnant cervical canal, a degree of incompetency exists. Bergman has described a rather simple method of demonstrating the presence of incompetency.[11] He found that if after inserting a #16 Foley catheter into the uterus, the bag is filled with one millimeter of saline and traction applied, the normal cervix will retain the catheter when 1000 gms is attached to it. The incompetent cervix allows passage of the Foley bag when 600 gms is attached.

One cannot overemphasize the fact that if this cervical defect is suspected in the pregnant patient, she should be observed very carefully. Weekly vaginal examination with visualization and digital exploration of the cervix will usually permit early recognition and therapy before the patient aborts. One must also realize, and emphasize to the patient that this procedure is not a panacea for all habitual aborters and that it is only after thorough investigation that the surgical procedure is undertaken.

Summary and Conclusions

1. Late abortion caused by the incompetent cervical os is discussed.
2. A modified Shirodkar procedure for correction of the incompetent os is described.
3. A fetal salvage rate of 75% following the procedure is in agreement with other reports in the literature.
4. The history is emphasized as the most important single factor in the diagnosis of this clinical entity.

BIBLIOGRAPHY

1. Lash, A. F., Lash, S. R.: Habitual abortion: The incompetent internal os of the cervix. *Am. J. Obst. & Gynec.* 59:68, 1950.
2. Shirodkar, V. N.: A new method of operative treatment for habitual abortions in the second trimester of pregnancy. *Antiseptic* 52:299, 1955.
3. Baden, W. F., Baden, E. E.: Cervical incompetence: Repair during pregnancy. *Am. J. Obst. & Gynec.* 74:241, 1957.
4. Barter, R. H., Dusbabek, J. A., Riva, H. L., Parks, J.: Surgical closure of the incompetent cervix during pregnancy. *Am. J. Obst. & Gynec.* 75:511, 1958.
5. McDonald, I. A.: Suture of the cervix for inevitable miscarriage. *J. Obst. & Gynaec. Brit. Emp.* 64:346, 1957.
6. Page, E. W.: Incompetent internal os of the cervix causing late abortion and premature labor. *Obst. & Gynec.* 12:509, 1958.
7. Taylor, E. S., Hansen, R. R.: Incompetent os of the

cervix as a cause of fetal loss. *J. A. M. A.* 171: 1312, 1959.
8. Durfee, R. B.: Surgical treatment of the incompetent cervix during pregnancy. *Obst. & Gynec.* 12: 91, 1958.
9. Dunn, L. J., Courtland, R., Steer, C. M.: Maternal death following suture of incompetent cervix during pregnancy. *Am. J. Obst. & Gynec.* 78:335, 1959.
10. Johnstone, J. W.: Cervical incompetence and habitual abortion. *J. Obst. & Gynaec. Brit. Emp.* 65: 208, 1958.
11. Bergman, P., Svennerund, S.: Traction test for demonstrating incompetence of the internal os of the cervix. *Internat. J. Fertil.* 2:163, 1957. ◄

The Journal of the Indiana State Medical Association

MEDICAL ESSAY CONTEST

for

Interns and Residents of Indiana Hospitals

During the intern and resident year of 1960-61 The Journal is sponsoring a medical essay contest open to interns and residents of hospitals in Indiana. The subject matter will be limited to clinical experience observed primarily in the teaching hospital of the author. Presentations may contain up to 4,000 words and preferably should be illustrated with clinical pictures, graphs or tables.

A first prize of $100.00, a second price of $75.00 and a third prize of $50.00 will be awarded. All entries are eligible for consideration for publication in The Journal.

Manuscripts will be judged by a prize award committee selected by the Editorial Board of The Journal and by the Dean, Indiana University School of Medicine.

Manuscripts should be prepared in accordance with the specifications outlined on the masthead page of The Journal.

Entries must be submitted prior to May 1, 1961.

The manuscript itself is to be identified only by the title. The author's name must not appear in the manuscript. Instead, a special title page bearing the title and the author's name and address should accompany the paper. Mail entries to Mr. James A. Waggener, 1021 Hume Mansur Bldg., Indianapolis 4.

Older Versus Newer Preanesthetic Drugs

DOUGLAS LAYMAN, M.D.
V. K. STOELTING, M.D.
*Indianapolis**

AN IDEAL anesthetic should be the goal of all anesthesiologists. This ideal may be described by listing criteria before, during and after the operation: (1) a restful night of sleep prior to the day of operation without a "hangover effect," (2) an ataraxic condition immediately prior to operation, (3) sedation, sub-hypnosis or sleep when the operation is to begin, (4) light hypnosis, satisfactory analgesia, muscle relaxation and suppressed reflexes during the operation, (5) prompt relief from hypnosis and muscular relaxation after the operation, with continuation of light analgesia, calmness and depression of the vomiting center for several hours.

To aid in achieving this ideal, patients are given preanesthetic drugs. The purpose of preanesthetic medication is threefold: to provide psychic sedation and retrograde amnesia, to reduce the amount of anesthetic agent needed and to minimize undesirable side effects of anesthesia.[6] Many agents ranging from alcohol and tribromethol to barbiturates, narcotics and ataraxic drugs have been and are being used.

Effects on Central Nervous System

The first recorded preanesthetic drug was morphine, used by Lorenzo Bruno of Turin in 1850. In 1869 Claude Bernard used morphine prior to induction of anesthesia by chloroform in animals.[10] Modern day preanesthetic drugs fall into three main classes: narcotics, barbiturates, and ataraxic drugs, or combinations of these agents. Since these agents affect the whole organism all have their values and their limitations. Effects of these drugs on the central nervous system, cardiovascular system and pulmonary system are of critical importance to the anesthesiologist.

Clinically, all the above agents cause depression of the central nervous system—the narcotics and barbiturates are general and the ataraxic drugs selective in the reticular formation of the pons and medulla and the subcortical centers.[19] Hopkins states that this quality "prepares the patient half-way for surgery."[13] Most forms of ataraxic drugs, including Benadryl, have been used in the preoperative preparation of patients, but primarily phenothiazine and its derivatives are currently most favored.

Dripps, Egbert, Eckenhoff and Norten,[5] using a double blind technic, found that promethazine caused drowsiness in all patients and reduced apprehension toward forthcoming surgery. In addition, this drug increased the central effects of meperidine and secobarbital. Comparing drowsiness, the authors felt that 50 mgs of promenthazine equaled 100 mgs of secobarbital.

In contrast Haxholdt found that chlorpromazine alone produced only mild sedation as compared to a combination of morphine and scopolamine and that mepazine (Pacatal ®) was useless as a preoperative medication.[12]

Lear et al., [19] using chlorpromazine as an adjunct to preanesthetic medication with Demerol

* From the Department of Anesthesiology, Indiana University Medical Center.

found a marked potentiating effect on the sensorium without a concomitant depression of the vital centers. In addition they noted marked ease of induction and reduction of amount of anesthetic agents. They believe that this is due to depression of the neurohypophysis-adrenal connection at the level of the hypothalamus thus directly depressing the body's reaction to stress. This effect seems to linger postoperatively as found by various authors[1, 5, 7, 8, 12, 14, 16, 18] producing a more tranquil recovery period without depression of vital functions or evidence of nausea and vomiting. It is particularly important in ophthalmic surgery where nausea and vomiting postoperatively may cause damage to the operated eye.[14]

Lessening Apprehension

Fethi et al.[21] using chlorpromazine in a dosage of 0.5 mgm/Kgm body weight found that in children there was definite preoperative calmness and a sense of well-being produced and that better relaxation with less anesthesia was the rule. Lear[19] and his associates also noted this effect in a study on general surgery patients. Marked lowering of apprehension required much less narcotic prior to anesthesia. This resultant low dosage of narcotics was desirable because it produced less respiratory depression. However, Dyrberg,[11] using meprobamate and atropine or placebo and atropine in 267 children, found no significant differences in preanesthetic apprehensiveness but did note a more quiet awakening when meprobamate was used with thiopental.

In comparison studies as to efficacy of narcotics, barbiturates and ataraxic drugs, Egbert, Dripps et al.[5] and Marx and Orkin[6] found that although barbiturates depressed patients they did not relieve apprehension and that Benadryl or promethazine produced comparable sedation with a more marked degree of laissez-faire attitude and without significant depression of vital centers.

Cohen and Beecher[10] did not corroborate these facts in their study but suggested that pentobarbital should become the drug of choice as preanesthetic medication. They felt that the calming effect gained by using morphine was not statistically greater but that narcotics produced more depression of vital centers and more postoperative complications. Eckenhoff and Helrich[9] have made some interesting comparisons in this same line. In a study of 1400 patients using either meperidine, Nisentil, morphine, secobarbital or placebo as preanesthetic medication the authors found that only 36% of patients given a placebo were apprehensive and of secobarbital recipients 21% were likewise apprehensive. Their conclusions were that routine use of narcotics preoperatively exposes all patients to the hazards of these drugs in an attempt to obtain sedation in 20% of patients and that the action of narcotics in prolonged recovery time is important, especially in hospitals where no recovery room is available.

Effects on Respiratory System

Effect of preanesthetic medication on respiratory function is of prime consideration to anesthesiologists. Orkin, Egge and Rovenstine[20] in clinical experiments on respiratory depression following narcotic administration found that morphine sulfate 10 mg depressed minute volume to 80% of normal with return to normal in 30 minutes, meperidine 100 mg. to 50% of normal with return to near normal in 15 minutes and Nisentil 60 mg to 70% with a gradual return to 85% of normal. Selective depression of the respiratory center by barbiturates was not noted in the literature but most authors seem to feel that depression of the respiratory center is not as marked, especially if an ataraxic drug is combined with the barbiturate to potentiate sedative effects in a smaller dosage.[6, 8, 19]

Ataraxic drugs in themselves do not decrease respiratory rate[5, 6] or minute volume and in fact produce a deep breathing cycle with occasional sighing respirations. They seem to have an antisialogogue activity, thus decreasing the amount of tracheo-bronchial secretions produced before and during anesthesia.[4, 6] These factors become important in patients whose respiratory function is impaired where the depressive effects of narcotics and barbiturates would not be desirable.

Cardiovascular Function

Cardiovascular function preoperatively and during surgery is of importance to both surgeon and anesthesiologist. This system can be directly affected by preanesthetic drugs. Morphine and its allied drugs do not affect cardiovascular function in man in therapeutic dosages. Barbiturates also seem to have little effect if the dosage is not excessive. A fall in blood pressure and pulse rate seen with barbiturate anesthesia is a side-

effect from the sedation of the patient and does not seem to be a direct effect on heart or blood vessels. However, with a large dose of barbiturates injected rapidly intravenously, a direct effect on musculature of smaller blood vessels may result in blood pressure drops to shock level.

Chlorpromazine and its derivatives do directly effect cardiovascular function. This is seen in two ways: its anti-adrenalinic action; and its depressant effect on the parasympathetic nervous system. In moderate dosages (50-100 mg) Dyrberg[14] found no tendency toward hypotension but patients did have a tachycardia probably due to vasodilatation. The author noted, however, that these patients received more blood transfusions probably due to weakened compensatory processes.

Burgeois and associates[15] also noted the vasodilatation and hypotension especially with higher dosages and that in small doses, chlorpromazine protected the heart against epinephrine-induced arrythmias. Attempts by the authors to relieve hypotension by sympathotonic drugs resulted in failure with less powerful drugs and modification of response to potent vasoconstrictors. This effect they attributed to complete or partial blockade of the drugs at the site of action. They felt that if hypotension developed the drugs of choice were levarterenol or Neo-Synephrine to elicit maximal reponse.

This was verified by Lear and associates,[19] in a study of chlorpromazine used as an adjunct to medication with narcotics. He found hypotension failed to respond to the usual vasopressors. However, in spite of the severity of the hypotension (50-60/30-40 mm Hg) concurrently running electrocardiograph tracings failed to reveal any ischemic or depressant changes in the myocardium. For this reason the authors treated the hypotension with fluids only and found that although the patient's blood pressure was extremely low, the pulse was slow, respiration was normal, the skin was warm and dry, nail beds were pink and the peripheral veins were not collapsed. The hypotensive effect lasted four to six hours and abated without noticeable aftereffects.

Potentiation of neuromuscular blocking agents by phenothiazine derivatives is still under investigation. Laboratory experiments on cat muscle by Dyrberg and Houg[15] have shown that chlorpromazine intensifies the effects of nondepolarizing drugs while it antagonizes the depolarizing substances. The theory of these actions is that chlorpromazine has an anticholinesterase activity and an anti-acetylcholine activity—the anti-acetylcholine effects seems to predominate. Clinically, however, the same author has found that no succinyl choline sparing action is evident.[14]

Although chlorpromazine and its derivative drugs have been the main study of this paper all groups of ataraxic drugs have been evaluated as to preanesthetic possibilities. Some (meprobamate, mepazine, promethazine and perphenazine) have been mentioned. Most of the other products have either toxic reactions which prohibit their general use in anesthesia or do not produce the desired clinical responses. Promethazine, perphenazine and chlorpromazine seem to be in vogue at the moment. Meprobamate, ethinamate and other mild neurosedatives have been relegated to night time sedation and do not seem to be of value in clinical anesthesia.

Ataraxic Drugs Unpredictable

From the preceding discussion of actions of preanesthetic drugs it can be seen that the unpredictability of response to present ataraxic drugs by surgical patients is one of the major drawbacks to routine use of them. Unpredictability of response may be due to the varying degree of sympathetic tone present.[17]

Clinical and laboratory research for new drugs which will satisfactorily elicit desired responses is continuing. One of the newer drugs levomepromazine, shows some promise of use as adjunct to clinical anesthesia with only four anesthetic results considered poor in a study of over 150 patients.[3] At the present time, however, ataraxic drugs, particularly the phenothiazine drugs, serve only an ancillary function in preanesthetic medication of surgical patients. The particular properties of psychically detaching the individual from his environment and the enhancing effect of narcotic and barbiturate effects without depressing vital functions may serve as a base line of further research.

Belladonna drugs or drugs with atropine-like actions are almost routinely given with narcotics or barbiturates. Atropine and scopolamine have become standards against which newer drugs are measured. They appear to act synergistically

with narcotics and barbiturates to perpetuate a state of restful amnesic tranquility and to reduce the amount of oropharyngeal and tracheo-bronchial secretions.

These drugs also prevent cardiovagal effect through their antiacetylcholine action. The atropine effect, although causing tachycardia, actually is a function of three elements: total dose, route of administration and rate of administration. A slow intravenous injection at high dosage will cause a bradycardia before tachycardia becomes apparent.[7] Scopolamine seems to have a weaker cardiovagal blocking effect but enhances retrograde amnesia and inhibits secretions to a greater degree than does atropine.[6] Scopolamine in itself has a sedative effect as substantiated by Marx et al.[6] when they found that 36% of patients given a placebo and scopolamine were sleepy as compared to none given atropine and a placebo.

Depressing Parasympathetic Activity

Recently antihistamines, tranquilizers and other anticholinergics have been used to depress parasympathetic activity—mainly secretory functions. Although Benadryl seems to be comparable to atropine in preventing secretions, it does not have the amnesic qualities of belladonna drugs. Phenothiazine antisialogogue activity was previously mentioned. Since this is only a mild side-effect of these drugs it would appear that stronger anti-parasympathetic drugs are needed to successfully prevent secretions. Their amnesic and tranquilizing properties need not be reiterated here. Other anticholinergics such as Banthine have also been used but reports as to their efficacy are conflicting.

Another facet of preanesthetic medication is the course of induction and the conduct of anesthesia itself. Preanesthetic drugs do influence the type of complication encountered during induction and course of anesthesia as found by Eckenhoff and Helrich.[9] They found that if Seconal was used as a preanesthetic and thiopental was used for induction coughing and laryngospasm were common. As might be surmised, more thiopental was used for induction and during the course of anesthesia if the patients were given placebos preoperatively. If cyclopropane or cyclopropane-ether anesthesia was used with secobarbital preparation, there were more coughing and respiratory tract secretions noted.

However, nitrous oxide-ether anesthesia was not seemingly influenced by the type of preanesthetic medication used. Preanesthetic medication with narcotics seemingly increased the incidence of excitement and unintentional apnea if cyclopropane was used. However, Cohen and Beecher,[10] in a study of 558 general surgical patients medicated preoperatively with morphine or barbiturates, noticed only a little less excitement with morphine.

Postoperatively patients prepared with morphine seem to complain less of pain than those prepared with barbiturates. No studies were found of postoperative pain in patients who received phenothiazines preoperatively but some authors have stated that less postoperative pain medication was needed. However, it is noted by various authors cited in this paper, who found postoperative nausea and vomiting, pulmonary complications, and postoperative restlessness to be less with phenothiazine prepared patients.

Summary

Preanesthetic medication is important in attempting to produce the ideal anesthetic. The drugs and dosage of choice should be carefully considered on an individual basis for each patient. Morphine or barbiturates still are the drugs of choice in most cases. Phenothiazines and other tranquilizers may be used as adjuncts to these drugs, if indicated, to obtain advantage of their specific effects i.e. antiemetic, sedative, etc. but all of the effects of these drugs should be known prior to their use. One of the belladonna drugs should be given concomitantly with the narcotic or barbiturate for the reasons previously stipulated. In this manner preanesthetic medication will be adequate for the vast majority of surgical patients.

BIBLIOGRAPHY

1. Smith, R. M.: Sedatives for Preoperative Use in Children. *Anes. & Anal.* 38:3, 166-172, May-June, 1959.
2. Egger, G. W. N., Coressen, G., Allen, C.: Comparison of Vasopressor Responses in Presence of Phenothiazine Derivatives. *Anesthes.* June, 1959, pp. 261-65.
3. Romagnoli, A.: Clinical Evaluation of Levomepromazine in Anesthesia. *Canad. J. Anes.* 6:3, 263-266, July, 1959.
4. Dobkin, A. B.: Efficacy of Ataraxic Drugs in Clinical Anesthesia. *Canad. J. Anes.* 5:177-208, April, 1958.
5. Egbert, L. D., Norton, M., Eckenhoff, J., Dripps, R.: A Comparison in Man of the Effects of Prome-

thazine, Secobarbital and Meperidine, Alone and in Combination on Certain Respiratory Functions and for Use in Preanesthetic Medication. *So. M. J.* 51: 9, 1173, Sept., 1958.

6. Marx, G. F., Orkin, L. B.: Comparison of Demerol, Nembutal or Benadryl with Atropine and Scopolamine for Preoperative Medication. *N. Y. State J. of Med.* 59:1, 78-85, Jan. 1, 1959.
7. Martin, H. J. V., Thomas, E. T.: Effect of Atropine on Heart Rate. *Lancet* 2:1313-1316, Dec. 20, 1958.
8. Harley, R. D., Mishler, J. E.: Ataraxics and Antiemetic Drugs in Cataract Surgery. *Opth.* 47:2, 177-184, Feb., 1959.
9. Eckenhoff, J. E., Helrich, M.: Study of Narcotics and Sedatives for Use in Preanesthetic Medication. *J.A.M.A.* 167:4, 415-421, May 24, 1958.
10. Cohen, E. N., Beecher, H. K.: Narcotics in Preanesthetic Medication. *J.A.M.A.* 1664-1668, Dec. 22, 1957.
11. Dyrberg, V.: Preanesthetic Medication with Meprobamate, *Acta Anesthesiologica Scand.* 1:147-152, 1957.
12. Haxholdt, B.: Preanesthetic Medication with New Drugs. *Brit. J. Anes.* 30:226-232, 1958.
13. Hopkins, D. A.: Foreign Letter Dept., *J.A.M.A.* 159:2, 142, Sept. 10, 1955.
14. Dyrberg, V.: Chlorpromazine in Anesthesia. *Acta Anesthesiologica Scand.* 2:133-147, 1958.
15. Dyrberg, V., Houg. W.: Investigation into Combined Effects of Chlorpromazine and Neuromuscular Blocking Agents on "Red" and "White" Muscle. *Acta Pharmacologica and Toxicologica* 14:130-137, 1958.
16. Haxholdt, B.: Preanesthetic Medication with New Drugs. *Brit. J. Anes.* 30:226-232, 1958.
17. Bourgois-Gavordin, M., Norveli, W., Margolis, G., Stephan, C. R.: Chlorpromazine, A Clinical and Laboratory Investigation. *Anesthes.* 16:6, 829-847, Nov., 1955.
18. Buxton-Hopkins, D. A.: Summary of Proceedings, *Brit. M. J.* 2:129, 1955.
19. Lear, E., et al: Chlorpromazine, An Adjunct to Premedication, *N. Y. J. of Med.* 55:1853-1857, 1955.
20. Orkin, Louis, R., Egge, R. K., Rovenstine, E. A.: Effect of Nisentil, Meperidine, and Morphine on Respirations in Man. *Anesthes.* 16:5, 699-707, Sept., 1955.
21. Tevetgoli, F., Abbey, J.: Preanesthetic Medication with Chlorpromazine. *J. Pediatrics* 51:2, 181-183. ◄

What Is Normal?

Dr. Robert F. Peck of the University of Texas Department of Psychology at Austin described "normality" thus in a recent issue of *Life:*

"What is it to be 'normal'? It is to be unreasonable with one's spouse, or children, several times a week, yet try in a fumbling, half inept, but sincere way to make it up. It is to spend money foolishly, then work hard to stretch what's left till pay day. It is to work all your life as a railroad man, wishing you'd finished school and gone into law, yet proud of your 25 years of service. It is to get drunk ever week for years, then 'get religion' and stop drinking, start doing church work. It is to marry in haste, divorce in haste, and marry five years later to a person you love all the rest of your life.

"Are there completely happy people?" No, we find no one whose life is, and has been, without some hard-hitting frustration or some profound sorrow. When a beloved parent dies, or a just-grown child—what door of escape is there? There is no way out of the grief except to live through it.

"For more than half of us, life is a matter of settling for a good deal less than we want. We know it; we've known it for years; and we are decidedly not happy at the many moments when we think about our losses, our disappointments and our never-will-be's. For such of us, life is never brilliantly happy. Unalloyed joy is an unknown or forgotten sensation. Too many hurts, big and little, have chipped the bright colors away."—*Texas State Journal of Medicine,* Sept. 1960.

Mental Health and the Transplanted School Child

*ESTHER J. SWENSON, Ph.D.**
University, Alabama

WHEN THE EVENTS of our existence do not run too smoothly, when some major disappointment or sorrow weighs heavily upon us, when today's activities seem pointless or unsuccessful, we often derive comfort from the thought that tomorrow may bring better experiences.

We have many expressions which point up the essential continuity of life: "Time marches on." "There'll always be tomorrow." "Life goes on." "Tomorrow will be another day." In fact, without such continuity life ends. But "the thread of life that runs so true" is not a simple, straightline, uniform sort of continuity. It has its ups and downs. The "thread of life" is sometimes strong as cables of steel, sometimes weak as a frazzled filament of cotton much the worse for wear. In either case, so long as there is life there is continuity of being. But the "thread" figure of speech is useful in only a limited way, for we are concerned here with the experiences of human beings and must deal with more life-oriented ideas. We must think in terms of living things or beings.

First, we should define two terms: *articulation* and *continuity of experience.*

"Articulation" means the act of joining parts, or the condition of being joined or jointed. In botany we say the leaf of the plant is articulated with the stem. In anatomy we say that bones are articulated at a joint. In phonetics we say that organs and their movements are adjusted for the articulation of sounds. In each case, we have distinguishable parts; the parts are somehow connected with the whole (plant, bone structure, or other whole); and the term "articulation" is applied either to the point of connection or the process of connecting the parts.

Bone articulation is considered poor if after injury the bones do not connect as smoothly and function as well as before. Articulation is considered good if the joint functions smoothly and efficiently. The application of the adjectives "good" and "poor" is similar in other cases of articulation. If the parts do not connect at all, we have "lack of articulation" or "inarticulation."

"Articulation" is usually defined in the literature of professional education in terms of the relationships among various elements of the school program and in terms of the interdependence of the several parts of that program. Attention has usually focused upon the various elements to be related. We find discussion of articulation of curriculum offerings with extra-curricular activities; of the instructional program with the guidance program; of the school's program with the educational programs of other community institutions and agencies; or articulation of the various levels of the educational system with one another, such as the elementary school and the junior high school.[1]

. . . In a further attempt to focus attention upon the process of articulation as it occurs in the learner's everyday living, another term will

* Professor of Education, University of Alabama; Speaker at The Scientific Session, ISMA Annual Convention, Indianapolis, 1958.

be frequently used, along with that of "articulation." That term is "continuity of learning experience."[2]

"Continuity of learning experience" may bring clearer emphasis upon what is happening to the learner than does the term "articulation," as the latter has commonly been used. The fundamental test of efforts at improving articulation in schools is found in what happens to the learners in those schools. Our aim is to further continuity of learning experience toward educational objectives. We seek to give boys and girls in the schools those learning experiences which will help them achieve their own and the school's objectives in the most efficient manner possible. At times this involves prevention or removal of barriers to pupil progress in the course of being educated.

"Continuity of learning experience" stresses the on-going learning process rather than formal administrative structure or even sequences of curricular activities. Emphasis is placed less upon how the school is organized into grades and levels, less upon what learning activities are prescribed at various levels, and more upon what happens to the learner as he goes from level to level or as he reacts to the various learning activities. After all, what happens to school learners collectively represents the sum total of the school's accomplishments, good or bad.[3]

Continuity in School Experience

Professional discussions of continuity of learning for school children have in recent years been directed to the learner's view of the situation much more than was true of discussions of articulation between school levels some years back. The 1958 Yearbook of the Association for Supervision and Curriculum Development is called *A Look At Continuity in the School Program*. Part One of that yearbook is entitled "Through Children's Eyes" because it is the report of a research study of children's experiences bearing on articulation.

The yearbook committee members wanted to know what school children could tell them about factors which had helped or hindered their steady progress up the educational ladder during the 12 or 13 years of schooling preceding graduation from high school. In spite of certain very real limitations in children's reports of their own past experiences, the committee members felt that they would better understand articulation and inarticulation in schools if they could have the advantage of looking at continuity of learning experience through children's eyes.[4]

Members of the yearbook committee, widely scattered throughout the United States, questioned children about the experiences which stood out in their minds as having helped or hindered their progress through school. Replies were gathered from more than 3,000 school children in 11 states. Included in those replies were accounts of 4,197 situations which children considered of enough importance to mention as representing helps or hindrances to their school progress. (Notice that both the positive and negative aspects of articulation were studied.)

Key Situations

An analysis of the types of situations which students reported as affecting their progress through school showed that their reports centered chiefly around four types, namely: moving to a new school community; teacher behavior; subject matter; and moving to a new school level. Definitions of these situations will be accompanied by quotations from pupils' reports to illustrate the meaning of each term and to point up the mixture of positive and negative comments concerning each.

Moving to a New Community: The child tells of moving to a new school for some reason other than being promoted to the next higher grade or school level. This transfer may come at the end of a school year or during the year, but the conclusion of a school term is not the reason for moving into a different school. Usually this situation comes about because the family changes its residence.

Illustrative Quotations: "Before I went to another school I was thinking how wonderful it was to get away from the old one. When I got there I felt so strange and awful. I was lonesome and scared. Afterwhile I felt better."

"I have attended six schools and I feel I have never had any troubles changing."

"The thing that has bothered me in school is the fact that my parents moved very often from town to town and state to state."[5]

Moving to a New School Level: In this situation the pupil moves to a new school because he has been promoted to the next higher administrative division of the school, such as going

from elementary school to junior high school. This category does not include promotion from grade to grade unless a change to another unit of the school system is involved. "Level" here does not mean "grade" but a more inclusive administrative unit, usually including three or more grades.

Illustrative Quotations: "I think the change from elementary to junior high was very good because I liked the change from one teacher to many."

"The most . . . difficulties of moving from grade to grade, is the changing of subjects, number of classes and number of teachers. But the hardest was after going into senior high school and the change of marks or grading, the tests which were all of a sudden thrown upon us, like mid-year and final examinations."

"All at once you were expected to be grown-up in the seventh grade. The teacher expected too much."[6]

Teacher Behavior

Situations reported under the category of "teacher behavior" are those for which the student's report centers around something the teacher does or says or the way the teacher acts.

Illustrative Quotations: "The teacher said, 'Why all of you ought to be ashamed, Polly is only six and she can spell it.' This embarrassed me and I found myself not wanting to progress to the point of being embarrassed in front of my friends."

The best school I ever went to was C——, probably because the teacher I had was nice. She explained things so it wasn't difficult to understand."

"The teacher won't help you at all. Thanks to her I flunked reading. The math teacher comes and stares over your shoulder and scares you so that chills go up and down you."

"One time when I was lying on the teeter-totter Miss X took a ruler and hit me real hard for doing that. I don't think it's right when I didn't know that rule. I think it's not right to be so quick."[7]

Subject Matter: The "subject matter" classification centers upon content studied in school. For example, the pupil tells of difficulties he had with arithmetic assignments in a certain grade or he comments favorably on the interesting content of his work in junior high science.

Illustrative Quotations: "In the fourth grade I was fouled up in my spelling. They gave me a third grade speller and I was a year behind in my spelling. When I went to the seventh grade, they gave me a seventh speller. So I never got the sixth grade speller."

"While I was at D—— in the third grade I didn't catch on to the division. I went through a quarter of the fourth not knowing how to do division. One day my mother saw my back division pages. That day she taught me to do division. Now division is my best subject."

"Things that have made it easier for me in this school are firm things like home economics. It helps me with things I need and it helps me get a passing grade."[8]

These types of situations are those which children reported most frequently as having helped or hindered their steady progress through school. Together these four situations account for almost three-fourths of all situations reported. They would seem to merit, therefore, very serious consideration by all persons who are concerned about the school progress of children and about their general mental health and wellbeing.

Importance of Transition Points

The four most frequent situations recognized by children as crucial in their school progress may appear on the surface to be rather diverse—moving to a new community, teacher behavior, subject matter, and moving to a new school level. Children's comments about these situations, however, show underlying similarities. The unifying idea is that of having to make a transition, sometimes made successfully, sometimes not; but the children recognize the significance of the occasion and the importance of their success or failure in negotiating the transition situation.

In moving to a new community, a child has many adjustments to make. He lives in a different house in a different neighborhood; he goes to a different school where he knows none of his classmates or teachers; the school's curriculum and details of routine procedure are different; even the members of his own family are different, for they too are changing their ways of doing things in order to fit into their own new environments.

Moving to the next higher school level includes many of the same adjustments as are involved in moving to a new community; but

there is not the same complete change. The student probably has some of the same classmates; that is a big help. His home situation has not changed in the marked way which is true when the family moves. Perhaps these stabilizing influences suggest one reason for the fact that this type of situation was not recorded as often as was moving to a new community.

On the other hand, some very real problems are associated with such a change. For instance, the transition from the elementary school to the junior high school often involves the use of different transportation facilities, association with more classmates who are strangers, getting acquainted with several new teachers instead of the one home room teacher in the elementary school and many differences in procedure such as the constant movement from room to room and variations among teachers as to making assignments or the routines of classroom management.

The category of teacher behavior might seem to involve less transition, but children's accounts of their reactions to teacher behavior reveal many transitional aspects. All experience is, of course, transitional as one moves from past to future through the present experience. The pupil must make the adjustment from one teacher personality to another. In high school he makes this adjustment every time he changes classes; it goes on every day. The child who moves into a new community or a new school level is greatly affected by the way teachers react to him. They help or they hinder his adjustment to his classmates, to the subject matter being learned, to his total school environment.

The learning of subject matter also has its transitional characteristics. Any teacher who has struggled with the myriad problems of sequence in organization of the curriculum for a single class or for the total school is well aware of this fact. The order in which the child is exposed to items of subject matter may be very important; a given order of introduction or speed of introduction of content which is suitable for one child may not fit another at all. The sequence of learning activities in one school or in one subject or under the direction of one teacher may or may not fit into a coherent pattern with that experienced by the learner in another school or in another subject or under the direction of another teacher. He may have missed out on a single basic idea and experience severe hindrance in later learning for lack of that understanding. A teacher may have supplied a key concept at just the right time to make his learning move smoothly and efficiently to the next concept.

Analogy—Transplanting Plants and Children

At times the drawing of analogies between the experiences of human beings and life processes outside the human realm can be very fruitful. Take, for example, an analogy between the transplanting of green plants and the "transplanting" of children. The obvious reason for drawing such an analogy is that both are living, ongoing entities; both have life. One distinction which is made between animals and plants is that animals are generally capable of voluntary motion while plants are not. No plant ever controls the *when* or the *how* or the *where* of its transplanting, nor even the decision to be moved. This is also often true of children and the type of "transplanting" to which they are subjected.

Elementary school children certainly and secondary school students usually do not have very much control over the types of transition mentioned earlier. They do not decide whether or when their fathers shall get a new job and move the whole family to a new community. They do not decide where they are to be placed when teachers and administrators make up class sections. They do not decide how or when they shall take up division of fractions. Both parents and teachers might well pause to consider how frequently children are subjected to major or minor transition with no more control of the situation than a plant being transplanted.

The fear or the challenge of the new and strange—that is, the unknown—is a greater reason for children's success or failure in satisfactory articulation of their learning experiences than adults sometimes realize. How much of the familiar is needed to balance with the new and the strange is different for every human being. It varies also in terms of the help which is available in making the transition.

The more a gardener knows about his plants—their individual characteristics, their natural habitat, their food and moisture needs, their particular weaknesses and strengths—the better he can handle the job of transplanting them from

one plant home to another. Also, the more he knows about plants in general, the more apt he is to do the right things and avoid the wrong procedures in moving them.

So it is with teachers and the school children who are, for one reason or another, transplanted. The teacher who understands a certain child and his problems can help prepare him for moving to a new and strange situation. The more the child's new teacher knows about him and about children in general, the more likely he is to be of help in making the adjustment as successful as possible. The wise teacher adjusts orientation technics for individual learners. Much is said, partly in jest and partly in earnest, about gardeners with a "green thumb;" but there is more to successful horticulture and successful teaching than luck and a natural bent for the work. Knowledge and interest and effort have much to do with success in either field.

Individual Differences

Some plants are hardier than others; the same is true of children. Some plants can tolerate wide variations in soil conditions or climate; some cannot. Some children can adjust quickly and easily to rather wide variations of social and phychological climate and to the physical factors in the environment; others are easily disturbed by such changes and can tolerate only minimum variations without suffering considerable hardship. This difference in the hardihood or sensitivity of children must be understood by parents and teachers who seek to help where help is needed.

Perhaps an optimum continuity of experience for a child in school is achieved when he has enough change to lend interest and variety and challenge but enough similarity of circumstance to lend stability and to promote growth toward appropriate objectives. Such continuity is most apt to be achieved when the differences between situations to which the child must adjust are not too great. In the child's school life, this means that the difference must be manageable for him—whether it be a difference in physical environment, curriculum, social relations, teaching-learning procedures or the mechanics of school regulations. It also means that the child must not need to deal with too many differences at once. A junior high school child might adjust fairly well to new course content and administrative patterns if he could share his new experience with some of the friends he had in elementary school. Teachers and parents need to assess the degree of adjustment and the number and types of changes to which they expect each child to adjust.

A Complex Situation

The consequences of transplanting living things are far-reaching and some of them irrevocable. In the ASCD research cited earlier in which 3,000 children told about situations in which they had been helped or hindered in their progress through school, positive and negative comments were rather evenly divided. "Half good and half bad" is hardly a satisfactory balance in this case. Many improvements need to be made in the ways which teachers and administrators approach the problems faced by pupils when they are transplanted from old and familiar situations to new and strange ones. The situation is by no means hopeless, however.

The skillful worker with plants pays attention to many factors when he transplants; he checks on soil, water, sunlight, the season of the year, the overall climate, the available room for growth, the maturity of the plants and the similarity or difference between the old and the new habitat. He is rewarded for his efforts when the plant stays green and fresh, when it grows straight and tall, and, most of all, when it sends out new shoots.

The teacher or administrator who recognizes his responsibilities in connection with children's problems in adjusting to new and different situations also takes note of many factors. A few detailed parallels might be appropriate in indicating some of the adjustments made by plants and by children.

For most plants soil is an essential. They need something to take root in. So do school children. They need the security of warm human relations in a schoolroom where they can feel at home. They need to be accepted by teacher and classmates as belonging in that group and being welcome there. How much thought is given to this consideration when school children make transitions from community to community, from school to school, or from one classroom to another?

Water for the plant might well be compared to the refreshing word of encouragement for a

pupil. Perhaps a teacher's clear explanation of an idea or a situation could refresh and lift the spirit. The experience of success in a learning activity has the same effect.

The plant gets its food from soil and water; a particular soil might conceivably be too rich for certain plants; too much water may flood them. The plants may fail to stand erect because of too muddy a footing. This thought reminds the teacher that a home-like schoolroom or the refreshing effects of encouragement for children will fail of their purpose if they are overdone. Children should not be smothered with affection or drowned in sentimentality. The school's aim should always be to provide a setting in which they can stand erect as strong individuals.

Attractive Learning Environment

Sunlight is equally necessary to plants and to pupils. The schoolroom should be cheerful both physically and psychologically. Time and money spent on making classrooms attractive is very well spent. To countless numbers of children, the school building is the most attractive interior they have ever seen; it is important that it be made as attractive an environment for learning as possible. But the psychological environment for learning is even more important. A well-lighted learning environment has not only the cheerful light of happy human relations but has as well the illuminating light of understanding which helps the learner move from fuzzy notions to clearly delineated ideas. Occasionally the learner experiences the shining inspiration of a sharp new insight. How much of this sparkle lights the daily routine in the average classroom? How much real sunlight is there and how many gloomy shadows of monotonous repetition of fact and phrase dulled by too little real thought and too little real concern? Again, we must remember the dangers of excessive sunlight can be damaging to both plants and humans. The sunlight of ideas must be used to warm and lift, not to burn.

Some plants may be moved at any time of year; others can more successfully be transplanted only at certain seasons. Some learning tasks for children too may be assigned at any time, e.g., the everyday and never-ending learning of acceptable social behavior. Other learning tasks have their appropriate seasons. For example, subject matter in mathematics tends to be more prescribed by sequences of concepts and processes than does subject matter in the social studies area. Even in mathematics, however, the sequence need not be nearly so rigid as is commonly believed. More important is the sequence of learning in terms of each child's own experience.

How simple it would be if only all learners in a class would be ready for each learning task simultaneously! But this is not true, and we must teach accordingly, to each in his season of readiness. (Notice that the period of readiness is not a moment in time, but a season; there is a vast difference.) The child who is transplanted into a new school setting may have been operating in a different sequential pattern of studies; the wise teacher will find out as much as possible about that pattern of past learning while helping the pupil to adjust to the new one. The wise teacher will also recognize that the child should not do all the adjusting, even with help; the teacher and the pattern must adjust also to meet varied pupil "seasons."

Maturity of plants should be considered when they are moved. It is commonly thought that the larger the plant, the poorer the chances of survival.

Young children, when transplanted from one school environment to another, need much help in getting properly introduced to the new school home, and any help given in preparing them for such change is all to the good. But it may be that school people have not paid enough attention to the difficulties faced by the older school child when he faces similar transition points in his educational life. Maybe we should pay more attention to how he is prepared for these transitions. Maybe we should "do it by hand" when we follow up his roots in the old situation, seeing to it that the process of pulling loose from the old soil is done considerately. Maybe we should remind ourselves that those roots must not be allowed to "dry out" during the transition, that he needs help to take root in the new setting as soon as possible.

The fact that a boy or girl is old enough to enter junior high school or senior high school or even college does not mean that removal from the old school home to the new one is just a routine matter. Often the minutest of details may cause difficulty, and because they are details

the boy or girl hesitates to make a point of them. In the meantime, they become much more than details.

Minute Details Important

For example, a boy moving from elementary school to junior high school is concerned about how he will get a locker in which to keep his things, or the girl entering senior high school in a new community is deeply worried about whether she can find her way around in a much larger building than she has known, or the college freshman may even hesitate to attend college because he fears the rumored complexity of registration methods and procedures. Educators and parents would do well to help students set these details in order before they create real barriers to the business of getting an education.

Any person who reads the 3,000 children's reports referred to earlier is bound to be impressed with their recognized need for the security of the familiar. The familiar face in the class, the familiar procedure, the familiar materials, the familiar time schedule are more important than teachers may realize. This does not mean we must resort to static conditions, for these same students also commented frequently on their satisfactory adjustment to the new when they had just a little help in facing it, when they were not expected to change in too many ways in too short a time.

Marie Rasey, in an address before an audience of educators a few years ago, told of a conversation she had had with a conservation official who reported a series of unsuccessful efforts to increase the population of a certain species of wild bird. The whole trend reversed when a different approach was used. The natural habitat of the birds—ruined by the removal of such items as their shelter in certain shrubs—was restored, and the bird population took care of itself.

Some features in students' habitat for learning are essentials; these essentials may be found in varied settings but they must not be ignored or removed. At transition points in school experience, we need to pay attention to the habitat in which the learners thrive, with enough of the familiar to give security and enough of the new to lead on to new adjustments and new learning in general.

Finally, any good set of directions for transplanting plants usually emphasizes the need for plenty of room for the roots to grow in. Does the school child have enough room for growing? When he moves to a new school community, when he moves to a higher school level, when he starts a new subject or when he gets a new teacher, how much of the plan for his learning recognizes this need to have room in which to grow? Every child needs a type of instruction which leads on to new skills, insights and capabilities. Every child needs to experience the satisfaction of being free to learn in ways that make sense to him.

Transition from one learning environment to another may be hard enough at best for many children; certainly they should be allowed room for reaching out to sources of mental and social and emotional nourishment in the new situation. Children need to know that "it's all right" for them to go beyond a uniform assignment; they need to know that "it's all right" to get a right answer by a different method than that used by the teacher or another child; they need to know at once the security and the challenge of the learning environment in which they have room to see where they are headed and have a part in choosing that direction.

Conclusion

The skillful teacher studies the chances of difficulty in any new situation and tries to prepare children for necessary adjustments; he removes unnecessary obstacles to understanding (and they are many); he works with other teachers to minimize confusion for the child who must in a sense please each of them; he looks at the curriculum as far as he can through the eyes of the boys and girls with varied backgrounds of experience and understanding; he seeks to understand children's home environments and to help parents understand the school's expectations; he helps other children to see how they can help the child who feels strange.

When the teacher does these things, he is rewarded for his efforts. The child loses none of his zest for school learning; it may increase. He maintains a lively interest in his new experiences and is challenged by them. He stands straight and tall among new-found friends. Best of all, like the successful transplant, he sends out new shoots of growth. In school achievement, in social relations, and in personal development he blossoms into fuller living and learning.

When these signs appear, the teacher knows that the transplanted child has taken root and is at home.

BIBLIOGRAPHY

1. Association for Supervision and Curriculum Development: A Look at Continuity in the School Program. *1958 Yearbook,* Washington, D.C., p. 4.
2. Ibid., pp. 5-6.
3. Ibid., p. 6.
4. Ibid., p. 11.
5. Ibid., p. 15.
6. Ibid., pp. 15-16.
7. Ibid., pp. 16-17.
8. Ibid., p. 17.
9. "Trees: How to Plant a Tree," World Book VI, 8156c. ◄

Confusion Compounded

Patients have long complained that medical terminology keeps them mystified about the details of their own cases.

But much technical medical language is confusing even to the physician, says Dr. J. E. Schmidt of Charlestown, Ind.

"Uretolysis," for example, he writes in *Modern Medicine,* "has three meanings: (1) an operation to free an ureter from adhesions; (2) rupture of an ureter; and (3) paralysis of an ureter.

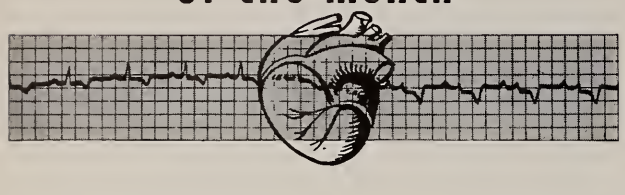
"Anaclasis is burdened with five meanings: forcible flexion of a limb, breaking up of an ankylosis, a reflex action, a refracture and refraction or reflection of light."

Another problem, Dr. Schmidt continued, is posed by words that have opposite meanings, such as thyrotoxin, which means both a toxic substance produced by the thyroid and a substance toxic to the thyroid.

"The existence of several words or synonyms for one concept is yet another plague. Thus we have madarosis, milphosis and ptilosis for loss of eyelashes. Similarly, we have aconitis, olenitis and olecranarthritis for inflammation of the elbow joint.

"Finally, even an incomplete list of the frailties of medical vocabulary would be incomplete without mention of its sesquipedalians, e.g., hepaticocholangiocholecystenterostomy."—*Medical News,* Sept. 28, 1960.

Electrocardiogram of the month



Presented as a regular feature of The JOURNAL, Electrocardiogram of the Month is a series of short talks on cardio-vascular diagnosis and treatment, edited by the staff of the Robert M. Moore Heart Clinic of the Marion County General Hospital, Indianapolis.

Myocardial Infarction

CHARLES FISCH, M.D.
Indianapolis

ELECTROCARDIOGRAPHIC diagnosis of myocardial infarction in the presence of significant Q waves, ST segment changes and T wave inversion does not present a problem and is rarely misleading. "Coronary" Q wave is believed to be due to the transmission of the initial negative cavity potential toward the exploring electrode through a myocardium made physiologically inert by the infarct.

In a number of instances, however, myocardial infarction occurs without Q waves and in such cases the physician must rely on the history, physical findings and other laboratory data. Patterns due to infarction but which are not accompanied by the appearance of the Q wave in the conventional 12 leads are: (1) subendocardial infarction, (2) pure posterior infarction, (3) infarction with a sufficient number of viable

Supported by the Krannert Fund of the Indiana Heart Association, Indiana State Board of Health and The National Heart Institute (H.T.S.-5363).

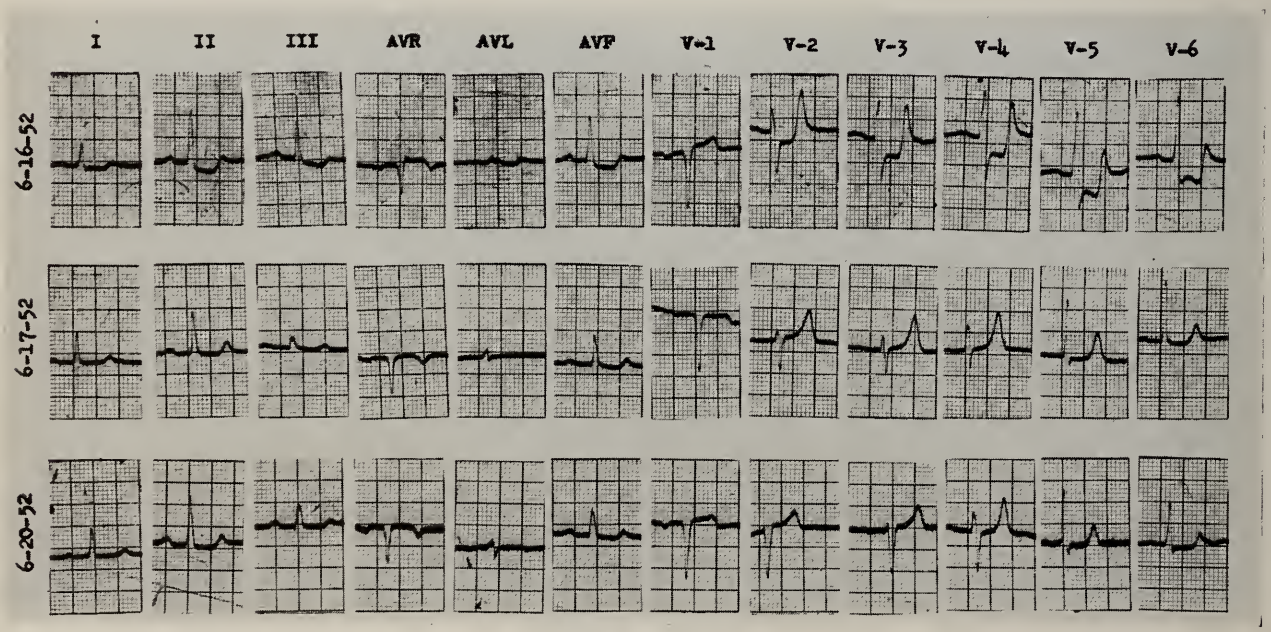


FIGURE 1 (CASE 1)

SUBENDOCARDIAL INFARCTION. Note the depression of ST segments on 6-16-1952, followed by loss of amplitude of R waves.

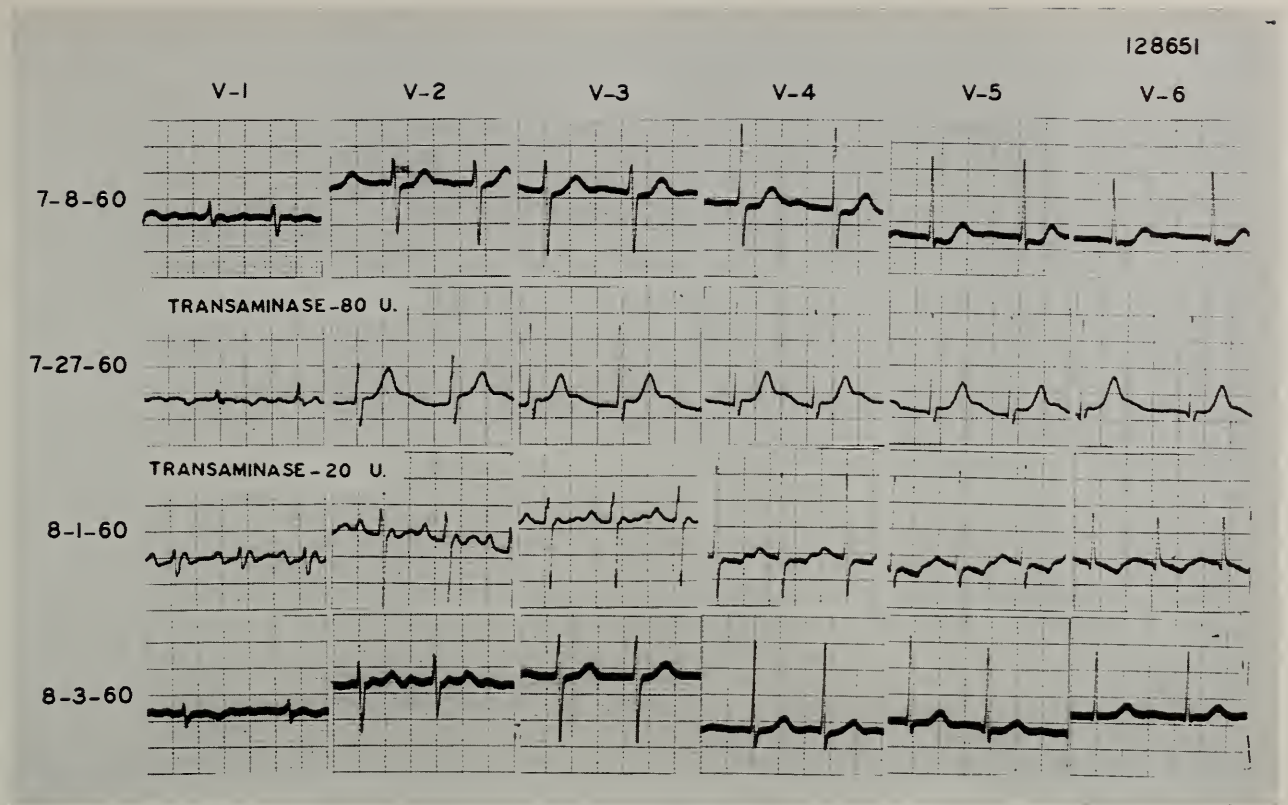


FIGURE 2 (CASE 2)

MYOCARDIAL INFARCTION with T wave changes only. Tracing on 7-8-60 is used as a control and shows atrial fibrillation. On 7-27-60 (day of admission) the T waves are taller and peaked, suggestive of ischemia. On 8-1-60 atrial tachycardia with 2:1 response is present and is accompanied by inversion of T waves. Transaminase on that day was 80 units. The P.A.T. with block as well as the T wave changes were transient and the cardiogram on 8-5-60 was similar to the controlled tracing.

islands to result in an initial R wave and (4) subepicardial infarction.

In this brief report we would like to present a case of subendocardial infarction and one of infarction with transient T wave changes only.

Subendocardial Infarction

Case 1—A 63-year-old man was admitted to the hospital on June 16, 1952, complaining of severe substernal chest pain. Essential physical findings were those of marked apprehension, dyspnea and shock. Despite all efforts the patient died and at autopsy a massive subendocardial infarction of the left ventricle was found.

An electrocardiogram taken on the day of admission (Figure 1) shows depression of ST segment in leads I, II, III, AVF, V2, V3, V4, V5 and V6. Serial tracings on 6-17 and 6-20, 1952, if viewed as isolated tracings would be considered normal. Serial tracings showed a definite diminution of amplitude of the R waves in V2, V3 and V4 which are the hallmarks of subendocardial infarction. The infarct involving the subendocardial layer only leaves sufficient variable epicardial tissue which results in an R wave. Loss of the inner portion (subendocardial) of the myocardium reduces the potential and consequently the amplitude of the R wave.

Transient T Wave Changes

Case 2—A 70-year-old woman with known rheumatic heart disease and documented atrial fibrillation since 1950, was admitted on 7-27-60, with a nine-hour story of severe substernal pain radiating to the neck and into the arms. Physical findings showed a somewhat apprehensive woman. Otherwise the findings were those of a mitral stenosis with atrial fibrillation. The electrocardiogram (Figure 2) taken on admission (7-27-60) showed essentially the same findings as was seen on 7-8-60, with exception of perhaps somewhat taller and more peaked T waves. The tracing taken on 8-1-60 shows a surprising arrhythmia, namely an atrial tachycardia with a 2:1 response and decrease of amplitude of T waves in V1, V2, V3 with inversion in V4, V5

and V6. A follow-up tracing on 8-3-60 shows a pattern identical to that seen on 7-8-60.

Transient T wave changes noted on 8-1-60 and perhaps the elevation and peaking of T waves suggestive of ischemia on 7-27-60 were the only clues to myocardial changes. That these were due to an accompanying infarction was suggested largely by the duration of the pain and associated elevation of temperature, leukocytosis and elevated sedimentation rate. Transaminase on admission was 40 units, on the day following admission, 80 units, and on 8-3, 40 units.

The purpose of presenting these two cases is to emphasize again that the classical textbook picture of myocardial infarction manifest by a Q wave may be absent in myocardial infarction. Exact incidence in cases in which the Q wave does not appear is unknown, but in our experience it seems to be of considerable size. ◄

Frozen Assets for Blood Banks

Insider's Newsletter reports good news for blood bankers and donors: A practical method has been found for long-term blood preservation. The U. S. Naval Hospital in Chelsea, Mass. has announced that it can freeze and keep blood for at least two years, possibly longer. Formerly, blood could only be kept about 21 days and then would have to be discarded as outdated.

This will mean: (1) the immediate reduction of blood wastage from outdating, (2) assurance of adequate supplies of rare types of blood without resorting to appeals for emergency donors, (3) greater chance of survival in any form of mass emergency when large quantities of blood are needed.—*Journal of Miss. S.M.A.,* Oct., 1960.

MEMO TO: ISMA MEMBERS

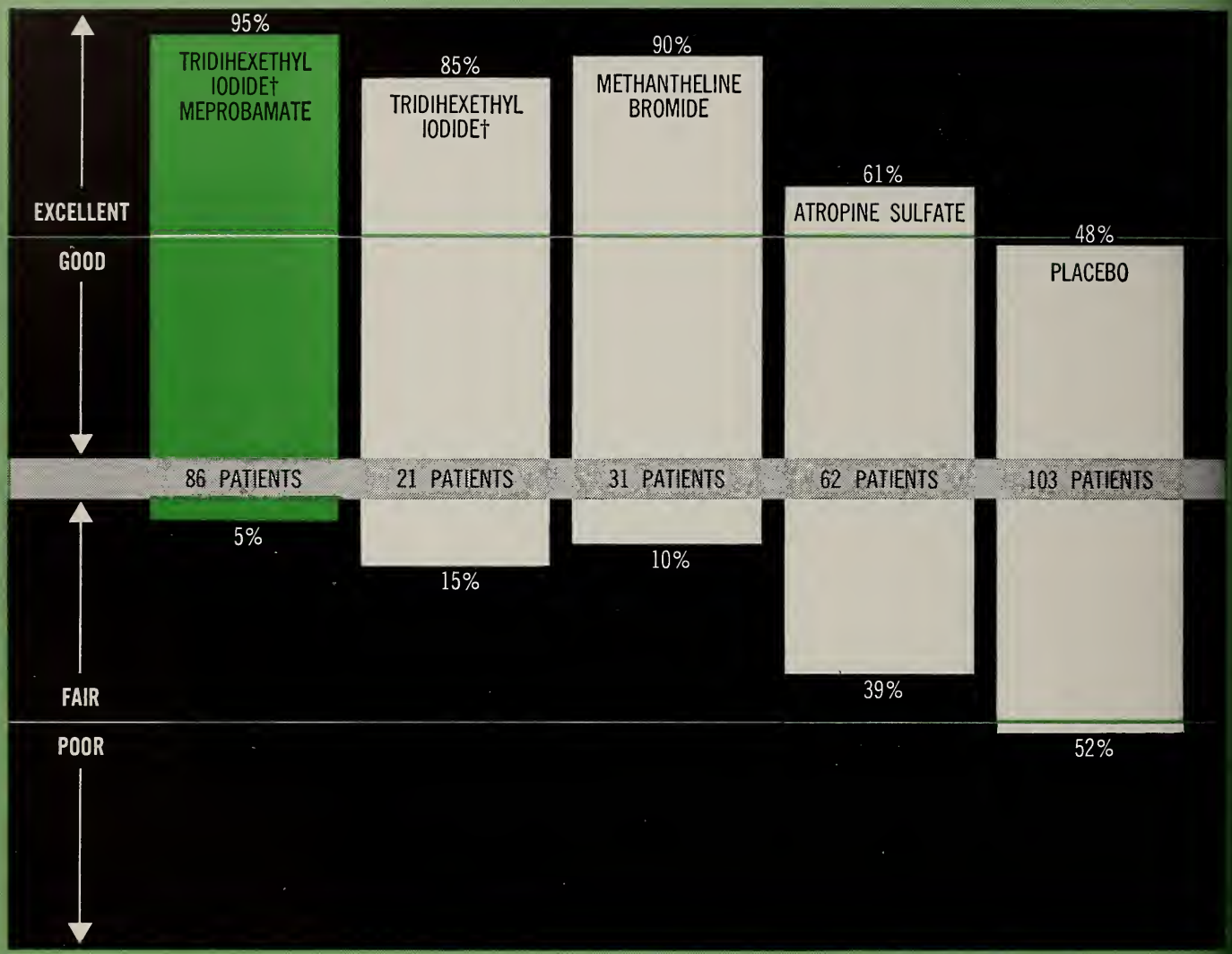
The JOURNAL is interested in full-length scientific papers and case reports for early publication. This is an open invitation to you to submit such work. Each paper is given careful consideration.

A few regulations regarding publication of papers are printed on the Contents page.

This announcement is made following a decision to increase the number of scientific papers published if sufficient material is available.

clinically proven efficacy.

in relieving tension . . . curbing hypermotility and excessive secretion in G. I. disorders



PATHIBAMATE combines two highly effective and well-tolerated therapeutic agents:

Meprobamate—widely accepted tranquilizer

and

PATHILON tridihexethyl chloride—anticholinergic noted for its effect on motility and gastrointestinal secretion with few unwanted side effects.

Contraindications: glaucoma, pyloric obstruction, and obstruction of the urinary bladder neck.

Two available dosage strengths permit adjusting therapy to the G.I. disorder and degree of associated tension.

Where a minimal meprobamate effect is preferred . . .
PATHIBAMATE-200 Tablets: 200 mg. of meprobamate; 25 mg. of PATHILON

Where a full meprobamate effect is preferred . . .
PATHIBAMATE-400 Tablets: 400 mg. of meprobamate; 25 mg. of PATHILON

Dosage: Average oral adult dose is 1 tablet t.i.d. at mealtime and 2 tablets at bedtime.

Pathibamate® 400 200

meprobamate with PATHILON® tridihexethyl chloride Lederle

clinically proven safety

The efficacy of **PATHIBAMATE** has been confirmed clinically in **duodenal ulcer, gastric ulcer, intestinal colic, spastic and irritable colon, ileitis, esophageal spasm, anxiety neurosis** with gastrointestinal symptoms, and **gastric hypermotility.**

Pictured are the results obtained with the PATHILON (tridihexethyl iodide)–meprobamate combination† in a double-blind study of 303 ulcer patients, extending over a period of 36 months.* They clearly demonstrate the efficacy of **PATHIBAMATE** in controlling the symptoms.

SIDE EFFECTS	TRIDIHEXETHYL IODIDE† MEPROBAMATE	TRIDIHEXETHYL IODIDE†	METHANTHELINE BROMIDE	ATROPINE SULFATE	PLACEBO
DRY MOUTH	1%	5%	72%	46%	5%
STOMATITIS	1%	0%	28%	14%	0%
VISUAL DISTURBANCES	0%	0%	50%	34%	1%
URINARY RETENTION	0%	0%	18%	11%	1%
DROWSINESS	20%	0%	0%	0%	0%
COMPLICATIONS OR SURGERY					
HEMORRHAGE	0%	9%	3%	9%	10%
PERFORATION	0%	0%	0%	6%	0%
OPERATION	0%	5%	5%	14%	2%
RECURRENCES					
NONE	28%	23%	25%	17%	26%
FEWER AND MILDER	67%	62%	52%	37%	24%
SAME OR MORE	5%	15%	23%	46%	50%

*Atwater, J. S., and Carson, J. M.: Therapeutic Principles in Management of Peptic Ulcer. **Am. J. Digest. Dis.** 4:1055 (Dec.) 1959.

†PATHILON is now supplied as tridihexethyl chloride instead of the iodide, an advantage permitting wider use, since the latter could distort the results of certain thyroid function tests.

Lederle LEDERLE LABORATORIES, A Division of AMERICAN CYANAMID COMPANY, Pearl River, New York

control the tension — treat the trauma

The Journal of the INDIANA STATE MEDICAL ASSOCIATION

Devoted to the interests of the medical profession of Indiana

Editor: Frank B. Ramsey, M.D., 1802 North Illinois Street, Indianapolis 2, Indiana

Associate Editors: A. W. Cavins, M.D., 221 South Sixth Street, Terre Haute, Indiana; Lall G. Montgomery, M.D., Ball Memorial Hospital, Muncie, Indiana; David A. Bickel, M.D., 515 Odd Fellows Building, South Bend, Indiana; Stephen L. Johnson, M.D., 521 Sycamore Street, Evansville, Indiana.

Editorial Board: Term Expires

George M. Johnson, M.D., Richmond . . Dec. 31, 1963
Irvin W. Wilkens, M.D., Indianapolis . Dec. 31, 1963
Harold D. Lynch, M.D., Evansville . . Dec. 31, 1961
Jene R. Bennett, South Bend . . . . Dec. 31, 1961
Samuel R. Mercer M.D., Fort Wayne . Dec. 31, 1962
Franklin F. Premuda, M.D., Hammond . Dec. 31, 1962

Necrologist: James B. Maple, M.D., 117 West Washington Street, Sullivan, Indiana.

Assistant Editor: Sara M. Snyder

Business Manager: James A. Waggener

1019 Hume Mansur Building, Indianapolis 4, Indiana

What Defeated MD Social Security?

During the session of Congress recently concluded the House of Representatives originated and passed a bill which would have placed doctors under compulsory social security coverage. When the bill was considered by the Senate Finance Committee it was defeated by a vote of 11 to 4.

What happened? The members of the Senate committee heard testimony from the AMA to the effect that, although several state medical associations had endorsed social security for physicians, the majority of physicians in the United States were opposed to it. Maybe they had also heard the charge that the AMA did not represent the views of the doctors at large.

Anyway, several committee members conducted their own polls among the physicians of their states. *Medical World News* reported recently on the results of some of these polls and the effect they had on the committee's final decision.

Committee chairman, Harry F. Byrd received 1,663 replies to the 2,900 questionnaires he sent out—613 were in favor, 1,050 were against.

Sen. Robert Kerr of Oklahoma found 60% of his state's doctors opposed.

Sen. Hartke got a return of 51% against, 49% for.

Sen. Paul Douglas of Illinois (the sucker state) reported a majority in favor of social security but found that he was an exception on the committee. Most of the others said their mail was the other way.

On the basis of their private polls the committee members voted the bill down. It did not reach the floor of the Senate.

So, it does do some good to write your Congressman and let him know what you think. It is evident that doctors will not be roped and tied into social security as long as more of us are opposed than in favor.

Seat Belts Can Control Death, Injury

POINTS OF INTEREST were noted in the annual report of Automotive Crash Injury Research, an activity of Cornell University, which originated in 1953 with limited statistical study of rural auto accident fatalities as reported by the Indiana State Police.

Indiana is honored as the "senior" state in the automobile accident data collecting program which at one time or another since 1953 has operated in 18 states and four cities, and soon will be operating in one other state and one more city.

Data on fatal and injury-producing accidents has now become so voluminous as to raise the question of utilizing electronic computors; ordinary machines and statisticans are not able to digest the information quickly enough.

In California about three percent of all automobiles involved in rural accidents had one or more seat belts installed. Among cars equipped with safety belts, only one-third had all of the installed belts worn by their occupants.

California Highway patrolmen overwhelmingly favor safety belts for control of death and injury. In the test period seat belt users experienced 35% fewer major-fatal injuries than nonusers in accidents of similar circumstance.

A full-year study of data from the Arizona Highway Patrol showed that speed, gross accident type and seated position had marked influences on injury severity. The presence of passengers seemed to influence injury, and death and injury may occur more frequently in foreign cars than in domestic cars.

Over the entire country-wide survey the rules established years ago were upheld. Ejection from a wrecked car increases the chances of severe and fatal injury. The biggest reason seat belts add to safety is probably their nonejection characteristic.

Recent reports also corroborate the early impression that cars manufactured in 1956 and later are safer because of their improved door locks.

Plans for the future include improved reporting forms, coding of data, possible use of large computors and repeated collections and analyses of data in order to establish and improve statistical validity. Increase of data is especially desired on cars of 1958 and 1959 manufacture.

Socialized Medicine Fails to Keep Promises

CURRENT DEBATE in national politics makes an up-to-date review of socialized medicine, as it is working out, especially apropos The August issue of *The Journal of the Oklahoma State Medical Association* contains an excellent editorial on this subject.

The occasion of the editorial is the announcement that a motion picture with sound track is now available to present a report on the first 10 years of government medicine in England.

Some of the startling facts which are made in this report are as follows:

1. 500,000 patients now are awaiting hospitalization.
2. Fewer additional beds have been provided in the last 10 years than in any decade since 1870—this despite the promises made prior to the plan that one advantage of it would be more and better hospitals.
3. More than 50% of all hospital beds in England are occupied by chronically ill.
4. One hospital has a list of more than 800 patients awaiting surgical operations, the longest wait being three years. In addition there are over 600 patients awaiting orthopedic operations; some of these have been on the list for six years.

The film may be obtained from the Film Library of the American Medical Association, 535 N. Dearborn St., Chicago.

Don't Relax Yet

THE FORAND BILL failed of passage by Congress. Good enough—but that doesn't settle the question. It will be back soon in identical or altered form. When the country decided it did not want socialized medicine as proposed by the bill for universal compulsory government medical insurance it was correctly predicted that socializers would attempt to establish the same thing piecemeal. The Forand Bill was one of those piecemeal attempts. Now that it has been voted down it is sure as taxes that a piece of the same idea will later be ballyhooed in a camouflaged or subtle form.

It has often been said that socializers can lose every year and still come back and try again. Those on the other side who favor doing things the right way can lose but once. So it is that everyone who believes in the private practice of medicine must be constantly on their guard. Now is a good time to be getting ready for the next attempt at socialization.

If you listen to the socialists you might get the impression that voluntary health insurance for people over 65 is nonexistent or has shriveled to the point that it is no help at all. As a matter of fact insurance coverage on the voluntary basis increased from 26% of the whole group to 43% in a period of seven years just prior to 1959. In 1959 and 1960 over 65 policies were the hottest thing in health insurance—outsold policies for all other age brackets.

Guest Editorial

Interprofessional Strength

AS THE FALLOUT from the Kefauver Drug Hearings increases along more and more unpredictable lines and we find a more demanding attitude in our own state Welfare Committee that we find a way to lower the cost of Welfare drugs, I believe the following reprint from *Drug Topics* very, very timely. Please read it carefully and thoughtfully:

"No discussion concerning the developments surrounding the growth of prescription services in this country can get too far away from the Kefauver hearings in Washington.

"Originally billed as an investigation of the drug industry's profits and prices, the hearings have now moved into such technical areas as the relative merits of drug products in terms of their efficacy and safety.

"No doubt the nimble-footed Senator from Tennessee can relate the originally announced intention of his investigations to this new phase, but there are many prognosticators in this country who contend that this is but the opening gun of a long-planned attack against private medical and pharmaceutical services.

"By undermining the confidence of the public in the judgment of the private physician to evaluate properly the therapeutic data presented to him by pharmaceutical manufacturers, he is giving aid and comfort to the proponents of complete governmental control over all aspects of medical care.

Patients Question Medication

"There are already reports that patients are questioning the judgment of their family physician when he prescribes a medication which has had some degree of 'Washingtonian' publicity.

"In a few instances pharmacists have been asked by their prescription patrons to reassure them as to the safety and therapeutic value of the prescribed medication.

"Needless to say, this can and is creating a potentially dangerous interprofessional situation.

"We have long been advocates of greatly intensified effort on the part of both physicians and pharmacists to establish well-organized inter-

professional groups within their local communities.

"Some pharmacists have questioned the need for such projects, indicating that there might be a lack of subject material which would provide a basis for the establishment of this type of organization.

Discussion Material Plentiful

"Long before Kefauver appeared on the scene, this objection could no longer be considered a valid one.

"The Senator, however, has provided an additional and, in all probability, a more demanding reason for such interprofessional efforts.

"And unless both pharmacists and physicians are alerted to the dangers inherent in these current moves on the Washington scene, we may find private practice as we know it today completely changed beyond all recognition within the next decade. Isn't this reason enough for moving ahead more aggressively to establish permanent interprofessional groups in your area?" —*The Indiana Pharmacist*, July, 1960.

Editorial Notes

"Mortality is higher among people whose blood pressure is above average than among those whose blood pressure is average or lower; generally, the higher the level of blood pressure the greater is the excess mortality." This from the "Build and Blood Pressure Study, 1959," by the Society of Actuaries and reported by the *Statistical Bulletin* of the Metropolitan Life Insurance Company.

The study also shows that blood pressures which are below average are associated with the lowest mortality. The increased mortality rates which are noted in those individuals with higher than average blood pressures are applicable to people who succumb to non-circulatory disorders, such as digestive diseases.

The SS Hope I, a 15,000 ton hospital ship, sailed on Sept. 22 to Southeast Asia, on a mission of emergency medical care and medical education. The ship is staffed by American doctors, nurses and medical technicians. This is a non-government program and is supported by voluntary contributions. More than $2 million has been received to cover the first year's anticipated expenses of $3.5 million. Fifty-two of the country's prescription drug manufacturers have contributed in excess of $780,000 in products and cash to the venture.

Hospital construction in the United States is at an all-time peak. In spite of this, the number of hospital beds is not increasing much faster than the population. From 1948 to 1959 civilian hospital beds increased by 30%, while the population was up by 20%. A tremendous amount of construction is needed to overcome the shortage which built up during the depression and the World War which followed. More than $1 billion was spent in 1958 in building civilian hospitals.

The number of graduate nurses has multiplied 2½ times since 1920, but a shortage still exists. In 1958, about 11% of the full-time nursing positions in hospitals were vacant, according to a report in "Patterns of Disease," published by Parke, Davis & Company. The trouble seems to be that the number of nursing jobs has increased faster than even the greatly increased production of nurses. Sixty percent of nurses now employed work in hospitals. Industrial nursing and school health nursing employ large numbers. About 37,000 nurses work in doctors' offices. There are 28,700 public health nurses in the country.

The Kefauver Subcommittee was back at it again in September. Lederle Laboratory

president testified that Lederle's antibiotics had dropped in price by 66% between 1948 and 1958. During the same time the price of milk, shoes and gasoline rose between 20% and 26%. Also during the same period Lederle spent over $100 million on research and development. And during the past 13 years Lederle has spent close to $12½ million on developing an oral polio vaccine, and at this time does not have a product on the market yet. The company has invested about $7 million during the past 20 years searching for drugs effective against cancer, but has no product of significant sales volume to show for it.

The population of 14 of the 50 states has more than 75% coverage with health insurance. New York State boasts the highest rate—90.7%. Indiana is included in the 14 with 77.7% coverage. Eleven of the 14 high-insurance states constitute a solid block and are located north of the Ohio River and east of the Mississippi. Colorado, Minnesota and Missouri are the other three. Idaho, New Mexico, Arkansas, Louisiana, Mississippi, Alaska and Hawaii each have less than 50% coverage. The remainder of the United States are between 50 and 75% as regards health insurance. The Health Insurance Institute which tabulates and reports the above statistics finds that all sections of the country are increasing in the number of insured persons, but the South is gaining fastest at present. "At the close of last year, 127,896,000 persons (4.8 million more than at the end of 1958) had health insurance for a national health insurance coverage figure of 72%."

The *Readers Digest* in its July 1960 issue had a short article by Albert Q. Maisel on **"Seven Ways to Cut your Medical Expenses."** The article has the qualified approval of the AMA. It is rated as basically sound. Two AMA comments are passed on by Leo Brown as follows: "First, Mr. Maisel says that since World War II doctors' fees and prescription charges have risen 50%. While this statement is true, AMA points out that since 1946 physicians' fees and prescription prices have risen only slightly more than the average for all items in the Consumer Price Index. Since the beginning of the inflationary period in 1939, moreover, physicians' fees and prescription prices have risen less than the average for all items. Second, the author suggests that you ask your doctor not to specify brand names in prescribing drugs. AMA has not taken an official stand on this issue."

Research completed recently measured **work capacity of persons who subjected themselves at various intervals to the 4 combinations of a good breakfast and a mid-morning "coffee break" with added food.** The investigation was done at the Iowa College of Medicine and was reported in *The Journal of the American Dietetic Association.*

Conclusions: All subjects did significantly more work when the dietary regimen included an adequate breakfast than when it was omitted.

The addition of a mid-morning break when an adequate breakfast was eaten resulted in no advantage as far as maximum work output was concerned.

The addition of a mid-morning break when breakfast was omitted showed a significant advantage for half of the subjects, in maximum work output.

The 1960 edition of "A List Of Worthwhile Health Insurance Books" is now being distributed by the Health Insurance Institute. **It lists a selection of books on health insurance currently available from commercial publishers or other sources, organizations with a relationship to health and the financing of health care, and periodicals that cover health insurance.** Copies of the 1960 "list" may be obtained free by addressing the Institute at 488 Madison Ave., New York City, 22.

U. S. medical schools have just received a supply of application blanks for the Smith Kline & French Foreign Fellowships. **Senior medical students are selected to spend approximately 12 weeks abroad observing and assisting in preventive and curative medicine in areas with limited facilities;** 29 students traveled last year to such countries as Bolivia, Ghana, Congo, Southern Rhodesia, India, Thailand and Java. Total grants of $50,000 were available to cover travel and living expenses. It is expected that 30 fellows will be selected in 1961. The project is designed to acquaint American students with health problems not

generally seen in this country, and to introduce them to physicians working where facilities are limited.

The passenger death rate in 1959 for scheduled U. S. airlines in domestic flights was 0.44 per 100,000,000 passenger miles, a decrease of 90% in 20 years. In international operations the U. S. lines had a fatality rate of 0.56, a reduction of 96% in 20 years. There were actually fewer deaths in 1957-59 than there were in 1947-49 even though the traffic volume as measured in passenger miles increased over four times. In comparison with other means of travel, the rate per 100,000,000 passenger miles for railroad passenger trains in 1959 was 0.13, for buses 0.19 and for passenger automobiles on turnpikes (safer than general highways) 1.28.

"Personal medical care is primarily the responsibility of the individual. When he is unable to provide this care for himself, the responsibility should properly pass to his family, the community, the county, the state, and only when all these fail, to the federal government, and then only in conjunction with the other levels of government, in the above order.

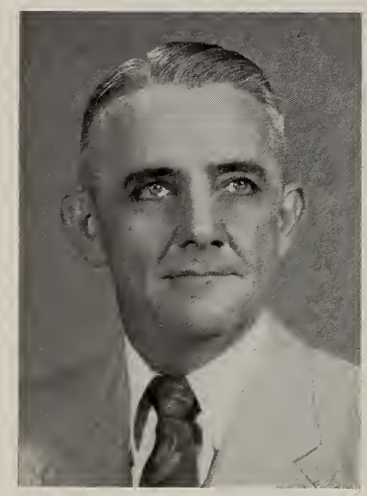
The determination of medical need should be made by a physician and the determination of eligibility should be made at the local level with local administration and control. The principle of freedom of choice should be preserved. The use of tax funds under the above conditions to pay for such care, whether through the purchase of health insurance or by direct payment, provided local option is assured, is inherent in this concept and is not inconsistent with previous actions of the House of Delegates of the American Medical Association."—Statement of policy adopted by the House of Delegates of the American Medical Association at its annual meeting, June 1960.

President's Page

Medicine: Social — Socialized — Socialistic

Events of the past few months have raised a question in the minds of many of our profession that any legislation which provides tax money for the social needs of the individual is in itself a step in the direction of compulsory nationalized medical care. For this reason we should, at the risk of dealing in semantics, clarify the meaning of *social* medicine, *socialized* medicine, and *socialistic* medicine.

Medicine, not unlike education and theology, was born wth a social conscience. The admonition that we are our brother's keeper is so deeply rooted in medicine that the dog-eat-dog type of social indifference never has been—and we hope and pray never will be—a part of our great profession.



To discriminate between the social aspects of medicine as opposed to socialized or socialistic medical care requires a definition of our objectives. No better explanation of these objectives has been given than in the recent policy statement of the House of Delegates of the AMA: "Personal medical care is primarily the responsibility of the individual. When he is unable to provide this care for himself the responsibility should properly pass to his family, the community, the county, the state and only when all these fail, the federal government, and then only in conjunction with the other levels of government in the above order.

"The determination of medical need should be made by a physician and the determination of eligibility should be made at the local level with local administration and control. The principle of freedom of choice should be preserved.

"The use of tax funds under the above conditions to pay for such care, whether through the purchase of health insurance or by direct payment, provided local option is assured, is inherent in this concept."

Continued

IN EMOTIONALLY PROJECTED SMOOTH-MUSCLE SPASM...

Prompt, Profound Protection...at both ends of the vagus

PRO-BANTHĪNE® *with* DARTAL®

Professional reliance on the therapeutic proficiency of Pro-Banthīne in functional gastrointestinal disorders has made it the most widely prescribed anticholinergic.

The consistent relief of emotional tensions afforded by Dartal makes this well-tolerated tranquilizer a rational choice to support the antispasmodic action of Pro-Banthīne in emotionally influenced smooth-muscle spasm.

These two reliable agents combined as Pro-Banthīne with Dartal consistently control both disturbed mood and disordered motility when emotional disturbances project themselves through the vagus to provoke such gastrointestinal dysfunctions as gastritis, pylorospasm, peptic ulcer, spastic colon or biliary dyskinesia.

USUAL ADULT DOSAGE:
One tablet three times a day.

SUPPLIED as aqua-colored, compression-coated tablets containing 15 mg. of Pro-Banthīne (brand of propantheline bromide) and 5 mg. of Dartal (brand of thiopropazate dihydrochloride).



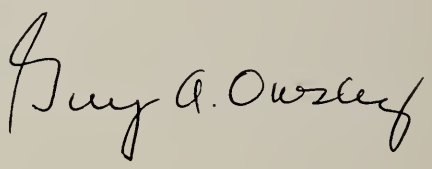
G. D. SEARLE & CO.
Chicago 80, Illinois
Research in the Service of Medicine

PRESIDENT'S PAGE

Continued

Illustrations of this policy in action are in the fields of mental illness, tuberculosis, leprosy and drug addiction and they are based in some degree upon the recognition that it is foolhardy to ignore the facts of life. For one who visualizes the Mills-Kerr Bill as only slightly less obnoxious than social security medicine, it is recommended that he not only examine his own social conscience but recognize the basic policy which dictated the philosophy behind this concept.

Recently a *Medical Times* editorial suggested, as a result of a survey conducted on a relatively small scale, that there was evidence that the public places an entirely different connotation upon the terms "socialized medicine" and "socialistic medicine." Two groups were interrogated, a Madison Avenue group and a Union Square Group. In each instance there were slight majorities who favored "socialized medicine" but likewise in each instance there were much larger majorities who opposed "socialistic medicine." The question is raised that since the laity apparently interprets "socialized medicine" as "social medicine in action" that it would be preferable in all future educational material to abandon the term "socialized medicine" and in its place use the term "socialistic medicine." It's food for thought.



new clinical study[1] cites beneficial results in over 90% of cases in dry, itchy, scaly skin with Sardo®

in the bath



Use of **SARDO** in 118 dermatological patients to relieve dry, itchy, scaly, fissured skin achieved these excellent results:

CASES	AFTER SARDO*		
	Excellent	Good	Poor
49 Senile skin	32	13	4
26 Dry Skin in younger patients (diabetes, etc.)	14	11	1
20 Atopic dermatitis	8	10	2
13 Actinic changes	9	4	—
10 Ichthyosis	3	4	3
Skin Conditions	Benefited	No Benefit	
20 Nummular dermatitis	19	1	
10 Neurodermatitis	10	—	

SARDO acts[1,2] to (A) lubricate and soften skin, (B) replenish natural emollient oil, (C) prevent excessive evaporation of essential moisture.

SARDO releases millions of microfine water-miscible globules to provide a soothing suspension which enhances the efficacy of your other therapy.

SARDO is pleasant, convenient, easy to use; non-sticky, non-sensitizing. Bottles of 4, 8 and 16 oz.

for **SAMPLES** and complete reprint of Weissberg paper, please write . . .

Sardeau, Inc. 75 East 55th Street, New York 22, N. Y.

1. Weissberg, G.: Clin. Med., June 1960.

2. Spoor, H. J.: N. Y. St. J. Med., Oct. 15, 1958.

**patent pending*
T.M. ©1960

The Woman's Auxiliary

REPORTS TO ISMA

Thirty minutes can be a long time; an eternity sometimes. Within 30 minutes it is possible to do many things—wash a car, make a sick call, watch a T.V. program, prepare a dinner—the list can go on forever. Thirty minutes can be the precious gem of a lifetime, depending on how it is used.

Thirty minutes can also be a short time—a deathly short time. WITHIN 30 MINUTES AN INTERCONTINENTAL BALLISTIC MISSILE CAN REACH THE UNITED STATES FROM HOSTILE SOIL. Authorities estimate that our warning time would be approximately 20 to 25 minutes.



Prepared as we are today what could the average individual do in 20 to 25 minutes? The answer is simple. Nothing!—except possibly pray. We are the guinea pigs waiting for the great experiment to begin. Possibly the world blow-up will never occur. We pray to God that it won't. But how are we to know? All it takes is one miscalculation—and then it is too late.

We read or hear about Civilian Defense and what does it mean to us? Judging from the public reaction, little or nothing. Most of us conveniently store the information that we do have in a far corner of our mind and then optimistically wall it off with the rose-colored thought—"*it* can never happen to us."—IT CAN HAPPEN TO US!

Continued

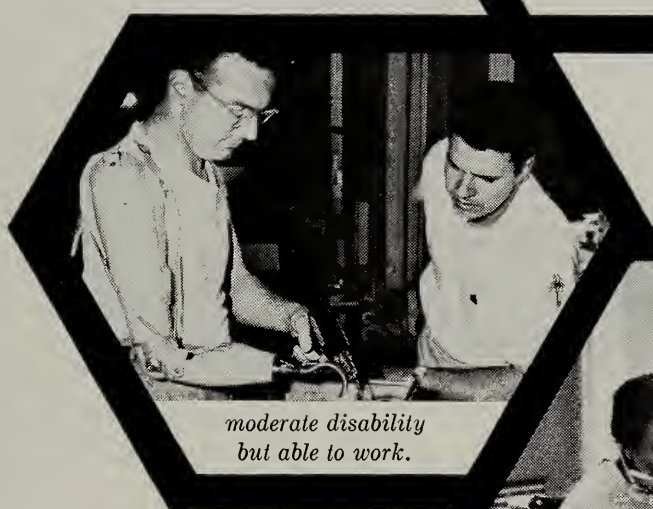
What is your goal...

in helping physically handicapped patients toward recovery?

The Rehabilitation Institute of Chicago Offers Three Possibilities:



return to normal.



moderate disability but able to work.



severely disabled but not totally incapacitated.

...through comprehensive rehabilitation for

- hemiplegia
- paraplegia
- quadriplegia
- amputations
- degenerative diseases of the nervous system
- traumatic disabilities of the hand
- arthropathies

Services Available for both in and out patients:

- Medical Care
- Nursing Care
- Laboratory Services
- Physical Therapy
- Occupational Therapy
- Speech Therapy
- Medical Social Service
- Vocational Counseling
- Psychological Service

Admission on Medical Referral Only—Referring physician has courtesy staff privileges, receives regular interim reports, complete summary at discharge, and a recommended program for continued treatment.

REHABILITATION INSTITUTE OF CHICAGO

401 E. OHIO ST., CHICAGO 11, ILL.

A UNIVERSITY AFFILIATED HOSPITAL

Direct Inquiries to:
Bernard J. Michela, M.D.
Director

THE WOMAN'S AUXILIARY

Continued

Don't be fooled by the gloom-shrouded pessimists who mutter—"If it happens we're all dead anyway so why bother." Preparedness *can* make a difference. Let's not fool ourselves; many will die regardless. But instead of losing eight out 10, wouldn't it be better to lose five out of 10? You may be one of those remaining five—or your wife—or your children. And another thought that should never be forgotten—the better prepared we are on our homeground, the less liable we are to attack.

Doctors are the core of any emergency. It is to you that the multitude will turn in case of attack. There is no question that you will know how to treat the scores of injured, but will you know how to save your own life?

This is vitally important because your life in an emergency of this kind will be worth a hundred of ours. Without your care tens of thousands could needlessly die. So, as the old adage goes, "Physician, heal thyself." Heal thyself with the knowledge for survival so that we all may be healed.

Civilian Defense *must* become a permanent part of our way of life. Your Auxiliary actively participates in the medium and smaller counties where there is no concrete program, but we need your cooperation, both to learn and to teach.

With the advent of Thanksgiving we are reminded that our Pilgrim forefathers came to this land to seek a new way of life. It was a difficult life full of danger and hardships. But they were prepared.

We must be prepared too.





IN COLDS AND SINUSITIS— THE RIGHT AMOUNT OF "INNER SPACE" RIGHT AWAY

Neo-Synephrine hydrochloride relieves the boggy feeling of colds immediately and safely, without causing systemic toxicity or chemical harm to nasal membranes. Turbinates shrink, sinus ostia open, ventilation and drainage resume, and mouth-breathing is no longer necessary.

Gentle Neo-Synephrine shrinks nasal membranes for from two to three hours without stinging or harming delicate respiratory tissues. Post-therapeutic turgescence is minimal. Neo-Synephrine does not lose its effectiveness with repeated applications nor does it cause central nervous stimulation, jitters, insomnia or tachycardia.

Neo-Synephrine solutions and sprays produce shrinkage of tissue without interfering with ciliary activity or the protective mucous blanket.

For wide latitude of effective and safe treatment, Neo-Synephrine hydrochloride is available in nasal sprays for adults and children; in solutions from 1/8% to 1%; and in aromatic solution and water soluble jelly.

Winthrop LABORATORIES
New York 18, N. Y.

NEO-SYNEPHRINE®
(Brand of phenylephrine hydrochloride)
hydrochloride
NASAL SOLUTIONS AND SPRAYS

One of the Finest

The American Medical Association looks forward to holding its 14th Clinical Meeting in Washington, D. C., Nov. 28-Dec. 1 because the physicians who attend this meeting in the nation's capital can anticipate one of the finest scientific programs of our day.

I want to welcome all physicians to this meeting and to urge all members of the American Medical Association to take part in the scientific activities, to visit the scientific and industrial exhibits, and to attend the sessions of our House of Delegates.

Considerable time has been spent to develop the finest scientific program possible, which will stress the theme, "New Developments in Old Diseases and Old Developments in New Diseases."

A feature of particular interest to the practicing physician will be the presentation of both sides of a question where differences exist concerning the management of a disease or medical condition. I personally look forward to some interesting debate on many subjects where opinions differ.

Topics to be covered by leading physicians and scientists from across the nation include gynecology, hematology, obstetrics, coronary disease, pathologic nodules, psychiatry, artificial kidneys, orthopedic surgery, ophthalmology, diarrhea, antibiotics and tranquilizers.

The scientific sessions, to be held in the National Guard Armory, will be so arranged so that three sections will take place simultaneously in both morning and afternoon. One section will be devoted to presentation of formal papers, another to panel discussions, and the third will be a symposium. Of course, all sections will be followed by question-and-answer periods.

During the meeting, the House of Delegates, AMA's policy-making body, will meet at the Sheraton Park Hotel. I cordially invite every member of AMA to attend the sessions of the House. Although only delegates are permitted to speak from the floor, any AMA member may express himself on issues in the reference committee meetings, scheduled to meet all day Tuesday, Nov. 29. This is one of the rights of AMA membership, and I hope any of you who wish will take advantage of it.

This participation by doctors from all over America is one of our guarantees that AMA will continue to serve its members best. There is no member who cannot be heard from, or who will be refused an audience. Not only is this a right, but I regard it as a duty of physicians to speak up on matters they think of interest or concern to the AMA and American medicine. Only in this way can we remain alert to changing opinions, new developments and whispering crises.

Whether you are a general practitioner or a specialist, a practicing physician or a research scientist, you cannot afford to miss this outstanding clinical meeting. On behalf of the American Medical Association, I cordially invite and urge you to attend. The success of our meetings is measured solely by how helpful and informative they are for you, the doctor.—E. Vincent Askey, M.D., President, American Medical Association. ◄

AMA Clinical Meeting Program Designed to Interest Both GP's and Specialists

THE 14TH CLINICAL MEETING of the American Medical Association in Washington, Nov. 28-Dec. 1, will offer a well-rounded, stimulating scientific program designed to interest both family physicians and specialists. The symposia, presentations and discussions will stress the theme, "New Developments in Old Diseases and Old Developments in New Diseases."

Participants will include proponents of both sides where different views exist on the management of a disease or medical condition. For example, should tonsils be removed when mildly involved or only when they are badly diseased?

The patient's side will also be heard on one symposium. Clarence B. Randall, an industrialist and special assistant to President Eisenhower, will talk on coronary disease from the patient's viewpoint. Other participants and their topics on this panel are:

A. Carlton Ernstene, Moderator, Cleveland, Ohio

Thomas W. Mattingly, Washington, D. C.
Can Coronary Patients be Predicted by Clinical or Physiologic Measurements?

Donald S. Fredrickson, Bethesda, Md.
Fat Metabolism as a Background to the Development of Coronary Atherosclerotic Disease

Victor A. McKusick, Baltimore, Md.
Genetic Background of Patients with Coronary Vascular Disease

Eugene A. Stead, Jr., Durham, N. C.
Management of the Dietary and Psychologic Problems of the Patient with Coronary Disease



The problem of management of nodules, always perplexing for both the specialist and the family physician, will be discussed by three panels concerned with breast nodules, the solitary pulmonary nodule, and nodules of the neck.

Another panel will discuss recent advances in the use of antibiotics and steroids, and additional symposia will cover areas in obstetrics-gynecology, pediatrics, edema, cirrhosis and liver diseases, renal problems, osteoporosis, thyrotoxicosis, eye problems, orthopedic surgery and trauma, clinical nutrition and bronchopulmonic disease.

Six one-hour, color television presentations

AMA CLINICAL MEETING

Continued

originating in Georgetown University Hospital will be shown at the National Guard Armory.

The live presentations, televised in a special studio or from operating rooms at the hospital, will deal with dermatology, pediatrics, emergency treatment of major injuries, newer methods in surgical treatment of peptic ulcer, orthopedics and pathology.

Using patients as examples, physicians will discuss various aspects of diagnosis and treatment.

Outstanding physicians and research scientists from throughout the nation will conduct the scientific program. The timetable of discussions has been arranged so that physicians may attend the maximum number of sessions and participate in discussions in the particular fields in which they are most interested.

Maj. Gen. Howard McC. Snyder, MC., USA, personal physician to President Eisenhower, will be the guest of honor at the House of Delegates dinner, Nov. 28.

President Eisenhower has been invited and is expected to attend if his official schedule permits.

Another important and integral part of the clinical meeting will be the Scientific Exhibit which will contain approximately 125 exhibits in the Armory. Many of these will relate to such specific subjects as cardiovascular conditions, arthritis and rheumatism, and cancer. Others will be grouped into rather broad areas such as neurology and psychiatry, pediatrics, orthopedics, dermatology, drug therapy, surgery, ophthalmology and otolaryngology, obstetrics and gynecology, and laboratory and clinical investigation. Special demonstration exhibits on fractures and problems in delivery will also be included.

Over 100 exhibits will make up the Industrial Exhibition, also in the Armory, where the products, services, and aids provided by industry to physicians and their patients will be on display and staffed by competent and knowledgeable attendants.

Three scientific breakfasts will be held on both Tuesday and Wednesday at the Statler Hotel with the themes of "To Do or Not To Do" and "Problems of Management" in particular diseases or types of cases.

The entire scientific program of the Clinical meeting appeared in the October 22 issue of the *Journal* of the American Medical Association. ◄

Reliable

PROFESSIONAL LIABILITY
INDIVIDUAL INSURANCE

with proficient defense
that cuts the cost

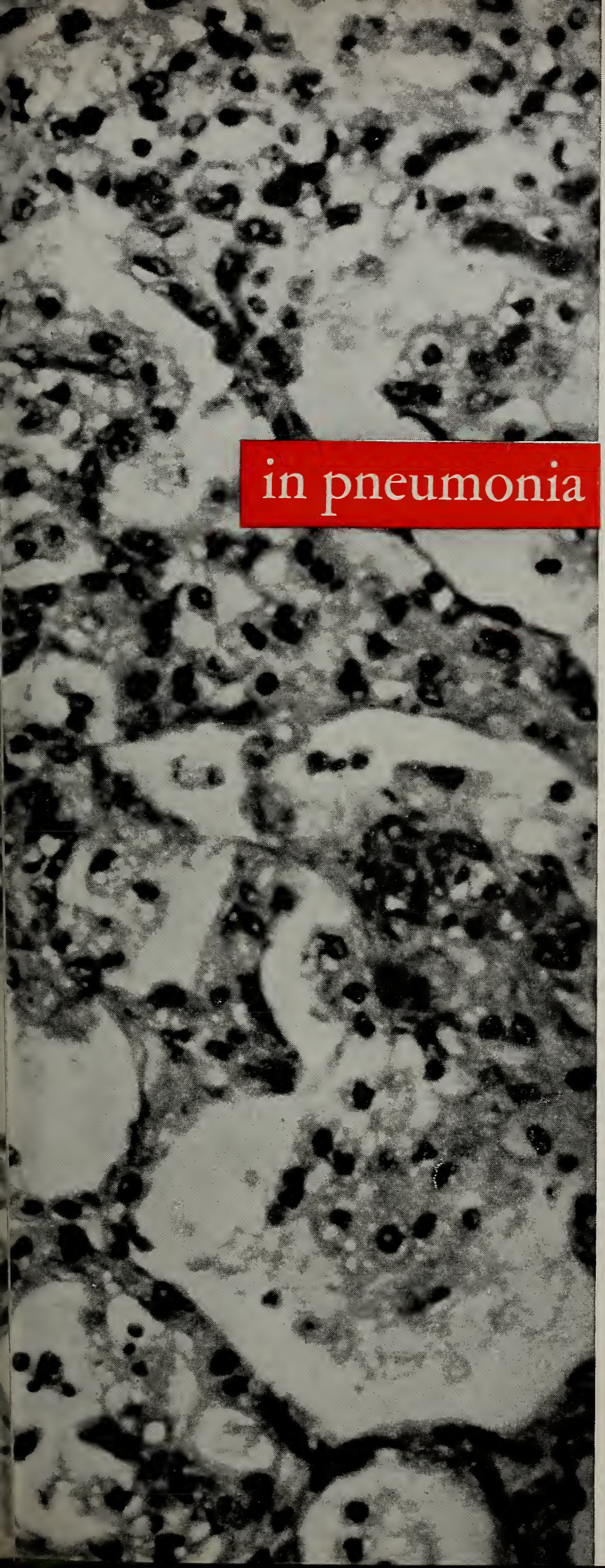
Unparalleled Experience ● Specialized Service ● Saving in Cost

THE
MEDICAL PROTECTIVE COMPANY
FORT WAYNE, INDIANA

Professional Protection Exclusively since 1899

INDIANAPOLIS OFFICE: Kenneth W. Moeller, Rep.
P.O. Box 20132, Indianapolis 20 Tel. CLifford 5-6525

FORT WAYNE OFFICE: A. Russell Quilhot, Rep.
5814 Reed Road, Fort Wayne Tel. Trinity 1161



in pneumonia

Therapeutic confidence

Panalba is effective against more than 30 commonly encountered pathogens including staphylococci resistant to other antibiotics. Right from the start, prescribing it gives you a high degree of assurance of obtaining the desired anti-infective action in this as in a wide variety of bacterial diseases.

Supplied: Capsules, each containing Panmycin* Phosphate (tetracycline phosphate complex), equivalent to 250 mg. tetracycline hydrochloride, and 125 mg. Albamycin,* as novobiocin sodium, in bottles of 16 and 100.

*Trademark. Reg. U. S. Pat. Off.

The Upjohn Compa
Kalamazoo, Michig

Upjohn

Panalba*

your broad-spectrum antibiotic of *first* resort

First Albert Stump Memorial Lecture

Medicine and the Law: A Socially Necessary Alliance

*ROBERT B. MURPHY**
Madison, Wisconsin

THIS LECTURESHIP has been established as a memorial to the late Albert Stump, Esquire, by his friends as a fitting tribute to his 40 years in the practice of law and more than 30 years of lecturing in medical jurisprudence before successive generations of this and other medical schools.

We are met here today to launch this well-conceived enterprise, which will also keep green the memory of a gentleman who lived in the finest tradition of the professional man.

There are areas where the professions of law and medicine meet one another, some of the time with such closeness that they are only artificially separable. It seems fitting that I undertake three topics, and even that number is undoubtedly too many. First, a quick survey to give you some slight intimation of what my profession, my discipline, are like; elements common to all professions, and second, a suggestion of areas of common or parallel problems, even where approaches and technics actually or apparently differ. Third, a request that for the good of society, as well as that of the two professions, a much closer understanding of each by the other be encouraged as the foundation for a closer working relationship.

What is a Profession?

First, let us consider what a profession is. I am not talking about the uncounted numbers of "persuaders," and the many recently developed skills, which their enthusiasts call "professions," nor am I discussing the many technologies. We cannot do better for a definition than to turn to Dr. Roscoe Pound, dean emeritus of the Harvard University Law School, and one of the most distinguished philosophers and historians of the law produced by this country. He writes:

> "By a profession, such as the ministry, medicine, law, teaching, we mean much more than a calling which has a certain traditional dignity and certain other callings which in recent times have achieved or claim a like dignity. There is much more in a profession than a traditionally dignified calling. The term refers to a group of men pursuing a learned art as a common calling in the spirit of a public service—no less a public service because it may incidentally be a means of livelihood. Pursuit of the learned art in the spirit of a public service is the primary purpose. Gaining a livelihood is incidental, whereas in a business or trade it is the entire purpose.
>
> "Historically there are three ideas involved in a profession: organization, learning, i.e., pursuit of a learned art, and a spirit of public service. These are essential. A further idea, that of gaining a livelihood is involved in all callings. It is the main if not the only purpose in the purely money-making callings. In a profession it is incidental.

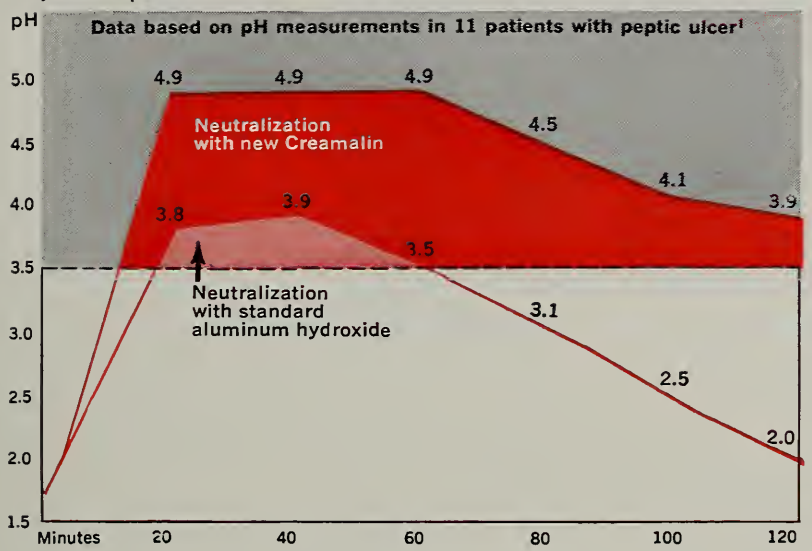
Continued

* Presented at the Indiana University Medical Center, Indianapolis, Jan. 27, 1960.

At the site of peptic ulcer



Following determination of basal secretion, intragastric pH was continuously determined by means of frequent readings over a two-hour period.



neutralization is much faster and twice as long with

New CREAMALIN® ANTACID TABLETS

New proof in vivo[1] of the much greater efficacy of new Creamalin tablets over standard aluminum hydroxide has now been obtained. Results of comparative tests on patients with peptic ulcer, measured by an intragastric pH electrode, show that new Creamalin neutralizes acid from 40 to 65 per cent faster than the standard preparation. This neutralization (pH 3.5 or above) is maintained for approximately one hour longer.

New Creamalin provides virtually the same effects as a liquid antacid[2] with the convenience of a tablet.

Nonconstipating and pleasant-tasting, new Creamalin antacid tablets will not produce "acid rebound" or alkalosis.

Each new Creamalin antacid tablet contains 320 mg. of specially processed, highly reactive, short polymer dried aluminum hydroxide gel (stabilized with hexitol) with 75 mg. of magnesium hydroxide. Minute particles of the powder offer a vastly increased surface area for quicker and more complete acid neutralization.

Dosage: Gastric hyperacidity — from 2 to 4 tablets as necessary. Peptic ulcer or gastritis — from 2 to 4 tablets every two to four hours. Tablets may be chewed, swallowed whole with water or milk, or allowed to dissolve in the mouth. **How supplied:** Bottles of 50, 100, 200 and 1000.

1. Data in the files of the Department of Medical Research, Winthrop Laboratories. 2. Hinkel, E. T., Jr.; Fisher, M. P., and Tainter, M. L.: **J. Am. Pharm. A.** (Scient. Ed.) 48:384, July, 1959.

for peptic ulcer ■ gastritis ■ gastric hyperacidity

Winthrop LABORATORIES
New York 18, N. Y.

"Both in idea and as a matter of history a profession is a learned profession; a body of learned men pursuing a learned art.

"Learning is one of the things which sets off a profession from a calling or vocation or occupation. Professions are learned not only from the nature of the art professed but historically have a cultural, an ideal, side which furthers the exercise of that art. Problems of human relations in society, problems of disease, problems of the upright life guided by religion are to be dealt with by resources of cultivated intelligence by lawyer, physician, and clergyman. To carry on their tasks most effectively they must be more than resourceful craftsmen. They must be learned men."*

Note the three elements which Dean Pound, after almost 70 years of outstanding scholarship and administration finds to be the distinguishing marks of a profession. They are first an organized body of men; second, a learned subject matter and third the practice of that subject matter by a trained and organized body in the spirit of public service. By the latter phrase is meant the subordination of self-interest and personal convenience to the interests of those served. The definition is strangely silent about a high I.Q., a clever mind, manual skills or an exceptional memory—all gifts, but all too often handicaps because of their misuse.

I glory in being a professional man. If any of you do not you should not enter nor should you stay in a profession. Apart from those elements of the ministry which are professionally trained, and apart from those all too fragmentary elements of the academic world which are likewise trained as learned men, the professions of law and medicine have by the very nature of things the greatest share of the burden of carrying on the richest heritage of the western world. On its religious side that tradition is Judaic-Christian; on its intellectual side it is Greco-Roman.

Enriched by Dual Tradition

The life of every one present has been infinitely enriched by those two mighty religious and intellectual traditions. Above all others a professional man is able to share and bring this dual tradition on a day by day basis to the general population, while himself enjoying the lifetime benefits of such stimulation. The teacher, except for those small elements who act as consultants outside their institutions, finds his professional contacts limited very largely by the classroom and the laboratory. To the average businessman the classroom and laboratory are rather remote influences, excepting as he may call upon them from time to time to solve practical problems rather than to consider the fundamental issues of life and of human conduct.

We of the professions are perhaps the last strongholds of rugged individualism, or even of cussed independence. All of us are frail, and by nature imperfect, but I venture to say that there are few professional men who in consequence of their training, reading, the precepts of their fellows and the urgings of their better natures, are not made conscious many times daily of the injunction that it is more blessed to

*Quoted from Roscoe Pound, *The Lawyer from Antiquity to Modern Times,* West Publishing Co., 1953, pp. 5, 6, 8 and 9.

COOK COUNTY
GRADUATE SCHOOL OF MEDICINE
INTENSIVE POSTGRADUATE COURSES
STARTING DATES — WINTER-SPRING, 1961

Surgical Technic, Two Weeks, December 5, January 30
Surgery of Colon & Rectum, One Week, March 6
Gallbladder Surgery, Three Days, April 17
Surgery of Hernia, Three Days, April 20
General Pediatrics, Two Weeks, April 3
Electrocardiography & Heart Disease, Two Weeks, Spring
Diagnostic Radiology, Two Weeks, April 3
Board of Surgery Review, Part II, Two Weeks, May 15
Gynecology, Office & Operative, Two Weeks, February 20
Vaginal Approach to Pelvic Surgery, One Week, January 30
Obstetrics, General & Surgical, Two Weeks, April 3
Fractures & Traumatic Surgery, Two Weeks, March 20
Practical Cystoscopy, Ten Days, by appointment
Surgery of the Hand, One Week, April 24
Advancements in Medicine, One Week, Spring
Urology, Two Weeks, April 24

TEACHING FACULTY—ATTENDING STAFF OF COOK COUNTY HOSPITAL

Address:
REGISTRAR, 707 South Wood Street, Chicago 12, Illinois

Tain

contain the bacteria-prone cold

(Triacetyloleandomycin, Triaminic® and Calurin®)



inner protection with...

safe antibiosis

Triacetyloleandomycin, equivalent to oleandomycin 125 mg. This is the URI antibiotic, clinically effective against certain antibiotic-resistant organisms.

fast decongestion

Triaminic®, 25 mg., three active components stop running noses. Relief starts in minutes, lasts for hours.

well-tolerated analgesia

Calurin®, calcium acetylsalicylate carbamide equivalent to aspirin 300 mg. This is the freely-soluble calcium aspirin that minimizes local irritation, chemical erosion, gastric damage. High, fast blood levels.

TAIN brings quick, symptomatic relief of the common cold (malaise, headache, muscular cramps, aches and pains) especially when susceptible organisms are likely to cause secondary infection. Usual adult dose is 2 Inlay-Tabs, q.i.d. In bottles of 50. ℞ only. Remember, to contain the bacteria-prone cold...TAIN.

SMITH-DORSEY · Lincoln, Nebraska
a division of The Wander Company

give than to receive. The professional man enjoys many rich returns unmeasured by money.

The profoundity of the subject in which he works makes him conscious that he will never be able to really master the field. He is only sure that true progress is painfully achieved and that nature yields her secrets reluctantly, even ungraciously. Possibly in recognizing the limitations in his mastery of science and art, the professional man speaks of "practicing his profession," whereas the business man speaks of "managing," "owning" or "operating" an enterprise, and those who head our political institutions are said to "govern," "boss" or in some cases to "dictate" to the general populace.

All this leads me to another consideration if it be a mark of a true profession—that it is and must remain a learned art. This requires that it have a scientific foundation, in the sense that "science" means a body of organized knowledge, whether in the field of the natural or the social sciences. Without learning a profession becomes only an art and, ultimately, only a technic.

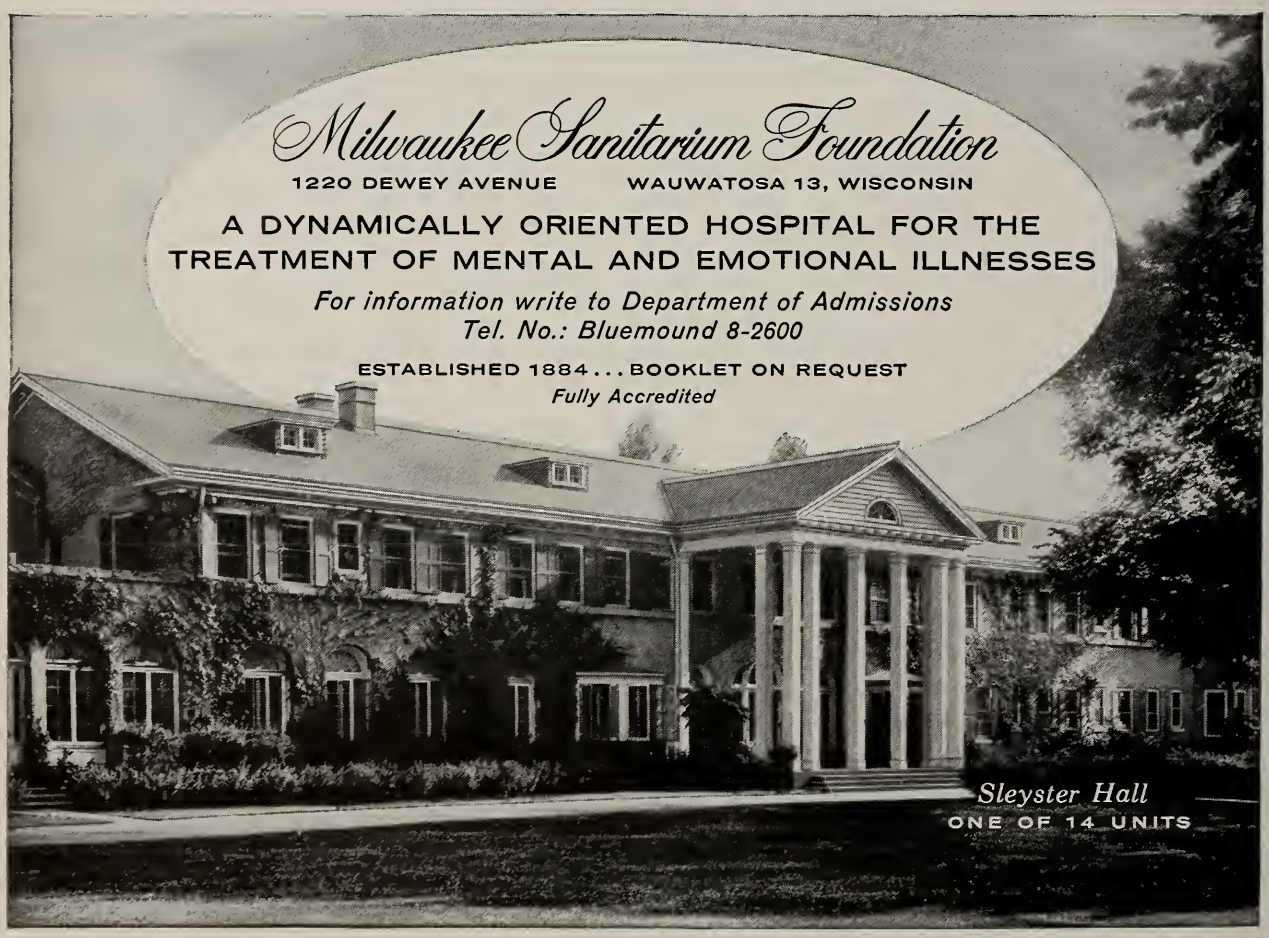
Current Anti-Intellectualism

I suggest to you that in a generation which has strong elements of anti-intellectualism, which neither respects nor values learning for its own sake, the professions are in great danger of deteriorating to the level of technologies, and their practitioners to the level of technicians. I mean no offense when I say that I believe that my profession has maintained a better balance in this respect than has yours.

It is my impression, based on more than 30 years of friendly observation, that your training, both at the pre-professional and professional levels, reflects an unsuccessful compromise between those who feel it essential to keep you abreast of the new science, and those who are unwilling to relinquish the old. The result is that with all too few exceptions, today's medical student is required to specialize in medical and related sciences before he has had ample opportunity to survey the world scene. Consequently, the rich tradition of the humanities, which would best prepare you to live sensitively and broadly, is kept beyond reach.

Such acquaintanceship as you have with lan-

Continued on pae 2075



Continued from page 2070

guages, mathematics and the biological and physical sciences is designed, vocationally that is, to provide you with working tools rather than to encourage your mastery of these subjects for their own sakes. Few of you, I fear, have any reasonably adequate knowledge of national history, much less of world history, or of the history of general science or even of medicine, of the great literary classics, of philosophy or fine arts, of government or economics. It is small wonder that there is frequently a failure of communication between medicine and the other professions, or between medicine and the non-professional world.

The seeming independence, but the actual close inter-relationship of various domains of learning is brilliantly treated in an article by Hon. Jack Pope, Associate Justice of the Texas Court of Civil Appeals. He wrote in an article appropriately entitled "The Unfolding Unity:"

> "Someone has compared our intellectual departments to a cluster of many islands in the ocean. We choose one of them as a place to dwell. We know that many others are scattered about, and we may even have visited on some of them or viewed them at close range at some time in the past; but for most of us, our knowledge is restricted to our own tiny domain which is isolated from all the rest. We treat inhabitants of the other domains as foreigners. Some isles may be better explored than others, but many are still undiscovered. We have given these imaginary islands of knowledge certain distinguishing names. Isles of Physics, Chemistry, Geology, Paleontology, Biology, Zoology, Genetics, Archaeology, Anthropology and Geography have been located and explored. Some of the more beautiful intellectual islands have been named Theology, Philosophy, Logic, Education, History, and Art.
>
> "One of the busiest of the separate domains is the Island of Medicine. Like so many of the others, it is actually a cluster of many tiny islets. Anatomy, Psychology, Hygiene, Dietetics, Physiology, Bacteriology, Parasitology, Surgery, Neurology are but a few of the many familiar names. Law comprises another island group. There are so many islands in the entire archipelago that one island has been named the Isle of Taxonomy, where records of names and classes are kept in more or less orderly fashion.
>
> "The occupants of each island have become so occupied with the significance of their own tiny domain that often they may devote their entire lives in isolation. They develop separate dialects and often find that they have completely lost the power of communication with other nearby isles even within the same group. There are adequate communication systems, and the mail is delivered daily between many of the islands, but such a tremendous mass of written material, some good and most bad, is produced by the prodigious work of all the ocean group, that there is hardly time to read any sizable quantity. So the islanders, instead of reading, simply accumulate the mountain of material and store it on Library Island.
>
> "Actually the islands are just the peaks of little mountains jutting up from a common ground that lies below, and beyond the range of our vision. We shall leave the metaphor,

OVER 80 YEARS' SPECIALIZED EXPERIENCE IN THE RESTORATIVE TREATMENT OF

"THE PROBLEM DRINKER"

At The Keeley Institute your patients are assured of receiving:

- the most modern, coordinated, comprehensive, rehabilitative regimen
- in addition to medical, nutritional and physiotherapeutic treatment, we also offer psychiatric diagnosis and psychotherapy
- full cooperation throughout with the referring physician
- in addition to the care of the alcoholic we also treat narcotic and drug addiction
- surprisingly low cost—to cover all medical care, medicines, laboratory work, room and excellent cuisine

You can obtain more detailed information by writing us direct.

WE WELCOME YOUR REFERRALS...

THE KEELEY INSTITUTE
DWIGHT, ILLINOIS

Member American Hospital Association, Member Illinois Hospital Association. Licensed by the Department of Public Health, State of Illinois.

for the point is clear. To conquer knowledge, we have divided it. The method is effective, but in dividing knowledge, we have also divided man—and divided man is not man at all. This is one of the countless paradoxes that confront total man. To know all we must isolate; and when we isolate, we cannot know all. Jerome Frank expresses the idea: 'Each specialist group, when functioning as such, in the interest of its special concerns, creates it own sub-universe, its special province of experience, and sets up immigration laws which bar *alien* facts from entering So, to a dentist, a man is a body surrounding his teeth; to an undertaker, a potential cadaver to be embalmed; to a sytologist, a collection of cells; to a painter, lines and colors, and shadows; to a precinct-committeeman, a voter."

"Schopenhauer told us that, 'Every man takes the limits of his own field of vision for the limits of the world.' "*

What I have been trying to say about the underlying importance of general learning was brilliantly summarized in a recent article which appeared interestingly enough in the *Wall Street Journal*, a publication which the uncritical might think of as dedicated wholly to the worship of Mammon. That article was by Dr. Richard M. Weaver, a professor of English at the University of Chicago. He stated:

"If man were merely an animal, his 'education' would consist only of scientific feeding and proper exercise. If he were merely a tool or an instrument, it would consist of training him in certain response and behavior patterns. If he were a mere pawn of the political state, it would consist of indoctrinating him so completely that he could not see beyond what his masters wanted him to believe. Strange as it may seem, adherents to each of these views can be found in the modern world. But our great tradition of liberal education supported by our intuitive feeling about the nature of man, rejects them all as partial descriptions.

"All others agree that the human being has a distinguishing attribute in mind. Now mind is something more than brain. Many anatomists and surgeons have seen a brain, but nobody has ever seen a mind. This is because we believe the mind is not merely a central exchange of the body's system, where nerve impulses are brought together and relayed; it is a still mysterious entity in which man associates together the various cognitive, aesthetic, moral and spiritual impulses which come to him from the outer and inner worlds. It is the seat of his rational faculty, but it is also the place where his inclinations are reduced to order and are directed. Most importantly for the concerns of education, mind is the place where symbols are understood and are acted upon.

"Man has, in fact, been defined as the 'symbol-using animal.' This definition makes symbol-using the distinguishing characteristic which separates him from all other creatures. Even though the definition may be a partial one, it points to the faculty which has enabled man to create cultures and civilizations. The significance of the symbol is that it enables us to express knowledge and to communicate.

"But symbolism is not used only to convey information. Through the use of symbols man expresses those feelings and states of being which are nonetheless real for being subjective. His feelings of love, of delight, of aversion have been put in forms transmissible from generation to generation through the use of symbols—letters in literature, notation in music, symbolic articles in dress and in ceremonials, and so on. It is impossible to realize how poor our lives would be without the intellectual and emotional creations which depend upon this symbolic activity." (Quoted from issue Oct. 9, 1959, p. 8.)

Respect Intellectual Disciplines

While it is a tragic fact that our present generation assigns little by way of prestige or price tags to a tradition of learning, I urge upon you as an organized body of men dedicated to the

---

* Quoted in *The Medico-Legal Reader,* Oceana Publications, New York, 1956; edited by Samuel Polsky. pp. 19-20.

The original article is from a Symposium on Law and Medicine. developed by Dr. Hubert W. Smith, Prof. of Law and Legal Medicine, University of Texas, to commemorate the founding of Emory University Medical School. It was published in the *Journal of Public Law,* Emory University, 1954.

THE ORIGINAL potassium phenethicillin

SYNCILLIN®

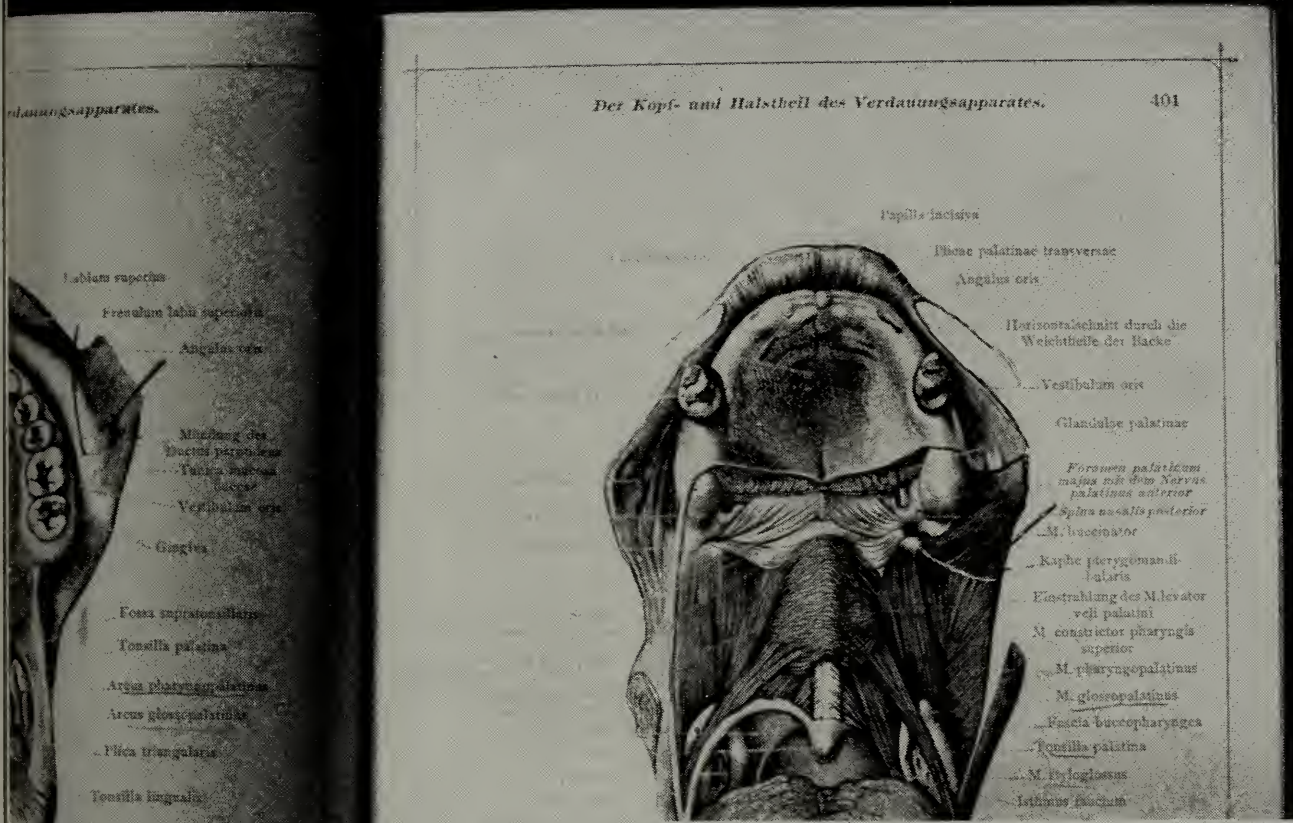
(phenoxyethyl penicillin potassium)

A dosage form to meet the individual requirements of patients of all ages in home, office, clinic, and hospital:

Syncillin Tablets – 250 mg. (400,000 units)... Syncillin Tablets – 125 mg. (200,000 units)
Syncillin for Oral Solution – 60 ml. bottles – when reconstituted, 125 mg. (200,000 units) per 5 ml.
Syncillin Pediatric Drops – 1.5 Gm. bottles. Calibrated dropper delivers 125 mg. (200,000 units)

Complete information on indications, dosage and precautions is included in the circular accompanying each package.

BRISTOL LABORATORIES, SYRACUSE, NEW YORK



Actual case summary from the files of Bristol Laboratories' Medical Department

ACUTE TONSILLITIS

SYNCILLIN®
250 mg. q.i.d. – 5 days

B.G. 9-year-old, white male. First seen Aug. 11, 1959 with acute tonsillitis. Illness of 3 days' duration. Beta hemolytic streptococcus extremely sensitive to SYNCILLIN cultured from the throat. Patient started on SYNCILLIN – 250 mg. q.i.d. After 5 days, the infection appeared cured and the antibiotic was discontinued. No subjective or objective evidence of side reactions.

practice of the healing art, as well as upon my profession, the necessity of respect for and something more than a nodding acquaintance with the great intellectual disciplines. I have two reasons for doing so. First, the subjects infinitely enrich the lives of those who make their acquaintance. As the late Justice Oliver Wendell Holmes once observed, a great idea stretches the mind in such a way that it can never thereafter resume its smaller earlier size. Second, without knowledge of the general intellectual tradition which is frequently referred to collectively as the humanities we are not ourselves part of the tradition of either the Judaic-Christian or the Greco-Roman worlds, and since we cannot participate in that tradition in any fullness we are not able to lead personal lives or to influence others at the level otherwise expected of a professional man.

Broadly speaking, prior to the French Revolution a professional man was first of all expected to be a person trained in the liberal arts and a gentleman. The extreme and false philosophy of equality has largely destroyed that standard. The simultaneous increase in scientific knowledge has so stepped up the pace of learning and living that we substituted intensive for extensive cultivation as the emphasis in professional training. Yet it was no less a person than Sir Walter Scott, himself a barrister, who wrote:

> "A lawyer without history or literature is a mechanic—a mere working mason; if he possesses some knowledge of these, he may venture to call himself an architect."

Similarly, the late General George Marshall is said to have observed that one of the great difficulties with the American people was that so often "they are not familiar with the minutes of the previous meetings." These comments have equal application to physicians, for history and literature give all of us needed perspective.

In brief, I am urging, yes, beseeching you to strive for the level of professional man, since the alternative is to decline to the level of the technician and the craftsman. I am not depreciating the technician or the craftsman, I am saying only that it is the broadly trained professional man who alone has the capacity to advance the basic arts and sciences and to lead those at lower intellectual levels. I know that this statement is not likely to win approval of an anti-intellectual generation, described as one in which "all men are equal, but in which some are even more equal

. . . MALNUTRITION OR
LEG CRAMPS DURING PREGNANCY?
OUTMODED AS GODEY'S FASHIONS!
℞ NEW
PRENALIN-O®
PRENATAL SUPPLEMENT
1. Oyster Shell Calcium - Phosphorus Free!
2. New Form of Iron!
3. Dry Filled Capsule - Sure, Quick Absorption!
4. Economical Once-A-Day Dosage!
5. Wider Range Nutritional Support!
6. Relieves Troublesome Leg Cramps!



EACH dry filled capsule (lavender and white) provides:

Ferrous Fumarate (Iron)	150 mg.	Vitamin B-12 (Cobalamin conc. NF)	2 mcg.
Deep sea oyster shell (Calcium)	600 mg.	Folic Acid	0.25 mg.
Vitamin C	50 mg.	Niacinamide	10 mg.
Vitamin A	4000 USP Units	Vitamin K (Menadione)	0.25 mg.
Vitamin D	400 USP Units	Rutin	10 mg.
Vitamin B-1	2 mg.	Sodium Molybdate	3 mg.
Vitamin B-2	2 mg.	Fluorine (Calcium Fluoride)	0.25 mg.
Vitamin B-6	0.8 mg.	Iodine (Potassium Iodide)	0.15 mg.

SAMPLES ON REQUEST
TUTAG
S. J. TUTAG & CO.
DETROIT 34, MICHIGAN

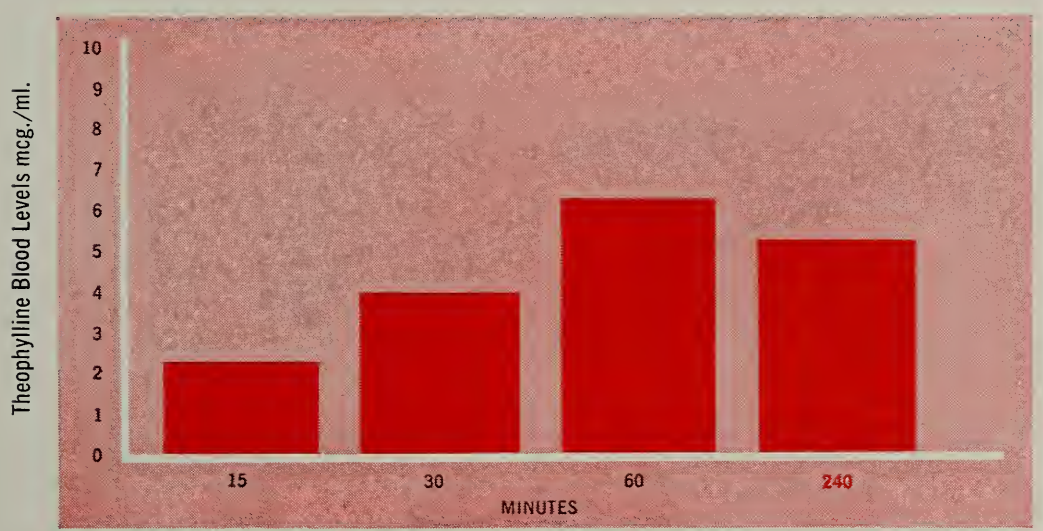
when winter colds provoke episodes of bronchial spasm and congestion

ELIXIR SYNOPHYLATE®

(Theophylline Sodium Glycinate)

ELIXIR SYNOPHYLATE acts *swiftly* to dilate constricted, edematous bronchi, improve pulmonary ventilation, and increase the lung's vital capacity. Rapidly absorbed, ELIXIR SYNOPHYLATE has been effectively used in acute bronchial asthma, providing *full* therapeutic xanthine levels in about one-half hour, lasting well over four hours after a *single* administration. Wheezing and dyspnea are usually relieved in 5 to 10 minutes.

Significant theophylline blood levels within 15 minutes...persisting for at least 4 hours after SINGLE ORAL DOSE of ELIXIR SYNOPHYLATE



Theophylline sodium glycinate, presented in ELIXIR SYNOPHYLATE, offers superior stability and toleration as compared with other forms of theophylline.[1,2] Thus, ELIXIR SYNOPHYLATE allows *higher, well-tolerated* dosage, where indicated, to achieve *maximum xanthine effect.*

Each tablespoonful (15 ml.) contains 0.33 Gm. (5 gr.) Synophylate (theophylline sodium glycinate), equiv. 0.16 Gm. (2½ gr.) Theophylline U.S.P.; 20% alcohol.
Supplied: Bottles of 1 pint and 1 gallon.

1. A.M.A. Council on Drugs: New and Nonofficial Drugs 1960, Philadelphia, Lippincott, 1960, p. 425. 2. Grollman, A.: Pharmacology and Therapeutics, ed. 3, Philadelphia, Lea & Febiger, 1958, p. 208.

Literature on request.
THE CENTRAL PHARMACAL COMPANY
Products Born of Continuous Research • Seymour, Indiana

than others." But I insist that without an elite corps we shall have nothing ahead of us but spiritual and intellectual retrogression and ultimate stagnation.

Decline in Historical Knowledge

The significant book, *The Movement of World Revolution,* written by the distinguished cultural and religious historian, Christopher Dawson and published by Sheed and Ward, in 1959, quotes on pages 6 and 7 an East Indian writer, Chaudhuri, on the dangers attendant upon a decline of interest in or understanding of historical knowledge. Chaudhuri wrote:*

> "In the last few decades there has certainly been seen in Europe, or at all events in England, a decline in historical knowledge, accompanied by a pronounced recoil from the historical attitude. This *is a retrograde phenomenon, for if there is anything that distinguishes man from the other animals, it is memory or consciousness of duration. . . . Are we witnessing a whole society's senile decay of memory?"* (emphasis supplied).

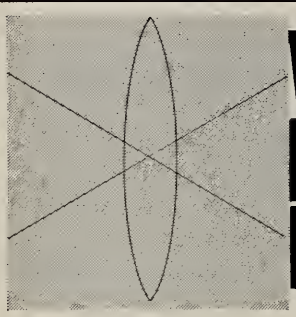
Let us now approach the subject a little closer, although still cautiously. Just what do I mean by the word "law." I am not talking about divine law, the so-called laws of nature or the laws of science. I am talking about rules established by humans for the better ordering of their social, economic and other relations, which are recognized and enforced by the authority of the state. This is frequently referred to as "positive law." Its first purpose is to achieve order. The second purpose of a mature system of law is to achieve justice, although that is not always attained, and in some parts of the world is not even the chief end of law. Still another purpose of many legal systems is to assist in the enforcement of the moral law through the power of the state. The enactment of law very often represents compromise; however, in the course of the process, moral elements are all too frequently squeezed out of the ultimate product.

Again, I am indebted to Dean Pound, who offers the following dual definition of "law" in his recently published five-volume work on Jurisprudence,

> "Law in the *sense of the legal order has for its subject matter* relations of individual human beings with each other and the conduct of individuals so far as they affect others or affect the social or economic order. Law in the *sense of the body of authoritative grounds of or guides to judicial decision and administrative action* has for *its subject matter* the expectations or claims or wants held or asserted by individual human beings or groups of human beings which affect their relations or determine their conduct. (Emphasis supplied.)
>
> "Historically, the oldest and longest continued use of 'law' in juristic writing is to mean the aggregate of laws, the whole body of legal precepts which obtain in a given politically organized society. But in a wider phase of this sense it may mean the body of authoritative grounds of, or guides to, judicial and administrative action, and so of prediction of such action, established or rec-

---

* *The Autobiography of an Unknown Indian,* by Nirad Chaudhuri, copyright, The Macmillan Co., 1951; used by permission.


VISION BEFORE PROGRESS

"Where there is no vision the people perish." The Bible tells us this, and its truth has never been more apparent than in the world today. Vision is a prerequisite to planning, but White-Haines has been planning for vision for more than a half-century. Fine ophthalmic craftsmanship, prompt service, your utter confidence in the exacting execution of the lens prescription you write . . . that's the credo of White Haines. It took vision to plan for that ultimate, too.

THE White-Haines OPTICAL COMPANY
34 Modern Laboratories
OHIO • PENNSYLVANIA • MARYLAND
KENTUCKY • W. VIRGINIA • INDIANA
MICHIGAN • ILLINOIS

in common Gram-positive infections due to susceptible organisms

YOU CAN COUNT ON

TAO®*

(triacetyloleandomycin)

even in many resistant Staph*



1,928 published cases in the two years since TAO was released for general use show:

94.3% effectiveness in respiratory infections (617 cases including tonsillitis, staphylococcal and streptococcal pharyngitis, bronchitis, infectious asthma, broncho-pneumonia, lobar pneumonia, bronchiectasis, lung abscess, otitis.) **You can count on TAO.**

92% effectiveness in skin and soft tissue infections (900 cases including pyoderma, impetigo, acne, infected skin disorders, wounds, incisions and burns, furunculosis, abscess, cellulitis, chronic ulcer, adenitis.) **You can count on TAO.**

87.1% effectiveness in genitourinary infections (349 cases including urethritis, cystitis, pyelitis, pyelonephritis, orchitis, pelvic inflammation, acute gonococcal urethritis, lymphogranuloma venereum.) **You can count on TAO.**

75.8% effectiveness in diverse infections (62 cases including fever of undetermined origin, peritoneal abscess, osteitis, periarthritis, septic arthritis, staphylococcal enterocolitis, gastroenteritis, carriers of staphylococci.) **You can count on TAO.**

95.6% of 1,928 cases free of side effects—in the remaining 4.4%, reactions were chiefly mild gastrointestinal disturbances which seldom necessitated discontinuance of therapy.

*In 884 of 1,928 cases the causative organisms were mostly staphylococci. The majority of clinical isolates were found to be resistant to at least one of the commonly used antibiotics and many patients had failed to respond to previous therapy with one or more antibiotics. **TAO proved 93.4% effective in these 884 cases.**

Complete bibliography available on request.

DOSAGE: varies according to severity of infection. Usual adult dose—250 to 500 mg. q.i.d. Usual pediatric dose: 3-5 mg./lb. body weight every 6 hours.

NOTE: In some children, when TAO was administered at considerably higher than therapeutic levels for extended periods, transient-jaundice and other indications of liver dysfunction have been noted. A rapid and complete return to normal occurred when TAO was withdrawn.

SUPPLY: TAO CAPSULES—250 mg. and 125 mg., bottles of 60. TAO ORAL SUSPENSION—125 mg. per 5 cc. when reconstituted, palatable cherry flavor, 60 cc. bottles. TAO PEDIATRIC DROPS—100 mg. per cc. when reconstituted, flavorful; special calibrated dropper, 10 cc. bottles. INTRAMUSCULAR or INTRAVENOUS—10 cc. vials, as oleandomycin phosphate.

OTHER TAO FORMULATIONS ALSO AVAILABLE: TAO®-AC (Tao, analgesic, antihistaminic compound) capsules, bottles of 36. TAOMID® (Tao with Triple Sulfas)—tablets, bottles of 60. Oral Suspension—60 cc. bottles.

For nutritional support VITERRA® Vitamins and Minerals

Formulated from Pfizer's line of fine pharmaceutical products.

ROERIG Rx

New York 17, N. Y.
Division, Chas. Pfizer & Co., Inc.
Science for the World's Well-Being™

ognized in such a society including precepts, technique, and received ideals."*

Meaning of Jurisprudence

Let us now consider what is meant by the term "jurisprudence." In its simplest form it means nothing more nor less than the "science of law." Dean Pound, himself a well-trained biologist, has described jurisprudence as "the comparative anatomy of developed systems of law." Its four classic divisions are usually given as philosophical, analytical, historical and sociological. By the latter is meant primarily the "law in action" as distinguished from the "law in theory."

Let us further consider what we mean by the phrase "medical jurisprudence," sometimes referred to as "forensic medicine," and sometimes as "legal medicine."

The late Louis J. Regan, who was both a doctor of medicine and an attorney, and who authored what is undoubtedly the outstanding recent text in legal medicine in this country, wrote as follows in the preface to the third edition of his book: *Doctor and Patient and the Law,* published by C. V. Mosby Co., St. Louis, which he completed only months before his death in late 1955:

> "Legal medicine deals with the many points of contact of law and medicine, particularly with the contribution which medical knowledge makes to the administration of justice.
>
> "A better conception of what is comprehended in the term may be achieved by considering legal medicine as consisting of two major subdivisions. The first involves a physician's practice of his special skills in medicolegal investigations—in the practice of forensic pathology, psychiatry, immunology, etc. . . .
>
> "The second subdivision of legal medicine involves a consideration of problems arising out of the unique duties, privileges, and obligations which attach to the physician before the law and in relation to his patient. . . ."

I like to think of myself today as a marriage broker, but as one with more than a one-time fee at stake. I am proposing at least a limited species of matrimony between the professions of law and medicine. Before I can expect the free assent of medicine and its spokesmen to any such relationship, I have the duty of persuading you that the match would be respectable, mutually beneficial, and that a third element is present which ought to be but is all too seldom considered between men and women, namely that such a union will be advantageous to society.

Judged by Art of Practice

As to the first point, I offer you a body of practitioners, comparable in integrity, devotion, intelligence and training to those who follow medicine. While the law is overwhelmingly art, so is medicine. Neither your profession nor mine will be judged ultimately by its science, which the public takes for granted, and often exaggerates. Rather it will be judged by the art with which it is practiced. You may think of medicine as more of a science than the law. Yet even this can be validly argued. The subject matter of the law likewise includes and assumes a substantial knowledge of the natural

* Quoted from Roscoe Pound, *Jurisprudence,* West Pub. Co., 1959, Vol. I, p. 12; Vol. III, p. 5.



WABASH VALLEY SANITARIUM—HOSPITAL

Lafayette, Indiana
Telephone Riverside 3-1679

A hospital for the treatment of neuro-psychiatric disorders.

Custodial cases are accepted in limited numbers.

— OPEN STAFF —

DONALD R. KINZER
Manager



The physician listens to a tense, nervous patient discuss her emotional problems. To help her, he prescribes Meprospan® (400 mg.), the only continuous-release form of meprobamate.



The patient takes one Meprospan-400 capsule at breakfast. She has been suffering from recurring states of anxiety which have no organic etiology.



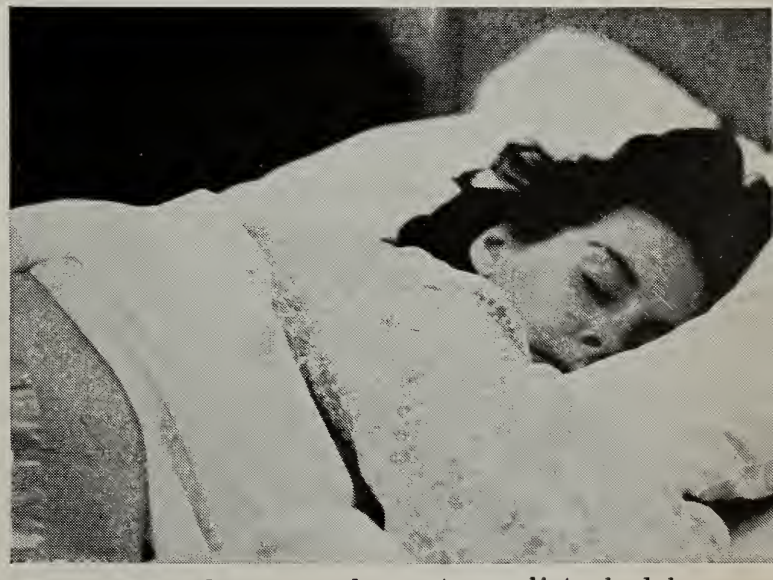
She stays calm while on Meprospan, even under the pressure of busy, crowded supermarket shopping. And she is not likely to experience any autonomic side reactions, sleepiness or other discomfort.



She takes another capsule of Meprospan-400 with her evening meal. She has enjoyed sustained tranquilization all day—and has had no between-dose letdowns. Now she can enjoy sustained tranquilization all through the night.



Relaxed, alert, attentive . . . she is able to listen carefully to P.T.A. proposals. For Meprospan does not affect either her mental or her physical efficiency.



Peacefully asleep . . . she rests, undisturbed by nervousness or tension. (Samples and literature on Meprospan available from Wallace Laboratories, Cranbury, N. J.)

MEDICINE AND LAW

Continued

sciences, although it does not use them in the same way as does medicine.

It may interest you to know how an acknowledged specialist in philosophy and jurisprudence viewed the intellectual and scientific aspects of the law and the relationship of other sciences to it. Thomas A. Cowan of Rutgers University wrote:

"Another cluster of disciplines akin to law is known under the collective name of science. All sciences are related to law since law is a body of knowledge. In addition, the fruits of all the sciences are of consequence to law. How to fit means to ends is the work of science and how law may most efficiently achieve its ends is therefore a scientific problem. The subject matter of law is human behavior and the behavioral sciences are law's nearest neighbors. History, anthropology, ethnology, psychology, social psychology and sociology beckon to us whenever we stray beyond the bounds of the law.

"At the heart of man's ancient quest for justice is the search for some measure of good and bad in the most powerful and flexible instrument of social control, the law. This problem of the ethical appraisal of law is no pseudo-question invented by philosophers. It is inescapably presented by the most fundamental of man's social institutions, and no philosopher of the first rank has been able to overlook it.

"Law without concepts or rational ideas, law that is not logical, is like pre-scientific medicine—a hodgepodge of sense and superstition, as has indeed been most of the world's common sense as distinguished from science.

"To urge that judges, for instance, should rely on their experience or intuition in disregard of logically formulated principles is to urge sentimental anarchy. Men will generalize in spite of themselves. If they do it consciously in accordance with logical principles, they will do it more carefully and will be liberally tolerant to other possible generalizations. But those who distrust all logic think that they deal with facts when they are occupied with the product of their own grotesque theories.

"Science, to be sure, is abstract. It tends to emphasize abstract considerations and deals with the definable classes rather than with the particular cases. But in doing so it forces us to see things from a wider point of view, and this tends to make us more just to the diversity of human interests. The air of unreality that science presents to the uninitiated is like the unreality which modern machinery presents to the old-fashioned artisan or to those who cultivate the soil by hand.

". . . We have only to point to the theoretical structure of science, to philosophy, to advanced legal systems, and to the progress in political ideals as evidence of human rationality. It is significant that this is the position of a distinguished biologist, Julian Huxley, who writes,

" 'The first and most obviously unique characteristic of man is his capacity for conceptual thought. . . ;' 'a cumulative tradition . . . capable of indefinite improvement in quality and increase in quantity' is another distinctively human attribute. He notes that '. . . man is the only organism normally and inevitably subject to psychological con-



PROTECTION AGAINST LOSS OF INCOME FROM ACCIDENT & SICKNESS AS WELL AS HOSPITAL EXPENSE BENEFITS FOR YOU AND ALL YOUR ELIGIBLE DEPENDENTS

ALL PREMIUMS COME FROM

PHYSICIANS SURGEONS DENTISTS

ALL BENEFITS GO TO

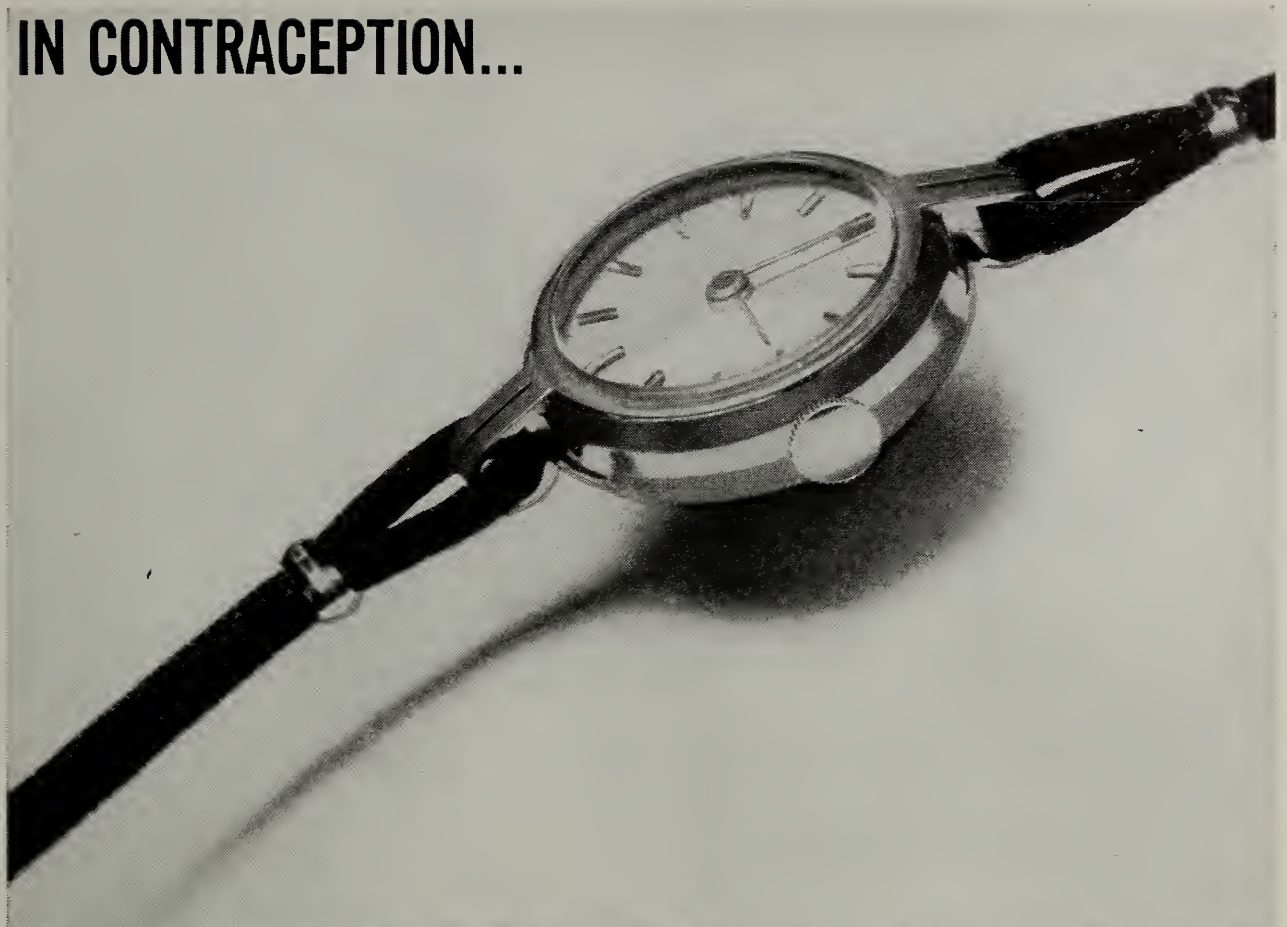
PHYSICIANS CASUALTY & HEALTH ASSOCIATIONS

OMAHA 31, NEBRASKA

Since 1902

Handsome Professional Appointment Book Sent to you FREE upon request.

IN CONTRACEPTION...



WHY IS SPEEDIER SPERMICIDAL ACTION IMPORTANT?

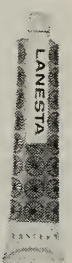
Because a swift-acting spermicide best meets the variables of spermatozoan activity.

Lanesta Gel, "...found to immobilize human spermatozoa in one-third to one-eighth the time required by five of the leading contraceptive products currently available . . ."* thus provides the *extra* margin of assurance in conception control. The accelerated action of Lanesta Gel — it kills sperm in minutes instead of hours — may well mean the difference between success and failure.

**Berberian, D. A., and Slighter, R. G.: J.A.M.A.* 168:2257 *(Dec. 27) 1958.*

In Lanesta Gel 7-*chloro-4-indanol,* a new, effective, nonirritating, nonallergenic spermicide produces immediate immobilization of spermatozoa in dilution of up to 1:4,000. Spermicidal action is greatly accelerated by the addition of 10% NaCl in ionic form. Ricinoleic acid facilitates the rapid inactivation and immobilization of spermatozoa and sodium lauryl sulfate acts as a dispersing agent and spermicidal detergent.

Lanesta Gel with a diaphragm provides one of the most effective means of conception control. However, whether used with or without a diaphragm, the patient and you, doctor, can be certain that Lanesta Gel provides faster spermicidal action — plus essential diffusion and retention of the spermicidal agents in a position where they can act upon the spermatozoa.



new Lanesta® Gel

Supplied: Lanesta Exquiset . . . with diaphragm of prescribed size and type; universal introducer; Lanesta Gel, 3 oz. tube, with easy clean applicator, in an attractive purse. Lanesta Gel, 3 oz. tube with applicator; 3 oz. refill tube — available at all pharmacies.

Manufactured by Esta Medical Laboratories, Inc., Alliance, Ohio Distributed by GEORGE A. BREON & Co., New York 18, N. Y.

A product of Lanteen® research.

flict.' He stresses man's 'conscious reason,' his 'conscious purpose and his set of values.' 'There may be other beings in this vast universe,' concludes Mr. Huxley, 'endowed with reason, purpose and aspiration; but we know nothing of them. So far as our knowledge goes, human mind and personality are unique and constitute the highest product yet achieved by the cosmos.' 'Biology thus reinstates man in a position analogous to that conferred on him as Lord of Creation by theology.'"*

The law draws heavily upon and uses the findings of the biological and physical sciences in health legislation, criminal codes and in such specialized types of law as those involving patents, mining and shipping. It needs and uses the findings of medical science in the course of helping the community function with some order and stability in the midst of its highly complex problems. It is also increasingly dependent upon the skills of the professional accountant, the statistician and the actuary. It draws openly and deeply upon and is heavily obligated to the materials and findings of history, anthropology, general psychology, social psychology, sociology and economics, to offer but an incomplete list. And the law is at all times in the heavy debt of those who have helped our language grow and have written and spoken it with special distinction. Without the power to communicate we are at a standstill.

It is probably true that lawyers are thought of first of all as effective persuaders. Persuasion may be the popular essence of advocacy, but advocacy is only hollow mockery unless it has been preceded by thorough investigation of the facts, then by an analysis, and after that by a process of reasoning in which appropriate legal principles are applied to those facts. If we find no established legal principle to control the case, we borrow one, and if we are imaginative enough, we invent one. That has been the history of the growth of the law.

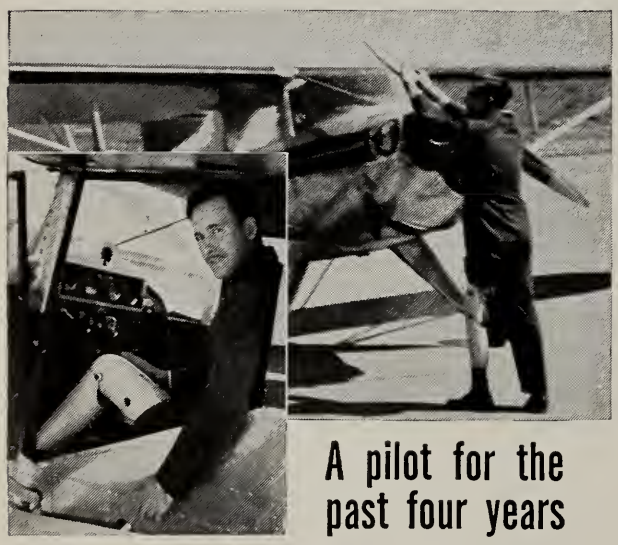
Law-Medical Methods Parallel

You should have little difficulty in recognizing the parallelism between your methods and ours. Both of us must first ascertain the facts, then pinpoint what we find by placing it in the proper category through the application of one or more principles to such facts. Only after that can you or we treat the case.

Nowhere have I found a more imaginative or striking treatment of the differences and similarities which exist side by side between the methods of the biological and physical sciences and those of the law, than in the article by Justice Pope earlier cited. While rather extended I consider the text so valuable as to be worthy of rather generous quotation. He wrote:

"Law and science from the standpoint of methods are perhaps as opposite as any two fields of learning that might be selected. It is the rare lawyer who can discourse upon the elementals of the scientific method, and few scientists either understand or care to understand the methods and problems of the common law. Yet the great new directions that have occurred in human thought have been born of an understanding of methods. Rationalism stimulated thinking, but empiricism added something new. When Bacon

* Thomas A. Cowan, *The American Jurisprudence Reader,* Oceana Publications, New York, 1956, Pages 8, 29-30, 32 and 47.

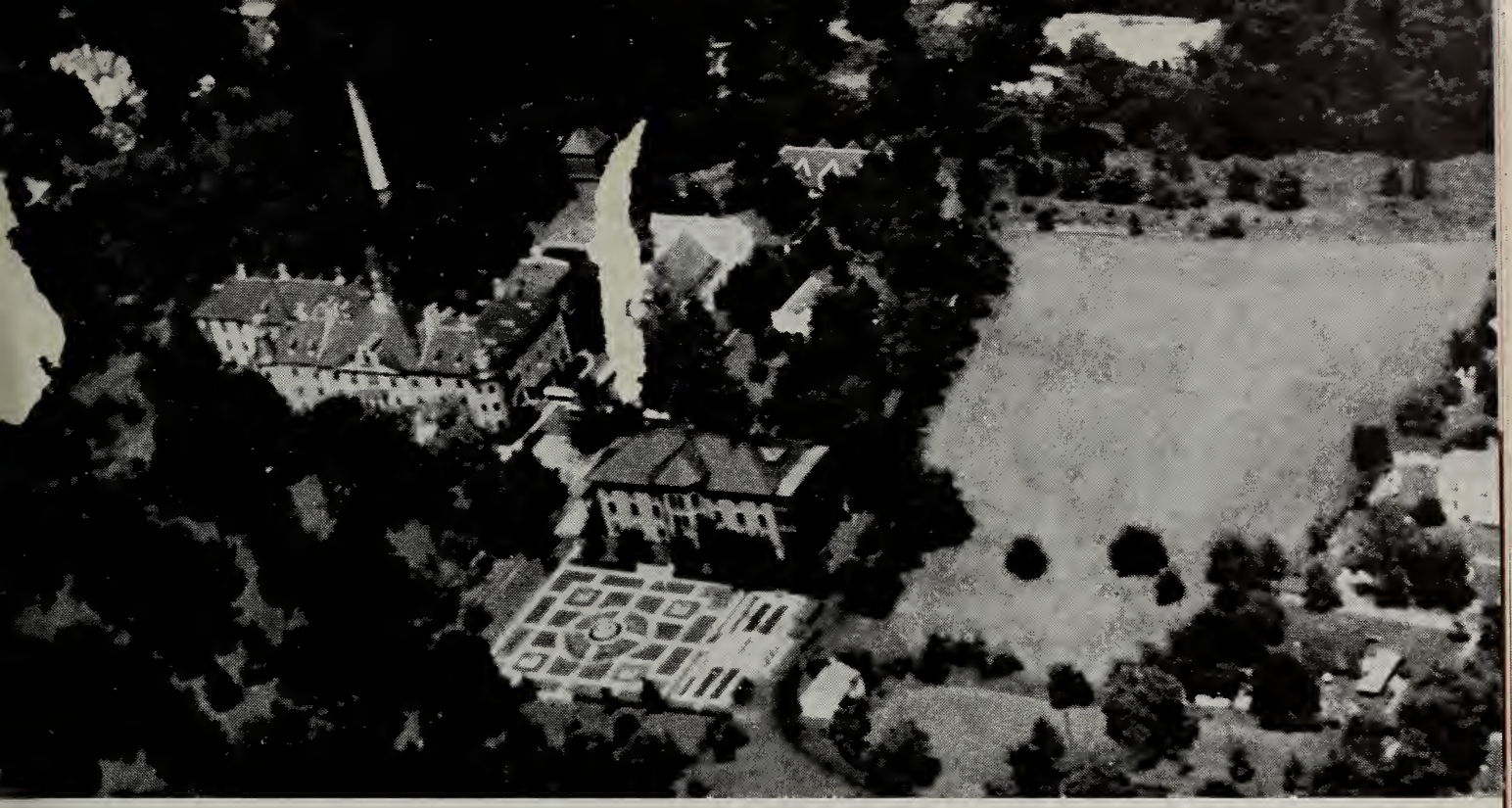


A pilot for the past four years

Charles Myers, an above knee amputee, wore his first Hanger Limb over eight years ago. "During that time I was in Central America, Mexico, and Canada. In Central America I worked on air route surveys under jungle conditions. I found that my Hanger Limb stood up well." The sturdiness and dependability of the Hanger Limb allaws wearers to return to narmal life. Many, such as Mr. Myers, find they can cantinue their unusual occupations.

Hanger PROSTHESES

1529-33 N. Illinois St., Indianapolis 2, Ind.
3108 Burnet Avenue, Cincinnati 29, Ohio
Fairfield at Pontiac, Fort Wyne, Ind.
418 N. Main St., Evansville, Ind.



SERENE SURROUNDINGS

ACCREDITED PSYCHIATRIC HOSPITAL FOR PRIVATE DIAGNOSIS AND TREATMENT

Approved by the Joint Commission on Accreditation of Hospitals.

Equipped to provide latest acceptable methods of treatment, including Out-Patient Pavilion.

Ample classification facilities with qualified psychiatric nursing.

Full occupational therapy and recreational activities.

Forty acre estate to assure privacy in a restful setting.

write to the address below for new illustrated brochure

WILLIAM E. HILLARD, M.D.
Medical Director

CHARLES W. MOCKBEE, M.D.
Associate Medical Director

ISABELLE DAULTON, R.N.
Director of Nursing

GRACE SPINDLER, R.N.
Associate Director of Nursing

ELLIOTT OTTE
Business Administrator

CHARLES M. CLIFFE
Associate Business Administrator



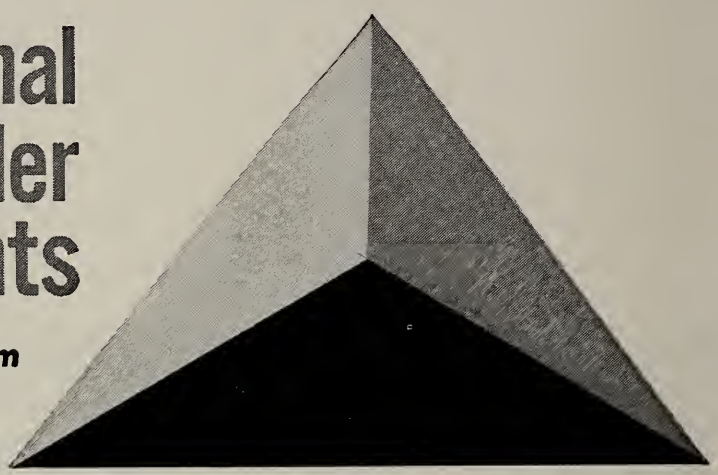
THE EMERSON A. NORTH HOSPITAL, Inc.
(Founded 1873)

5642 HAMILTON AVENUE, CINCINNATI 24, OHIO
Telephones: KIrby 1-0135 KIrby 1-0136

wrote about the grand new method, Galileo was already busy practicing it, but it was Bacon who showed the way for thousands of lesser Galileos. No scientist or judge can perform to capacity unless he has an understanding of his own methods. If that be true with reference to the scientist dealing with science and the judge or lawyer dealing with law, it would seem that the best results and the greatest hope for this effort toward integration would be found in a willingness on the part of the scientist to learn something about the legal and other methods and a desire by the lawyer to learn something about the scientific method. It is not necessary that the one shall become a pseudo-scientist nor the other a pseudo-lawyer. It is enough if we understand the respective methods, understand wherein they may be mutually useful, and learn to appreciate the differences and limitations of each.

"What must we learn about method? We lawyers must learn that science has certain productive techniques which fall into a rather common sequence. Sometimes one step plays a more important role than others. Step one is usually a critical review of the relevant literature. Step two is one of observation or of experiment under carefully controlled conditions. Step three is the correlation of the information gathered, and a defining of the problem. It is one of analysis and synthesis. By step four, the scientist ceases staring and begins to imagine and suppose. Hypotheses are made, as many as possible. And finally, the hypotheses are tested by experiments. But there is more to his mental processes than that. He infers, he compares, he draws analogies, he classifies. He knows that some problems are unanswerable by one method, but may be by another. When the scientist moves from matter into life, he may find an evolutionary or historical method more helpful. The lawyer, for identically the same reasons as the scientist, may turn to the same methods when faced with problems of human customs and institutions. As a substitute for more reliable scientific methods, by necessity we both often turn to the statistical method. The scientist at times deduces, sometimes he induces, and at other times he does both in-

3-dimensional support for older patients



BOLSTERS... ▲ *tissue metabolism*
▲ *interest, vitality*
▲ *failing nutrition*

NEW 1 small capsule every morning
GEVRESTIN®
Geriatric Vitamins-Minerals-Hormones-d-Amphetamine Lederle

Each capsule contains: Ethinyl Estradiol 0.01 mg. • Methyl Testosterone 2.5 mg. • d-Amphetamine Sulfate 2.5 mg. • Vitamin A (Acetate) 5,000 U.S.P. Units • Vitamin D 500 U.S.P. Units • Vitamin B_{12} with AUTRINIC® Intrinsic Factor Concentrate 1/15 U.S.P. Unit (Oral) • Thiamine Mononitrate (B_1) 5 mg. • Riboflavin (B_2) 5 mg. • Niacinamide 15 mg. • Pyridoxine HCl (B_6) 0.5 mg. • Calcium Pantothenate 5 mg. • Choline Bitartrate 25 mg. • Inositol 25 mg. • Ascorbic Acid (C) as Calcium Ascorbate 50 mg. • l-Lysine Monohydrochloride 25 mg. • Vitamin E (Tocopherol Acid Succinate) 10 Int. Units • Rutin 12.5 mg. • Ferrous Fumarate (Elemental iron, 10 mg.) 30.4 mg. • Iodine (as KI) 0.1 mg. • Calcium (as $CaHPO_4$) 35 mg. • Phosphorus (as $CaHPO_4$) 27 mg. • Fluorine (as CaF_2) 0.1 mg. • Copper (as CuO) 1 mg. • Potassium (as K_2SO_4) 5 mg. • Manganese (as MnO_2) 1 mg. • Zinc (as ZnO) 0.5 mg. • Magnesium (MgO) 1 mg. • Boron (as $Na_2B_4O_7.10H_2O$) 0.1 mg. Bottles of 100, 1000.

LEDERLE LABORATORIES, a Division of AMERICAN CYANAMID COMPANY, Pearl River, New York Lederle



if you're treating a coccal infection...

you can't prescribe a more effective antibiotic than

ERYTHROCIN

Erythromycin, Abbott

How much "spectrum" do you need in treating an infection? Clearly, you want an antibiotic that will show the greatest activity against the offending organism, *and the least activity against non-pathogenic gastro-intestinal flora.*

Weigh these criteria—and make this comparison—when treating your next coccal infection. Erythrocin is a medium-spectrum antibiotic, notably effective against gram-positive organisms. In this it comes close to being a "specific" for coccal infections—*which means it is delivering a high degree of activity against the majority of common infection-producing bacteria.*

And against many of the troublesome "staph" strains—a group which shows increasing resistance to penicillin and certain other antibiotics—Erythrocin continues to provide bactericidal activity. Yet, as potent as Erythrocin is, *it rarely has a disturbing effect on normal gastro-intestinal flora.* Comes in easy-to-swallow Filmtabs®, 100 and 250 mg. Usual adult dose is 250 mg. every six hours. Children, in proportion to age and weight. Won't you try Erythrocin?

®Filmtab—Film-sealed tablets, Abbott.

ABBOTT

011297

termittently. His methods must be suited to the problem, some of which may help, while others may be entirely fruitless. A study of these methods and why they are sometimes adequate and at other times barren, will point to many facts, one of which may be that the point at which science commences to lag is often the point at which the matter is handed over to the law for solution. We may learn to borrow methods, and it very well could be that we are already doing so without knowing it. The advance and comparative study of governments of the world by the constitutional fathers which resulted in the forming of new hypotheses drawn from the limited data of history and stated in our American Constitution, may, upon study, show that our most significant example of social and legal engineering is an adaptation of the scientific method.

"And what of the legal methods? We must ourselves understand them; and then make them more fully understood. We must understand the setting in which we find law. The significance of human environment upon the legal method, the fact that law exists in a social milieu rather than in theory, that law must be expressible in terms of a semantic culture, be capable of interpretation to large numbers of citizens, the need for a measure of stability amid a need for change, that it must strive toward consistency and symmetry, that a system is often better measured by its historical dangers than by its present advantages, the continuity of progress and the evolution of institutions, the vastness of legal materials, the methods by which new materials are absorbed by the law, the availability of new materials, and the criteria for their acceptance are the concerns of the law. Perhaps *stare decisis* is as strange to the scientist as is the method of concomitant variations to the lawyer. The method of analogy and logic, the method of history and emergent law, the method of philosophy, the method of tradition and custom, the method of sociology, and all the other ingredients of what Cardozo has termed the 'judicial brew,' are worthy of inquiry by nonlawyers. Perhaps the greatest good from the mutual study of methods would come from its demonstration of the reasons for differences in methods. Why a method is used in one body of learning and may be of slight use in the other, would at least produce understanding.

"In a general way, we might assert that science achieves its greatest success when it works with the exact physical sciences where control over variable conditions is easily achievable. But as matter moves into life, and life into mind, and many minds into the many currents of human society, the simple things become obscured, and the identifiable becomes elusive. Problems presented by sociology, political science, history, human rights, personality, delinquency, criminology, prohibitions against and immunities from unwarranted searches, the anatomy of freedom, the paradoxes of the law, must often find solutions without benefit of experiment. The known and the unknown, seen and unseen forces of heredity, environment and cumulative tradition present difficulties for science and law alike. Successful experi-

Yes Doctor

I am happy, thankful and glad you sent me and my family to Heid's for correct shoes—this eliminates one of our handicaps.



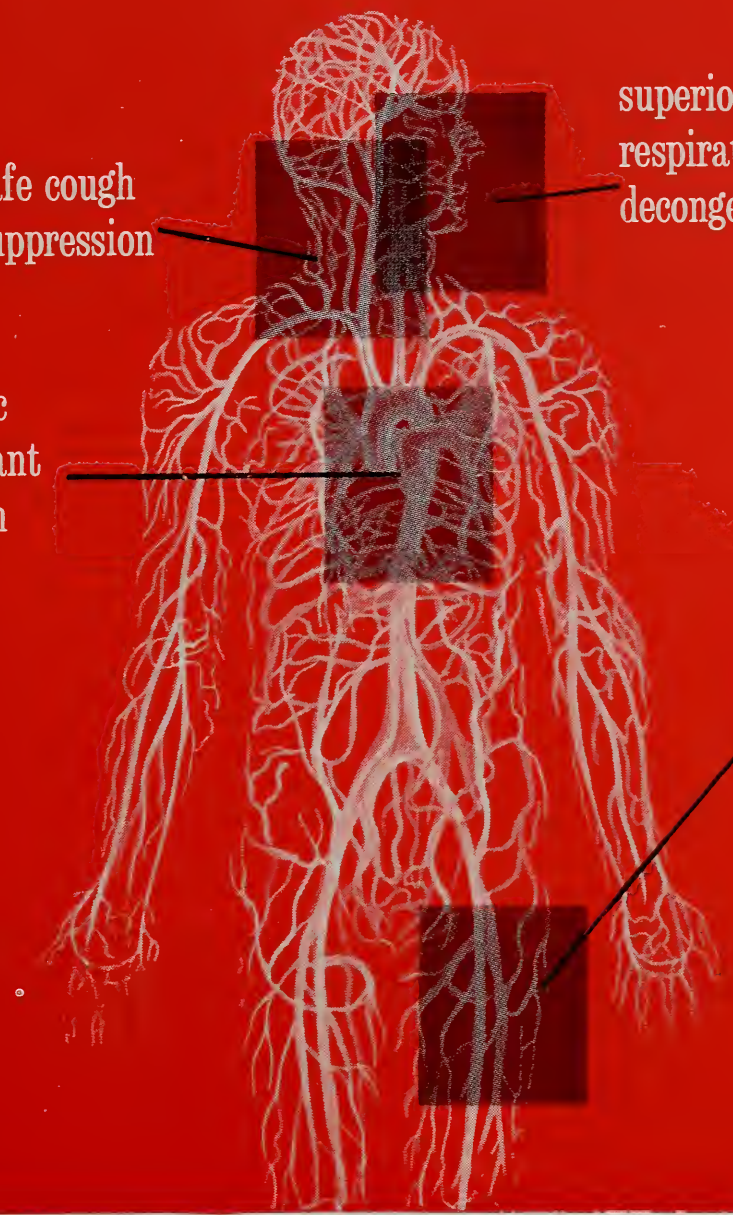
HEID'S 50th Year

Shoes for Men, Women, Children

411 N. Illinois, Indianapolis

Phone MElrose 5-4247 Drive-In Parking

for relief from the total cold syndrome...



Tussagesic*

timed-release tablets/suspension

Each Tussagesic timed-release Tablet provides:

TRIAMINIC®	50 mg.
DORMETHAN (brand of dextromethorphan HBr)	30 mg.
TERPIN HYDRATE	180 mg.
APAP (acetaminophen)	325 mg.

Dosage: *Adults and children over 12* — one tablet in the morning, midafternoon and at bedtime. Each tablet should be swallowed whole to preserve the timed-release action.

Each tsp. (5 ml.) of Tussagesic Suspension provides:

TRIAMINIC®	25 mg.
DORMETHAN (brand of dextromethorphan HBr)	15 mg.
TERPIN HYDRATE	90 mg.
APAP (acetaminophen)	120 mg.

Tussagesic Suspension is especially suited for children and for adults who prefer liquid medication; it is pleasantly flavored, non-narcotic and non-alcoholic.

Dosage (to be taken every 3 or 4 hours): *Adults and children over 12* — 1 or 2 tsp.; *Children 6 to 12* — 1 tsp.; *Children 1 to 6* — ½ tsp.; *Children under 1* — ¼ tsp.

TRADEMARK

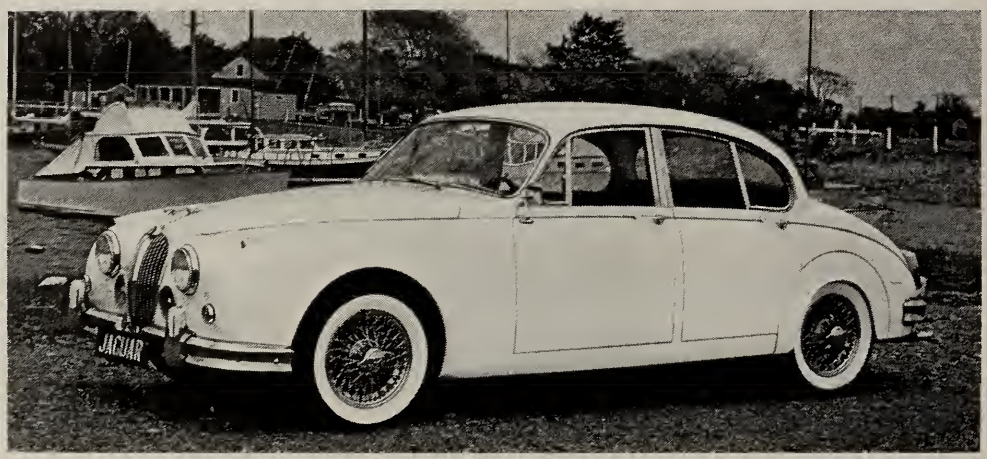
SMITH-DORSEY • a division of The Wander Company • Lincoln, Nebraska

ments upon society have been few in number. The scientist may study successive and deliberate litters of guinea pigs, but the sociologist can hardly control the marriages and progeny of successive young men and women. And even if he could, only one hundred generations have occurred since the time of Socrates, which is hardly a fair sampling. How, therefore, can one fathom society's manifold conditions; how can its infinite extraneous influences, even if knowable, be controlled; and how can those latent forces be scientifically observed and measured?

"It is believed that a step forward will be made when scientist and sociologist appreciate that the differences in methods are occasioned by the differences in subject matter. What are some of these differences?

"Social science, not correctly termed science, is more complex than natural science. In the case of natural science, experiments may be selected; problems are handed over at random to social science. For natural science, success is commensurate with the amount of control exercised over the experiment, but for social science, a control, if achieved at all, is far from complete. Natural sciences isolate phenomena for study; in law, at best, we isolate them in thought. The natural scientist eliminates variables; the lawyer rather than eliminating them, must take them into consideration and correlate the variables. The scientist by isolating his material creates a negative or artificial environment; the lawyer must accept the full environment. The natural scientist searches for the cause; the lawyer often must be satisfied with several contributing and multiple causes.

"Natural science is capable of repeatable experiments. The lawyer can make few experiments. Natural science has the aid of instruments; social science often has only the tools of the intellect. Induction is the star in the scientific backfield. Often, for lack of anything else, the lawyer is left with deduction and analogy. Experiments in the



For the Family Man of Adventurous Spirit...the Jaguar 3.8 Litre Family Sports Sedan

The brilliant new 5-passenger "Three-Point-Eight" sedan is the ideal Jaguar for the sports car enthusiast with a family! COMPACT, without sacrificing roominess, comfort and luxury, it incorporates such features as optional power steering, automatic transmission, 4-wheel disc brakes, polished walnut dashboard and glove leather upholstery. Powered by the new 3.8 litre XK engine, this proud new Jaguar has a top cruising speed of 120 m.p.h. . . . the "fastest sedan of its class in the world!" See the other 1961 Jaguars, too . . . the luxurious Mark IX sedan and the XK 150 sports models. Convenient terms!

JAGUAR
2330 NORTH MERIDIAN STREET

MIDWEST DISTRIBUTORS, Inc.
• INDIANAPOLIS

for acute
upper respiratory infections

Tetrex®

capsules

The Original Tetracycline Phosphate Complex

U.S. PAT. NO. 2,791,609

effective control of pathogens...with an unsurpassed record of safety and tolerance



BRISTOL LABORATORIES, SYRACUSE, NEW YORK
Div. of Bristol-Myers Co.

BRISTOL™

SUPPLY: TETREX Capsules — tetracycline phosphate complex — each equivalent to 250 mg. tetracycline HCl activity. Bottles of 16 and 100.

TETREX Syrup — tetracycline (ammonium polyphosphate buffered) syrup — equivalent to 125 mg. tetracycline HCl activity per 5 ml. teaspoonful. Bottles of 2 fl. oz. and 1 pint.

November 1960 2093

Continued

laboratory are relatively simple. Experiments with a segment of society would be as diffuse as the affairs of men and often impossible. A tolerant public will wait for years while science pursues an important research problem; an impatient party and critical public clamor for prompt judgment, even a wrong one, in the courthouse, perhaps on a matter concerning the same research.

"The natural scientist is on the outside of his experiment and observes the subject matter objectively. The lawyer as the observer is also a part of the very human material with which he works. The scientist may be objective about an outside object. The lawyer, when dealing with people, can hardly register zero on subjectivity, and be an advocate. The scientist goes about his work as a neutral inquirer; the lawyer more often is cast in the midst of human controversy. The scientist assumes the consent of the object studied; in the case of the lawyer it is more often refused. As J. W. N. Sullivan has said: 'Similarly Newton's demonstration of the law of inverse squares roused no horror anywhere. Nobody had a strong emotional preference for the law of inverse cubes.' But he then compares that indifference toward inanimate matters, with those in which some 'human' interest is present such as the Copernican theory, the Darwinian theory, and we might add also the more recent Kinsey Report.' He cryptically adds: 'Science is truthful because it has practically no temptation to be anything else.' These differences have practical results also. Funds for scientific research are more liberally furnished than are funds for research into controversial matters, where the donor rather than seeking answers desires to perpetuate an idea. The scientist has a technical jargon; the lawyer, since his work must be interpreted to the public, client and jury, will forever work under a limitation of a less exact language. The scientist seeks often for the 'is'; the lawyer more often for the 'ought.' A scientist selects a hypothesis. On that point perhaps the lawyer is doing the same thing, in his way, when he chooses and selects the less certain lessons of history.

"The scientist has his Bureau of Standards, but the best that lawyers can achieve is a Supreme Court. We have no Naval Almanac. We may know that Halley's Comet will return, but we have no way of knowing whether the ordinary prudent man in 1986 will be behaving the same then as now. We have no social Palomar to bring our human problems in closer and better focus. This is not to say that law as applied sociology cannot improve its methods. Rather, it is to show that we cannot unless we take a good look at successful methods and manifest a willingness to follow the flag of truth wherever it may lead and without regard to which professional body may unfurl it. Hence, while the doctor may not profit from an institute on 'How to try a trespass to any title suit,' perhaps he could be stimulated by a comparative study of methods and a finer appreciation of our mutual inadequacies. Unity can be achieved even through an understanding of our differences.

"A mechanistic science once believed that the determination of certain facts would provide a predictability as in the case of the movement of the stars, but essays are now being written explaining why some facts will forever be unknowable. Scientists who once sought a certainty through science in 1932 awarded Dr. Heisenberg, a physicist and mathematician, the Nobel prize for his work on the 'principles of uncertainty.'

"Humility, not pride of knowledge, is the unifying principle. Who can help? Who can bring some donation to our meager fund of knowledge? We must accept aid from many sources and it hardly befits any of us to claim positions of eminence."*

Misunderstood Technicalities

Lest we think that giants are always people who live far away, whom we never meet, let me say that one of the most distinguished living authorities on jurisprudence in any English-speaking country is Professor Jerome Hall of the Law School of Indiana University. He has made some observations on the problems of legal science which richly merit consideration. Following are some excerpts which touch upon the much misunderstood subjects of legal tech-

* Pope, Ibid. pp. 22-28, 29.

Continued on page 2098

RELIEVE ALL COMMON COLD SYMPTOMS AT ONCE



WITH

'EMPRAZIL'®

THE TOTAL COLD-THERAPY TABLET

nasal decongestant • analgesic antipyretic • antihistamine

The ingredients combined in each 'Emprazil' tablet provide multiple drug action for prompt symptomatic relief of aches, pains, fever and respiratory congestion—due to common colds, flu or grippe—without gastric irritation.

Dosage: Adults and older children—One or two tablets t.i.d. as required. Children 6 to 12 years of age—One tablet t.i.d. as required.

Supplied: Bottles of 100 or 1000

Each orange and yellow layered tablet contains:

'Sudafed'® brand Pseudoephedrine Hydrochloride	20 mg.
'Perazil'® brand Chlorcyclizine Hydrochloride	15 mg.
Acetophenetidin	150 mg.
Aspirin (Acetylsalicylic Acid)	200 mg.
Caffeine	30 mg.

Complete literature available on request.

BURROUGHS WELLCOME & CO.
(U.S.A.) INC., Tuckahoe, N. Y.

Continued from page 2094

nicalities, the language of the law, legal procedure and reliance upon precedent. He wrote:

"The layman is critical of the lawyer's technicality, ascribing it to a desire for prestige, an intent to mystify and impress, and to sheer inertia. There is a grain of truth in this criticism. But it requires little investigation to discover that, by and large, the language of legal science is neither arbitrary nor whimsical. The principal reason, indeed necessity, for legal technicality can be seen when one considers that there are thousands of rules of law, millions of human beings, and an infinite number of facts and interpersonal relationships. It would be utterly impossible to determine the legal significance of these countless transactions and fact-situations with any degree of reliability unless there were common ideas by means of which an organization of the complex data of decision could be constructed and used. Technical terminology is the vehicle of these ideas. In short, legal science is an instance of the endless search for 'the one in the many.' Such terms as 'right,' 'duty,' 'contract,' 'trust,' 'fee simple,' and so on, refer to common aspects of legally significant situations. They are unifying agents, essential to, indeed, presupposed in, any system of law. The absence of such fundamental notions would imply the lack of any legal science and a state of primitive law which would be analogous to the crudest beginnings of physics or chemistry when such basic notions as matter, force, inertia, element, compound, and the like, were non-existent. A technical terminology is the necessary adjunct of specialized ideas; hence, the direction of progress is toward more, rather than less, technicality."

"The language of the law developed typically under conditions beyond the control of individuals. It acquired and represents meanings that are objective in the sense that they are determined in part by external data, and they are shared, rather than private, meanings. Anyone who wishes to communicate must conform to the conditions, to the objective meaning of the words. Mistakes in meaning are not uncommon if problems are difficult; so, too, prejudice is a perennial hazard and, rarely, officials are perverse or dishonest. But none of these contingencies, though they dispel any hope for certainty in admittedly problematic social situations, disprove the substantial reliability of the normal process of cognition, painstakingly applied to facts and language."

"But the presence of many gaps in the legal system, the vagueness and ambiguity in the meaning of the rules, and the discretionary power to modify them, though they seriously undermine the traditional theory, do not support the extreme skepticism that law is subjective, uncontrolled caprice and that it is impossible to generalize legal meaning beyond the confines of each particular decision. For we must take account not only of the vagueness of the rules but also of their core of certainty; not only of the ambiguity of words but also of their relative univocality when defined in many decisions; not only of the individual differences in the personality of judges but also of their common psychological processes, their conditioning in a common culture, their training in and use of a science of law, the physical and biological

The Norbury Sanatorium

Established 1901 — Incorporated
Licensed — Jacksonville, Illinois

FRANK GARM NORBURY, A.M., M.D., Medical Director
HENRY A. DOLLEAR, M.D., Superintendent
FRANK B. NORBURY, M.D., Physician

Operating

Maplecrest—

Restful, congenial, homelike surroundings are combined with the most modern diagnostic and therapeutic equipment.

Maplewood—

Most comfortable home for individuals requiring rest, scientific diagnosis and treatment. Fireproof construction.



Use of pHisoHex for washing the skin augments any other therapy for acne — brings better results. Now, pHisoAc Cream, a new acne remedy for topical application, suppresses and masks lesions — dries, peels and degerms the skin. Together, pHisoHex and pHisoAc provide **basic** complementary topical therapy for acne.

pHisoHex, antibacterial detergent with 3 per cent hexachlorophene, removes soil and oil better than soap — provides **continuous** degerming action when used often. pHisoHex is nonalkaline, nonirritating and hypoallergenic.

When pHisoAc Cream is used with pHisoHex washings, it unplugs follicles, helps prevent development of comedones, pustules and scarring. New pHisoAc Cream is flesh-toned, not greasy. It contains colloidal sulfur 6 per cent, resorcinol 1.5 per cent, and hexachlorophene 0.3 per cent in a specially prepared base. pHisoAc is pleasant to use.

A new "self-help" booklet, **Teen-aged? Have acne? Feel lonely?,** gives important **psychologic first aid** for patients with acne and describes the proper use of pHisoHex and pHisoAc. Ask your Winthrop representative for copies.

pHisoAc is available in 1½ oz. tubes and pHisoHex is available in 5 oz. plastic squeeze bottles and in bottles of 16 oz.

pHisoHex® and pHisoAc for acne

trademark

Winthrop
LABORATORIES
New York 18, N. Y.

constants, the endurance of basic ideas, the inertia of institutions, and the pervasive bulk of language. These assure sufficient cretainty in the legal process."

"Modern legal procedure, no less than scientific method, is the product of a long evolution. For countless centuries the settlement of disputes was an affair of magic and religion, of resort to the Oracle, the Medicine Man, or to God by prescribed and sometimes elaborate rituals. One may believe that the improved methods of modern procedure secure more adequate enlistment of divine aid in the ascertainment of the truth. Nonetheless, the substitution of rational methods of trial for magic and superstition represents a very considerable progress—one that is far more significant than many important inventions of applied science. For every sound use of legal method is an experience in truth-seeking and right-seeking that has inherent value regardless of the actual outcome.

"In addition to procedure, legal method includes, among other components the logical analysis of authoritative materials. The logic of legal method functions under direction of *stare decisis,* the doctrine that any present litigation must be decided in conformity with the rules laid down in past cases. Legal method therefore depends largely on reasoning by analogy. This involves the search for similarities in fact-situations of known legal significance and fact-situations whose legal significance is to be determined. When a lawyer comes into court with an armful of law books, his purpose is to persuade the judge that the instant case must be decided in a certain way because very similar cases were decided that way in the past; and the principle of *stare decisis* enjoins continuity. The argument is similar to that employed in scientific method. If the inquiry concerns the existence of life on Mars, the scientist discovers and accumulates what he regards as significant similarities between Mars and Earth—the presence of oxygen, a certain range in temperature, and the like. He knows that life exists on Earth and, as the conditions of life increase on Mars, the probability rises that life exists there too. So, also, as the similarity between the facts in the instant case and those in cases decided in the past increases, the duty to apply the same rules tends to become established. On the other hand, important differences in the data compared diminish the analogy. The crucial question is whether the compared sets of facts are 'sufficiently' alike."*

Lawyers have been called the "architects of order," and they have lived up to this description sufficiently well so that you take for granted what is actually a very complicated machinery which assures relative social order and security 24 hours a day. When the rules of orders are violated, death, injury, erratic conduct, danger to others or to property may occur. These are not exclusively legal or exclusively medical problems; rather, they are medico-legal problems.

We may be concerned over the mental capacity of a child to understand the effect of an oath; of the mental ability of a person under guardianship to make certain decisions; or that of an aged or sick individual to sign an instrument with sufficient awareness so that it is a valid will. From the standpoint of the lawyer, these and many other problems come to him as part of his practice, but he cannot solve them intelligently or authoritatively without consulting the judgment of medical men.

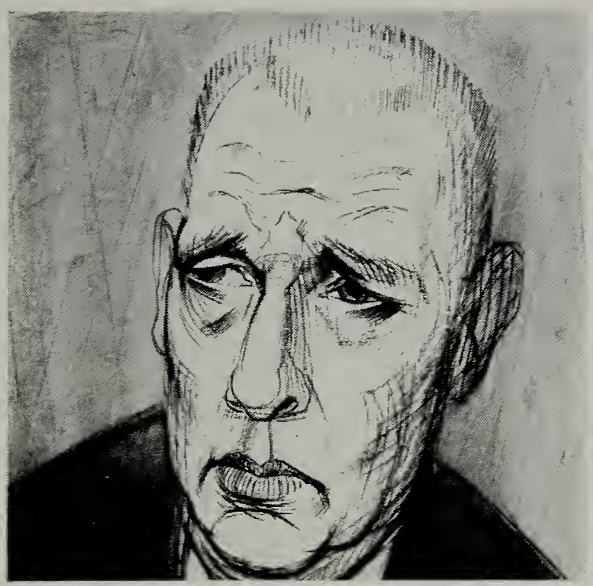
The design of schools and other public buildings, the effects of noise on our hearing and of congestion and continued rushing on the nervous system, the content of educational curricula and

* Quoted from essay entitled "Law and Legal Method" in *Living Law of Democratic Society,* by Jerome Hall, Bobbs-Merrill Co., 1949, pages 37-8, 42, and 44-8.

Invest in the future health of the nation and your profession

Give to medical education through AMEF

American Medical Education Foundation AMEF 535 N. Dearborn St. Chicago 10, Ill.



whenever depression complicates the picture

Tofrānil®

brand of imipramine HCl



hastens recovery

Geigy

In many seemingly mild physical disorders an element of depression plays an insidious etiologic or complicating role.

Because of its efficacy as an antidepressant, coupled with its simplicity of usage, Tofrānil is admirably adapted to use in the home or office in these milder "depression-complicated" cases.

It is always wise to recognize that depression may be an underlying factor...that Tofrānil may speed recovery in "hypochondriasis"; in convalescence when recovery is inexplicably prolonged; in chronic illness with dejection; in the menopausal patient whose emotional disturbances resist hormone therapy; and in many other comparable situations in which latent depression may play a part.

Detailed Literature Available on Request.

Tofrānil®, brand of imipramine hydrochloride, tablets of 25 mg. Ampuls for intramuscular administration, 25 mg. in 2 cc. of solution.

Geigy, Ardsley, New York

160-60

the very basic congregate and individual problems of food, clothing, shelter and recreation may at first sound to you like governmental responsibilities, but they are not soluble by government alone. One reason they have not been solved more fully is that the medical profession has not been active enough in bringing its vast knowledge and experience to bear on the solutions.

Need for Individualized Advice

You men of medicine have learned how to prolong the lives of people over 65 in very dramatic fashion the last 30 years. Just how much individualized advice is your profession really giving to these people, their children and relatives, or to employers and to governmental representatives on how to keep that rapidly growing segment of our population usefully and happily occupied through programs and adjustments which will permit the best use of their spiritual, intellectual, physical and economic resources? Do you think you have done the job merely because you cared for individual cases? Does not your profession as such owe something more to society?

If the validity of my argument be granted, will it not be, in part at least, through services of lawyers, legislators and governmental agencies that your experience and recommendations are translated into workable standards and programs? You and I often complain about the social worker and the bureaucrat. We call them unrealistic, self-seeking, unbalanced and many other less complimentary terms. Would not an objective survey of the facts demonstrate that your profession and mine have largely abandoned the unfortunate and the helpless to these unprofessional groups, of whom it can be said that at least they atack the problems before them with energy, enthusiasm and frequently with dedication?

Demographers, self-professed experts in generations yet unborn, tell us that land will be in increasingly short supply as the population on this planet increases. They emphasize that all but a small fraction of the earth's surface is under water, and that only a fraction of the remainder can be used to grow food at the present time. Your training in sustaining life through advising on the basic food, housing and similar requirements, and my profession's responsibility for helping plan the best use of our social and economic resources demand a continuing comparison of notes and a continuing cooperative effort. These problems are so basic to the very life of the human race that they call for more powers of prophesy than I have, to say that John Q. Public will not at some time and in one or more ways—demand immediate and possibly second rate solutions to his urgent problems of land, food, housing and a job. Will you and I be ready? Will our professions?

As I review my remarks, I find that I have passed over quickly or not even alluded to three classes of legal subjects which hold special interest for the practitioners of medicine. One is the field of personal injury litigation, whether caused by employment or not. It has been estimated that not less than 70% of all civil litigation in this country involves medical testimony of some kind. That percentage, of course, includes automobile litigation, workmen's compensation claims, sanity proceedings, guardianships, adoptions and will contests.

The second includes those branches of forensic medicine to which the physician brings his special knowledge, essential to the very enforcement of those portions of the law. On the civil side, I refer to so-called "public health laws." These are designed to control contagious diseases, gather vital statistics and help educate on a mass basis in matters of general health and sanitation. Your training in immunology and in epidemiology is vital here. A physician needs an increasingly substantial amount of knowledge about licensure, the legal restriction on the use of various drugs and on what he is required to report or not permitted to report.

In the enforcement of the criminal law medical and related sciences play an increasingly signifi-

It's your professional privilege to replenish your ranks . . .

Give to medical education through AMEF

American Medical Education Foundation
535 N. Dearborn St., Chicago 10, Ill.



What's she doing that's of medical interest?

She's drinking a glass of pure Florida orange juice. And that's important to her physician for several reasons.

How your patients obtain their vitamins or any of the other nutrients found in citrus fruits is of great medical interest—considering the fact there are so many wrong ways of doing it, so many substitutes and imitations for the real thing.

Actually, there's no better way for this young lady to obtain her vitamin C than by doing just what she is doing, for there's no better source than oranges and grapefruit ripened in the Florida sunshine. There's no substitute for the result of nature's own mysterious chemistry, flourishing in the warmth of this luxurious peninsula.

An obvious truth, you might say, but not so obvious to the parents of many teen-agers.

We know that a tall glass of orange juice is just about the best thing they can reach for when they raid the refrigerator. We also know that if you encourage this refreshing and healthful habit among your young patients — and for that matter, your patients of any age — you'll be helping them to the finest between-meals drink there is.

Nothing has ever matched the quality of Florida citrus—watched over as it is by a State Commission that enforces the world's highest standards for quality in fresh, frozen, canned or cartoned citrus fruits and juices.

That's why the young lady's activities are of medical interest.

©Florida Citrus Commission, Lakeland, Florida

cant role. Public administrators of the criminal law are highly dependent on the findings of pathologists or toxicologists in making such determinations as whether cause of a given death was murder, suicide or accident. Such matters as artificial insemination, induced abortions, sterilization, intoxication, drug addiction, fee-splitting, mental illness accompanied by criminal acts, are neither exclusively medical nor exclusively legal; rather, they are both, and all the knowledge and judgment of the two professions are acutely needed for their intelligent handling. I am leaving out any references to the social or moral aspects of these matters because I have not been asked to speak to those subjects.

Third, I have neglected those branches of the civil law which are incidental to the practice of medicine. An obvious example is the liability of the physician for acts of alleged professional negligence. This often goes by the unpleasant name of malpractice. Another is the field of medical testimony and its proper preparation prior to being offered before an administrative body. Modern psychiatry has already left its mark on the law of evidence, but much remains to be done in that area. Still another is the contract relationship between physician and patient, its obligations and its limits. Privileged communication is a matter of statute in more than one-half the states, and while this is designed in the patient interest, it inevitably involves the physician and his office and hospital records.

Conductors of Knowledge

There is also the less publicized obligation which is recognized universally and exists as an ethical precept, independent of positive law—the obligation not to disclose professional communications willfully.

I have been studying and practicing law for more than 30 years. For almost as long a time, I have been an admirer and an observer of the elements of medicine, and of many of its practitioners. It is my conviction that these two great arts, sciences, traditions, disciplines, describe them as you will, have the potential above all others to serve as effective conductors of philosophic, scientific and other knowledge from the scholar's desk and the laboratory to the home and the place of business of the general population.

I am not suggesting that we stand alone in this effort, or that we can succeed without the help of the rest of society, even though we combine our forces. I am not addressing myself to any such proposition. I do ask that you assume with me the validity of my proposition that the professions of medicine and law can better fulfill their responsibilities to society by uniting for some purposes in areas of common interest; that to help achieve this end, each profession must communicate more fully, more comprehensively and more intelligibly with the other than it has done in the past. As I earlier indicated, I claim no prophetic powers whatever. If medicine and the law do not combine their efforts and act in closer union than they have in the past, neither society nor the two professions will necessarily fall apart. If they do combine and strive their utmost, society may still fall apart. I suggest only that the chances for maintaining or restoring balance, as particular areas of our society may need one or the other, are much enhanced by such a joint effort. To say the least, without such joint endeavor, society will be needlessly deprived of the greater effectiveness which each of our professions would enjoy through collective effort in appropriate areas of thought and action.

Recommendations

We live in a practical world. It is not enough to find fault, for we know that imperfection is all about us. Having made a diagnosis of imperfection, we then have an obligation to suggest one or more forms of therapy. Even that is not enough. Having suggested a remedial program, we have a professional and social obligation to try our utmost to make that program work.

In that spirit I offer the following three-stage program which I should be grateful to have all of you improve upon, but more importantly, act upon.

First, at pre-professional level, I hope that premedical students can be given the time and the encouragement to develop at least a speaking acquaintance with one or more of the languages, great literature, one or more of the fine arts, history, and one or more of the social sciences. It is equally my hope that a larger portion of the pre-law students will study those same subjects more conscientiously and maturely than many now do; also that an increasing number of them

Blood pressure that goes up with stress often comes down with SERPASIL®

(reserpine CIBA)

One reason that many cases of hypertension respond to Serpasil is that many cases are associated with stress. Stress situations produce stimuli which pass through the sympathetic nerves, constricting blood vessels, and increasing heart rate. Hyperactivity of the sympathetic nervous system may elevate blood pressure; if prolonged, this may produce frank hypertension. By blocking the flow of excessive stimuli to the sympathetic nervous system, Serpasil guards against stress-induced vasoconstriction, brings blood pressure down slowly and gently.

In mild to moderate hypertension, Serpasil is basic therapy, effective alone "...in about 70 per cent of cases..."*

In severe hypertension, Serpasil is valuable as a primer. By adjusting the patient to the physiologic setting of lower pressure, it smooths the way for more potent antihypertensives.

In all grades of hypertension, Serpasil may be used as a background agent. By permitting lower dosage of more potent antihypertensives, Serpasil minimizes the incidence and severity of their side effects.

CIBA
SUMMIT, N. J.

*Coan, J. P., McAlpine, J. C., and Boone, J. A.: J. South Carolina M. A. 51:417 (Dec.) 1955. /2330MB

Complete information available on request.



will seek an acquaintanceship with one or more of the biological or physical sciences.

Second, at the professional school level, it is my earnest hope that as rapidly as time can be assigned and qualified instructors made available, schools both of medicine and law will really teach legal medicine. By this, I mean do the job adequately rather than grudgingly or superficially. In my judgment, such interdisciplinary communication, education, and cross-fertilization of medicine and law should prove as fruitful scientifically as it is needed socially.

Third, at the postgraduate level, it is essential that the two professions continue what has been begun in the schools; also, that the two professions develop means of improved and sustained communication and joint effort in order to achieve a common program at the many points of common or parallel interest.

I shall feel amply rewarded for my efforts if I have succeeded in communicating to you even a fraction of my concern over the importance of increased joint effort by our two professions, and of my confidence that society, as well as the professions, will be the beneficiaries of any such program. ◄



"Now how long have you had this feeling that you weren't quite all there?"

The Harding Sanitarium

WORTHINGTON
OHIO

For the Diagnosis and Treatment of Psychiatric Disorders
and with
Limited Facilities for the Aging

GEORGE T. HARDING, M.D.
HARRISON S. EVANS, M.D.
Medical Directors

CHARLES W. HARDING, M.D.
Clinical Director

DONALD H. BURK, M.D.
CLARENCE E. CARNAHAN, M.D.
GEORGE T. HARDING, Jr., M.D.
HERNDON P. HARDING, M.D.
C. RICHARD JOHNSON, M.D.
ARNOLD L. NIELSEN, M.D.
R. EUGENE PROUT, M.D.

GRACE M. COLLET, Ph.D.
VERNON W. SHAFER, Ph.D.
Clinical Psychologists

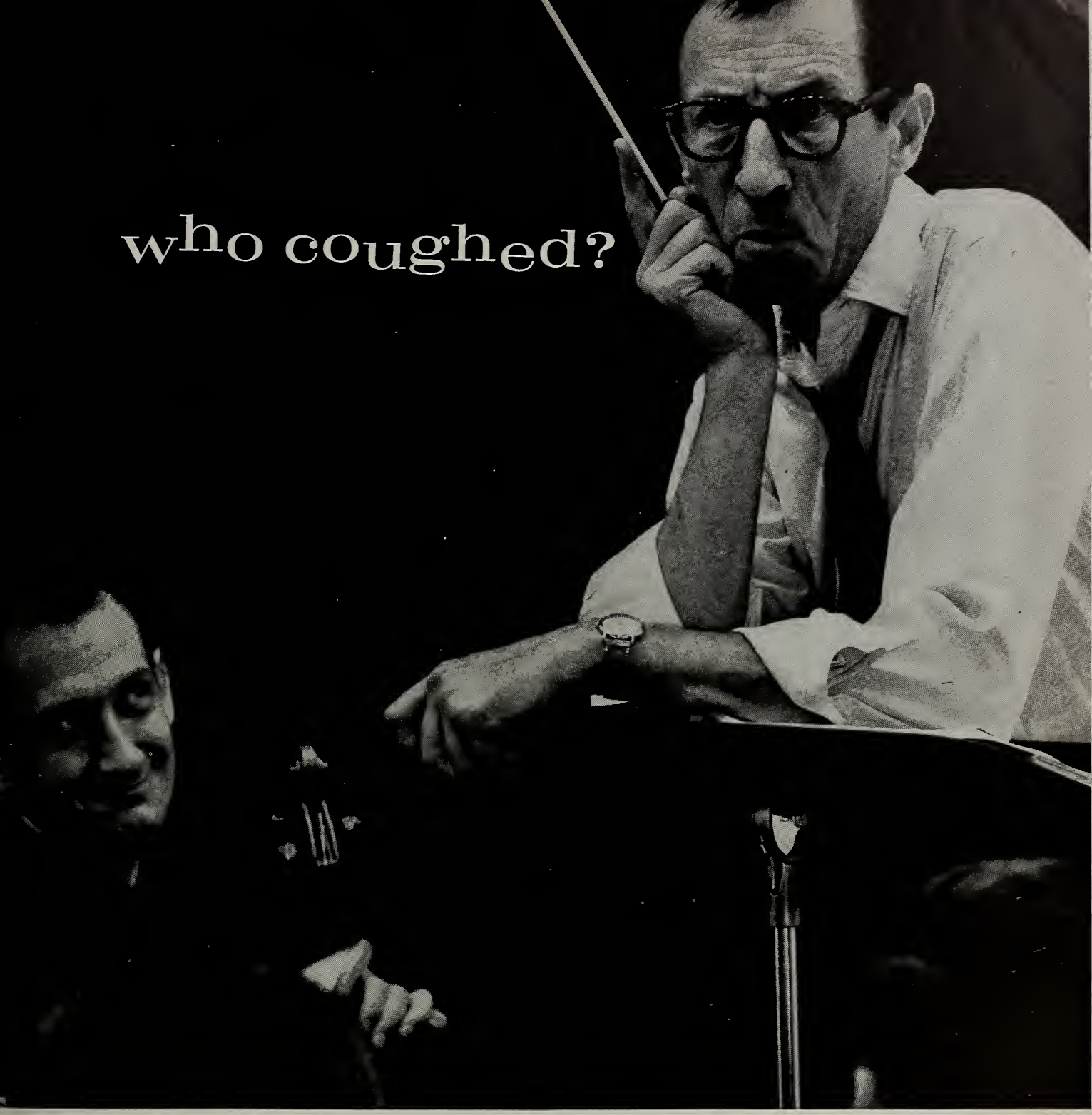
MARY JANE McCONAUGHEY, M.S.W.
BENJAMIN E. WHEATLEY, M.S.W.
Psychiatric Social Workers

PAULINE L. TOOILL, R.R.L.
Medical Record Librarian

JAMES L. HAGLE, M.B.A.
Administrator

ESTHER L. SIMPSON, R.N.
Director of Nurses

Phone: Columbus TUXEDO 5-5381



WHENEVER COUGH THERAPY IS INDICATED

HYCOMINE® Syrup

THE COMPLETE Rx FOR COUGH CONTROL

cough sedative / antihistamine
decongestant / expectorant

■ relieves cough and associated symptoms in 15-20 minutes ■ effective for 6 hours or longer ■ promotes expectoration ■ rarely constipates ■ agreeably cherry-flavored

Each teaspoonful (5 cc.) of HYCOMINE* Syrup contains:

Hycodan®		
Dihydrocodeinone Bitartrate	5 mg.	6.5 mg.
(Warning: May be habit-forming)		
Homatropine Methylbromide	1.5 mg.	
Pyrilamine Maleate		12.5 mg.
Phenylephrine Hydrochloride		10 mg.
Ammonium Chloride		60 mg.
Sodium Citrate		85 mg.

Average adult dose: One teaspoonful after meals and at bedtime. May be habit-forming. Federal law permits oral prescription.

Endo®

Literature on request

ENDO LABORATORIES
Richmond Hill 18, New York

*U.S. Pat. 2,630,400

Medicine At Law

DECISIONS AND OPINIONS

Highlights of recent court actions pertaining to health and medicine from *The Citation* prepared by the Law Division of AMA.

Failure to Obtain "Informed Consent" Constitutes Malpractice—Two recent decisions held that a physician who fails to inform the patient, generally, of the possible serious collateral hazards of a medical procedure may be held liable for malpractice even though he follows approved standards of medical care.

On April 9, 1960, the Supreme Court of Kansas held that if the defendant radiologist failed to fully advise his patient of the possible hazards of cobalt irradiation treatments, he would be guilty of malpractice. The court was careful to point out that such a holding would not be based on a charge of assault and battery, but rather on negligence for the failure to obtain an informed consent. At the same time, the court stated that where the patient is fully aware of the dangers involved, his consent to the proposed treatment would constitute an informed consent. The court acknowledged that there is a privilege based on therapeutic grounds to withhold a specific diagnosis where the disclosure would seriously jeopardize the recovery of an unstable person. But, the court added, in the ordinary case, there is no warrant for suppressing facts relating to treatment.

On April 11, the Supreme Court of Missouri held that the defendant physicians "owed their patient in possession of his faculties the duty to inform him, generally, of the possible serious collateral hazards" of combined electro-shock and insulin subcoma therapy. This treatment was administered to the patient for a "rather severe emotional illness." Following the seventh insulin treatment, the patient suffered a grand mal seizure which resulted in a compression fracture of the 5th, 6th and 7th dorsal vertebrae. He brought suit to recover damages for these specific injuries. The patient denied that the doctors informed him of the possible injuries that he might sustain and stated that if he had known of these possible dangers he would not have consented to the treatment.—*Natanson v. Kline,* 250 P. 2d 1093 (Kan., April 9, 1960). *Mitchell v. Robinson,* 334 S.W. 2d 11 (Mo., April 11, 1960).

Surgery Without Consent

Judgment Rendered Against Surgeons Who Performed a Total Hysterectomy Without Proper Consent—The Louisiana Court of Appeal awarded $3,800.00 plus interest to a woman and her husband against two physicians and their insurer for the performance of an unauthorized operation. The woman had consented only to a simple appendectomy but, at the same time, a total hysterectomy was performed. The physician in charge of the operation testified that no emergency existed but that he removed the female organs as a precautionary measure and because he felt it was good surgical procedure.

"...extraordinarily effective diuretic..."[1]

Efficocy ond expanding clinical use are making Naturetin the diuretic of choice in edema and hypertension. It mointoins o favorable urinary sodium-potossium excretion rotio, retains o balanced electrolyte pattern, ond causes o relatively small increose in the urinary pH.[2] More potent than other diuretics, Naturetin usually provides 18-hour diuretic action with just o single 5 mg. tablet per day — economical, once-a-day dosoge for the patient. Naturetin c̄ K — for added protection in those special conditions predisposing to hypokalemia and for patients on long-term theropy.

Supplied: Naturetin Toblets, 5 mg., scored, ond 2.5 mg. Noturetin c̄ K (5 c̄ 500) Toblets, copsule-shaped, contoining 5 mg. benzydroflumethiozide ond 500 mg. potossium chloride. Noturetin c̄ K (2.5 c̄ 500) Tablets, copsule-shoped, contoining 2.5 mg. benzydroflumethiazide ond 500 mg. potossium chloride. For complete information consult pockoge circular or write Professional Service Dept., Squibb, 745 Fifth Avenue, New York 22, N. Y.

References: 1. David, N. A.; Porter, G. A., and Gray, R. H.: Monographs on Therapy 5:60 (Feb.) 1960. 2. Ford, R. V.: Current Therap. Res. 2:92 (Mar.) 1960.

Naturetin Squibb Benzydroflumethiazide

Naturetin c̄ K Squibb Benzydroflumethiazide with Potassium Chloride

SQUIBB



'NATURETIN'® IS A SQUIBB TRADEMARK.

In the finding for the plaintiffs, the court stated: (1) the woman had shown a desire to have children; (2) no emergency existed; (3) the husband was not contacted during the operation for his consent to the hysterectomy; and (4) the consent form used was "so ambiguous as to be almost completely worthless."—*Rogers v Lumbermens Mutual Casualty Company,* 119 So. 2d 649 (La., April 28, 1960).

Evidence That Psychiatrist Had Beaten Patient Makes Out a Prima Facie Case of Malpractice—The New York Court of Appeals held that the testimony of three witnesses indicating that the defendant physician had beaten the plaintiff on a number of occasions made out a prima facie case of malpractice.

The defense argued that there was no expert testimony to support the plaintiff's charge of malpractice. The court, in ordering a new trial, held: ". . . the simple answer is that the very nature of the acts complained of bespeaks improper treatment and malpractice and that, if the defendant chooses to justify those acts as proper treatment, he is under the necessity of offering evidence to that effect."

The plaintiff, suffering from schizophrenia, had been treated by the defendant for seven years.—*Hammer v. Rosen,* 198 N.Y.S. 2d 65 (N.Y., March 3, 1960).

Osteopath Denied Staff Position

Revocation of Osteopath's Staff Privileges Upheld—On May 21, 1960 Judge Snyder of the Preston County Circuit Court, West Virginia, held that the Board of Trustees of the Preston County Memorial Hospital had the right to deny an osteopath staff privileges.

The hospital had withdrawn the osteopath's privileges when the Joint Commission on Accreditation of Hospitals revoked the hospital's accreditation because of the presence of an osteopath on its medical staff. On March 8, Judge Snyder ordered the temporary reinstatement of the osteopath on the staff.

In his decision, upholding the action of the Board, Judge Snyder said:

> "Doctors, regardless of whatever school of medicine they represent, do not have a constitutional and legislative right to practice their profession in a public hospital. The board of trustees has a discretion in the granting of this privilege. The action of the board will not be disturbed unless it has been exercised in an unreasonable or arbitrary manner."

It is anticipated that this decision will be appealed. Judge Synder has indicated that he would certify the case to the West Virginia Supreme Court of Appeals for final adjudication.—*Wallington v. Zinn, et al.,* Preston County Circuit Court, Preston County, W. Va. (May 21, 1960).

Liability of Hospital for Injuries Sustained by Patient Who Fell Out of Bed—Question for Jury—The plaintiff sued the defendant hospital for injuries sustained when he fell out of bed following electric shock treatment. The hospital record contained an entry that the plaintiff reported he climbed over the side rails and fell hurting his right shoulder. However, three nurses testified that they did not know if the side rails were up at the time of the plaintiff's fall. It was acknowledged that they should have been up. The trial court directed a verdict for the hospital holding "that the evidence was overwhelming in favor of defendant hospital," and that the "plaintiff apparently knew enough to know what he was doing so that maybe he was contributorily negligent in what he did." The Supreme Court of Minnesota reversed the decision and granted a new trial stating "we have difficulty in ascribing to the evidence any such overwhelming weight."

In its opinion the Supreme Court stated:

> "It is a well-recognized rule that a patient entering a hospital operated for the treatment and cure of mental and nervous disorders, for private gain, is admitted under an implied obligation that the hospital will exercise such care and attention for his safety as his mental and physical condition, if known, may require. The degree of care and attention must be in proportion to the physical and mental ailments of the patient, and the question whether such requirements have been met generally, presents an issue to be determined by the jury."
>
> * * *
>
> ". . . although it is not an insurer of the safety of a patient, (the hospital) must exercise such reasonable care for the protection and well-being of the patient as his

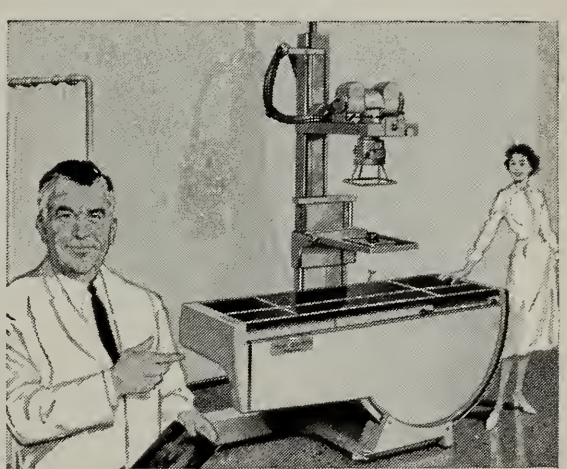
Don't settle for "slow-power" x-ray



get a full 200-ma with your Patrician combination

When anatomical motion threatens to blur radiographs, the 200-ma Patrician can answer with extreme exposure speed, *twice* that of any 100-ma installation. Film images show improved diagnostic readability . . . retakes are fewer. And you'll find the G-E Patrician is like this in everything for radiography and fluoroscopy: built right, priced sensibly, *uncompromising* in assuring you all basic professional advantages. Full-size 81" table . . . independent tubestand . . . shutter limiting device . . . automatic tube protection . . . counterbalanced fluoroscope, x-ray tube and Bucky . . . full-wave x-ray output.

You also can rent the Patrician— through G-E Maxiservice® x-ray rental plan. Gives you the complete x-ray unit, *plus* maintenance, parts, tubes, insurance, local taxes — *everything*—for one, uniform monthly fee. Get details from your local G-E x-ray representative listed below.



Progress Is Our Most Important Product

GENERAL ELECTRIC

DIRECT FACTORY BRANCHES

CHICAGO
1061 W. Jackson Blvd. • SEeley 3-0700
CINCINNATI
3056 W. McMicken Ave. • MUlberry 1-7230—31
INDIANAPOLIS
1845 W. 18th St. • MElrose 5-4576
LOUISVILLE
501 W. Oak St. • JUniper 3-9562

RESIDENT REPRESENTATIVES

FORT WAYNE
H. J. WALLACE, 918 Oakdale • KEnmore 9749

known physical and mental condition requires or as is required by his condition as it ought to be known to the hospital in the exercise of ordinary care."

* * *

"The mere fact that the defendant did not anticipate the injury that did happen does not relieve the defendant. If the act is one which the hospital, in the exercise of ordinary care, ought to have anticipated was liable to result in injury to the patient, then the hospital would be liable for any injury proximately resulting from it although the hospital could not have anticipated the particular injury which did happen."—*Quick v. Benedictine Sisters Hospital Association*, 102 N.W. 2d 36 (Minn., March 25, 1960).

Establish Screening Board

Panel Established in Reno, Nevada to Screen Medical Professional Liability Claims—The Washoe County Medical Society and Washoe County Bar Association have recently adopted a joint plan for screening medical malpractice cases.

The stated purposes of the plan are "on the one hand, to prevent where possible the filing in court of actions against physicians and their employees for professional malpractice in situations where the facts do not permit at least a reasonable inference of malpractice; and, on the other hand, to make possible the fair and equitable disposition of such claims against physicians as are, or reasonably may be, well-founded."

The plan is similar to the Pima County, Tucson, Ariz., plan.

Massachusetts Medical Society Denied Tax Exemption on Its Real Estate—The Supreme Judicial Court of Massachusetts has recently sustained an assessment against the Massachusetts Medical Society on its real estate. The Society had sought an abatement on the basis that it was exempt as a charitable institution. The court found that inasmuch as the Society was operated primarily for the betterment "of a particular limited group of persons," namely, physicians, it was not a charity and hence, not entitled to an exemption.

Fails to Prove Injury

Malpractice Action of Patient, Injured in Auto Accident, Dismissed when She Failed to Prove Injury from Treatment—The plaintiff sustained injuries in an automobile accident. She was treated by the defendant physician and brought an action against him to recover damages for alleged malpractice. The defendant had applied a cast to the plaintiff's left leg when, in fact, she was suffering a fracture of her right knee cap. The plaintiff alleged that as a result of the defendant's diagnosis and treatment she experienced stiffness in her right knee and limitation of motion. The trial court granted the defendant's motion for nonsuit. On appeal, the District Court of Appeal assumed that the evidence was sufficient to give rise to an inference of negligence. However, the court stated: "The burden was upon the plaintiff to establish that because of negligence of the defendant her injuries were aggravated or she received some injury or damage which would not have otherwise occurred." The court held that the plaintiff did not sustain this burden and accordingly, affirmed the judgment of nonsuit.—*Deckard v. Sorenson*, 10 Neligence Cases (2d) 891, Cal.

for a HAPPY HOLIDAY
just a Short Drive away

The Dearborn Inn
Colonial Homes
and
Motor House

You'll like the fine services, excellent food, restful atmosphere of this pleasant country Inn. You'll also enjoy visits to Henry Ford Museum and Greenfield Village, famous Ford Rotunda. See, too, the delightful McGuffey and Burbank buildings of our new Motor House. They add 54 large, beautifully-appointed rooms to the Inn's accommodations, providing in all 185 guest rooms from $9 single, $13 double. May we send you our brochure?

The Dearborn Inn
OAKWOOD BLVD. DEARBORN, MICH. LO 5-3000
Neighbor of
HENRY FORD MUSEUM and GREENFIELD VILLAGE



"What do you mean I'm irresponsible?
I've got Blue Shield!"



Blue Shield

Mutual Medical Insurance, Inc.
110 N. Illinois St., Indianapolis 9, Ind.
Phone MElrose 5-9411

Sponsored by the Indiana State Medical Association

District Court of Appeal, Fourth District, No. 6270 (January 21, 1960).

United States Supreme Court to Review Connecticut Contraception Statutes—The Supreme Court of the United States agreed late in May to rule on the constitutionality of the Connecticut laws prohibiting the use and prescription of contraceptive devices. Recently, several different actions were brought which challenged the constitutionality of these laws. Previously, these laws had been challenged in an action brought by a licensed physician to determine whether the statutes forbade him from prescribing the use of contraceptives by married women in cases where pregnancy would endanger life or health. In this case, *Tileston v. Ullman,* 26 A. 2d 582 (Conn., 1942), the laws were upheld.

The recent actions were brought by a licensed physician, a married woman living with her husband, and two married couples, all claiming that the statutes deprived them of rights guaranteed by the Fourteenth Amendment. The plaintiffs in each of the four actions present interesting factual situations. The physician's case is based upon the fact that he has medically sound information which he is forbidden by law to give to his patients. The married woman plaintiff claims that another pregnancy could be exceedingly dangerous to her life and that she needs the knowledge which the physician is forbidden by law to transmit to her. One of the cases involving a couple as plaintiffs is concerned with the fact the wife has given birth to three abnormal children, none of whom has lived for an appreciable period of time. It is claimed that these abnormalities are believed to be genetic and the prospect of another pregnancy is disturbing to her. The fourth case involves a married couple as plaintiffs who have no living children, and it is believed that the blood groupings of this couple make the prospect that they can procreate a normal child very unlikely.

These cases were instituted to test the constitutionality of the Connecticut statutes. On Dec. 22, 1959, in *Buxton v. Ullman,* 156 A. 2d 508, the Supreme Court of Errors of Connecticut held that the statutes were a constitutional exercise of legislative power.—*Buxton v. Ullman,* Supreme Court of the United States, October Term, 1959, No. 811.

Damages from Cutter Vaccine

Appellate Court Affirms Judgment Against Cutter in Polio Cases—Verdicts totalling $147,300 have been affirmed for two children and their parents for damages suffered when the children contracted poliomyelitis after being inoculated with Cutter Salk Vaccine. The jury had found the defendant not guilty of negligence but had awarded judgment for breach of implied warranty. The appellate court stated that the principle question was, can the defendant manufacturer be liable upon implied warranty in the absence of a direct sale of the vaccine to the plaintiffs. The court answered that question in the affirmative.

In its opinion the court stated: "Defendant's vaccine contained live and active poliomyelitis. Thus the vacine was not 'wholesome'—it was neither merchantable nor fit for its intended purpose."—*Gottsdanker v. Cutter* and *Phipps v. Cutter,* Dist. Ct. of App. of the State of Calif., First Dist., Div. 2, 1 Civ. No. 18413 and 1 Civ. No. 18414 (July 12, 1960).

New Trial Ordered in Physician's Suit to Treat Patients in Proprietary Hospital—A member of the Shreveport Medical Society brought an action against a proprietary hospital and others seeking a judgment recognizing his right to treat his patients in the hospital. Trial court held there was no cause of action and dismissed the case. Bylaws of the hospital provide that no physician in good standing in the Shreveport Medical Society can be prevented from treating patients in the hospital. The appellate court held, "Under . . . defendant's by-laws . . . we think plaintiff's petition states a cause of action. . . ." Accordingly, the court remanded the case for trial.—*Clark v. Physicians & Surgeons*

AMEF
A Symbol to Support . . .
American Medical Education Foundation
535 N. Dearborn St., Chicago 10, Ill.

Preventive medicine has been practiced here at the Home Lawn Mineral Springs for over 60 years

The activities of the Medical Department here at the Home Lawn Mineral Springs are held to sound medical and scientific standards as it works in close harmony with . . .

the department of hydro-therapy where only trained attendants are in charge of the famous mineral water baths and treatments

the department of electro-therapy completely outfitted with modern equipment and operated by an especially trained person

the department of X-ray, cardiograph, and laboratory supervised by competent and dependable operators

the department of food preparation for those requiring special diets supervised by a trained dietitian.

The Medical Department at Home Lawn Mineral Springs is equipped to care for certain types of rheumatism, arthritis, and allied conditions, as well as nutritional diseases, heart conditions, hypertension, gout, and diabetes.

Various types of mineral baths, as directed by the Medical Department, are highly beneficial in keeping your weight at the proper level according to your activity and time in life.

We in America, young and old, are now much more conscious than ever before as to the need of weight control for good health and a happier, longer life.

Treatment baths in the famous mineral waters here at Home Lawn Mineral Springs under medical direction, along with the health building program, have made Home Lawn known over a wide area of the nation, which justifies the slogan . . . "One of the three best known watering places in America."

HOME LAWN MINERAL SPRINGS

Martinsville, Indiana

M. C. PITKIN, M.D., *Medical Director*

J. W. Gibbs, M.D., *Associate*

Hospital, Inc., 121 So. 2d 752 (La., June 22, 1960).

Blood Test Rules Out Paternity in Bastardy Proceeding—The defendant was alleged to be the father of twins. Blood tests excluded him from being the father of one of the twins but not the other. However, the fact that he was not excluded from being the father of the second twin, did not mean that he was the father of that twin. On the basis of the blood tests, the court disbelieved the prosecuting witness' testimony that she had no sexual relations with another man. Accordingly, the court concluded that the defendant was not the father of either twin.—*State of Maryland v. Pernell,* In The Criminal Court of Baltimore City, B.I. 872/1956 (Aug. 6, 1960).

Judgment Upheld for Surgeon Who Allegedly Cut Certain Nerves While Removing a Tumor—The Court of Civil Appeals of Texas has affirmed a judgment for a surgeon who allegedly negligently cut and severed the right median and right ulnar nerves while removing a tumor from the plaintiff's right armpit. The court held, "The mere fact that appellant suffered injuries as a result of the operation . . . standing alone would not entitled her to recover damages." The court concluded that the plaintiff had not proven that the injuries were negligently caused by the surgeon.—*Amerine v. Hunter,* 335 S.W. 2d 643 (Tex., April 20, 1960).

Not Liable for Reaction

State Held Not Liable for Tetanus Antitoxin Serum Reaction—The plaintiff became permanently and totally paralyzed below the tenth vertebra as a result of a intraspinous injection by his own physician of T.A.T. This serum had been made and given to the doctor free of charge by the State Department of Public Health. The State included a brochure with the serum which stated: "The antitoxin may be administered intraspinously, intravenously and intramuscularly. The intraspinous and the intravenous methods are generally recognized as far superior to the intramuscular for the initial injection." The plaintiff claimed that the intraspinous and intravenous methods were not generally recognized as superior at that time, and that the state was negligent in saying so. The court in reversing the judgment for the plaintiff stated, "There is no authority that a doctor . . . must use what some doctors consider the best method if a method which is accepted by respectable medical authority is adopted.

". . . By honestly accepting one field of respectable medical opinion, though other, and perhaps more numerous, medical opinions may differ, does not constitute negligence simply because in a particular case the result was disastrous."

Accordingly, the plaintiff's claim was dismissed.—*Gielskie v. State,* 200 N.Y.S. 2d 691 (N.Y., May 16, 1960).

"Bedrail" Case Reversed in Favor of Hospital—The Supreme Court of Washington has reversed a judgment for a 68-year-old patient who sustained injuries in a fall from a hospital bed. The accident occurred during routine morning care after the nurse had lowered the patient's bedrails and stepped out of the room momentarily. While the patient had been given five electroshock treatments over a period of eight days prior to her fall, there was no evidence that she was "confused" on the morning of the fall. The court also found there was no evidence that at the time of the accident the patient was in such a condition that reasonable care required raised bedrails. Accordingly, the court concluded that the submission of the defendant's negligence to the jury was error.—*Roth v. Havens, Inc.,* 353 P. 159 (Wash., June 23, 1960).

Summary Judgment for Hospital Reversed—Jury to Determine Question of Negligence—In an action against a hospital for injuries sustained by a newborn child, a Florida appellate court has reversed and remanded the suit for trial. It is alleged that the child was permitted to strangle on his own mucus and that he "stopped breathing" for 45 minutes. The court stated, "Naturally, a higher degree of care is required in attending a newborn baby than an adult." And the court held, "The determination . . . of whether this newborn baby was left unattended for an unreasonable and unsafe period of time, should be for the jury."—*Sprick v. North Shore Hospital Inc.,* 121 So. 2d 682 (Fla., June 27, 1960). ◄



Dependable Pain Reliever

Professional confidence in the uniformity, potency and purity of Bayer Aspirin is evidenced by ever increasing recommendation. Bayer Aspirin is the most widely accepted brand of analgesic the world has ever known.

We welcome your requests for samples of Bayer Aspirin and Flavored Bayer Aspirin for Children.



THE BAYER COMPANY, DIVISION OF STERLING DRUG INC., 1450 BROADWAY, NEW YORK 18, N.Y.

ABSTRACTS

BOOK REVIEWS

SEA WITHIN: *The Story of Our Body Fluid*

By William D. Snively, Jr., M.D., Cloth, 150 pp., $3.95, J. B. Lippincott Company, Philadelphia, 1960.

An outstanding exposition on body fluid and electrolytes. It is written for, and will be understood by laymen. It will also be of value to physicians and all technicians ancillary to medicine. It is written with unusual clarity and in simple terms, but at the same time is scientifically accurate and complete enough to be of clinical value.

Dr. Snively relates the body electrolytes to the sea from which all animate life is descended. While explaining the function of water, salts and foodstuffs in the body fluid, he also explains some of the processes of evolution, and discusses the alterations of fluid and electrolytes in disease.

His description of a milliequivalent is the clearest of any this reviewer has read.

Any physicians, and particularly those in practice, will find this book to be interesting and profitable reading.

Frank B. Ramsey, M.D.
Indianapolis

PATIENTS AND PONIES

By M. Murray Nierman, M.D. Cloth, 174 pp. $3.50, Random House, 457 Madison Ave., New York, 1960.

This book distills enough fun out of horse-owning and horseracing to offset that terrible feeling when your favorite finishes fourth or worse every time all afternoon.

Maybe all horse owners are distinguished by their ability to enjoy the humorous side of racing enough to balance the headaches. Whether all owners do or not, Dr. Nierman does, and he makes a fine book out of his experiences.

It may have been written to warn others about the pony racket, but in case it doesn't do that, it will give any backslider an idea of what to expect. What to expect, that is, if the backslider has a good sense of humor. Dr. Nierman has a good sense of same, and can write.

Recommended reading.

Frank B. Ramsey, M.D.
Indianapolis

HERITABLE DISORDERS OF CONNECTIVE TISSUE

By Victor A. McKusick, M.D., Associate Professor of Medicine, Johns Hopkins University School of Medicine; Physician, Johns Hopkins Hospital; Assistant Professor of Epidemiology, Johns Hopkins University School of Hygiene and Public Health. 333 pp. Price $12.00. Second edition, The C. V. Mosby Company, Baltimore, 1960.

This book of approximately 300 pages devotes a chapter to the clinical behavior of hereditary syndromes, the biology of normal connective tissue and a chapter each to the Marfan Syndrome, the Ehlers-Danlos Syndrome, Osteogenesis Imperfecta, Pseudoxanthoma Elasticum, The Hurler Syndrome and finally, a chapter of concluding comments.

One can justly conclude that the book deals with disorders rarely seen in private practice. Yet, because of the wide variability of the clinical severity of the manifestations, the "forme fruste" which they demonstrate, and not the least, the obligation of the physician to be a student of disease, whether rare or common, the general practitioner, the internist, and the pediatrician should realize that its message is addressed to them.

The content of the book is well documented by clinical photographs and the references are voluminous. The text is directed to the clinician with emphasis on the variability of the syndromes. The author has accumulated his data largely from the files of the Johns Hopkins Hospital and in his capacity as Associate Professor of Medicine at that institution has had opportunity to study personally many examples of each.

While the first two and final chapters of the book are by no means essential to its understanding, still the clinician seeking to widen his sphere of interest should otherwise thoroughly enjoy the text and the illustrations.

Jene Bennett, M.D.
South Bend

Abstracts from the literature prepared by the AMA.

INTRACTABLE UTERINE HEMORRHAGE

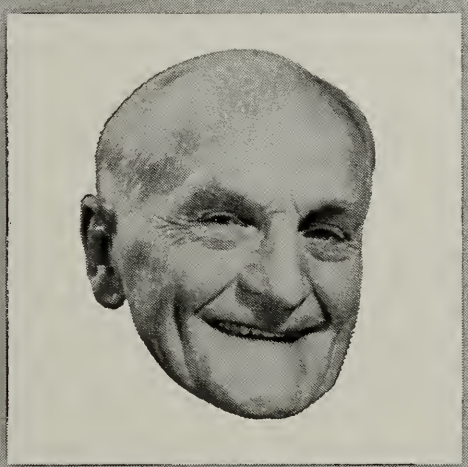
Two women, aged 25 and 24 years, respectively, underwent hysterectomy for recurrent exsanguinating menorrhagia. The first patient had a painless hemorrhage six months after a normal childbirth. Although no abnormality was found in the cervix, uterine body or adnexae, the hemorrhage recurred frequently. A roentgenographic examination revealed an abnormal contour of the cavity in the uterine body, suggestive of a filling defect, probably a tumor. Emergency hysterectomy was performed when the patient's condition deteriorated after a sudden hemorrhage and in spite of massive blood transfusion. The second patient had similar episodes and course starting eight months after a miscarriage.

Pathological examination of the excised uteri revealed large, thick-walled blood-vessels coursing radially from the vascular plexus in the outer myometrium to the endometrium, giving off smaller branches. These ves-

for baby
for mother
for grandpa
all age groups







DESITIN®
OINTMENT

to soothe, protect,
lubricate, and stimulate healing in

rash • chafing • irritations
lacerations • ulcerations • burns

DESITIN OINTMENT...
the pioneer external cod liver oil therapy for
care of the skin in every member of the family

Request samples from . . .

DESITIN CHEMICAL COMPANY
812 Branch Avenue. Providence 4, R. I.

sels had undergone pathological changes, becoming almost totally defective in muscle and elastic fibers, with increased fibrous tissues and intima layers. The authors regard these abnormal radial myometrial blood-vessels as remnants of the placental bed which had failed to involute in the normal way.

Salm, R. Simons, P. N.: Intractable Uterine Hemorrhage. *British Medical Journal* 1:1534, May 21, 1960.

SEGMENTAL (ULCERATIVE) COLITIS

The authors report on 63 male and 77 female patients, three to 65 years of age, with segmental colitis, the type of non-specific ulcerative colitis in which the more distal segments of the colon and also the rectum are free of the disease. These 140 patients were observed for periods of up to 30 years. It is recognized that a larger percentage of the cases of localized colitis are regional or right-sided in nature, and that many of these localized cases are pathologically probably granulomatous as well as ulcerative in nature. Cases restricted to the right or proximal colon do not extend distally to the same extent as they were formerly believed to do.

There exists today, therefore, greater confidence in protracted medical therapy. Not only is more time allowed for conservative observation, but also better-considered means of treatment, particularly the use of large if not massive doses of corticosteroids, offers a very promising field of therapy. Of 71 patients treated surgically, 56 underwent ileosigmoidostomy with proximal colonic resection; this is the operation of choice; permanent relief of symptoms was obtained in 20 of 56 patients. The longer period of follow-up, however, brings to light a higher percentage of late surgical disappointments, for which permanent ileostomy and total colectomy are the only means for the preservation of life and comfort of the patients. For patients with extensive disease and those with complications and severe constitutional symptoms radical surgical intervention offers the one ultimate hope for restoration of efficiency and preservation of life.

Yarnis, H., Crohn, B. B.: Segmental (Ulcerative) Colitis. *Gastroenterology* 38:721 May, 1960.

RUBELLA IN PREGNANCY

Six women had their pregnancy terminated because of rubella during the first trimester. The method of termination was abdominal hysterotomy in four patients, vaginal hysterotomy in one, and hysterectomy in one. Three of the six fetus had abnormalities in the ears, heart, and eyes, respectively. There was also possible lesion of the lens in one, and in one the lens was inadequate for examination. It is suggested that the fetal lesions are the result of cell destruction following invasion by the rubella virus. At the time of the infection the fetus is incapable of responding with an inflammatory reaction. Although maternal antibodies penetrate the fetus, the intracellular virus is probably protected from them. If the virus kill cells, it will be liberated and mopped up by circulating maternal antibodies, and concentrated foci of destruction may appear as simple absence of tissue.

If the hypothesis of virus survival is correct, it may be possible to recover the virus from affected lenses removed at operation, or even after death. Another possibility is that the virus continues to survive in other, perhaps in many, tissue cells, for the mortality among babies affected by maternal rubella is unduly high.

Gray, J. E.: Rubella in Pregnancy. *British Medical Journal* 1:1388, May 7, 1960.

SMOKING AND PERSONALITY

Theories that smoking causes lung cancer have received much support. The investigation reported here was carried out to test deductions from an alternative theory according to which both smoking and lung cancer are symptoms of the same underlying factor related to genotypic differences between smokers and non-smokers. It was hypothesized that cigarette smokers would be (1) more extroverted, (2) less rigid, and (3) more neurotic than non-smokers.

An empirical investigation of 2,360 male subjects, selected so as to conform to a predetermined sampling scheme and stratified according to age, social class and smoking habits strongly confirmed the first of these hypotheses, weakly confirmed the second, and failed to confirm the third. Pipe smokers were found to be quite different from cigarette smokers from the point of view of personality, being the most introverted group studied. On the whole the data confirm the view that genotypic differences exist between smokers and non-smokers, and between cigarette smokers and pipe smokers.

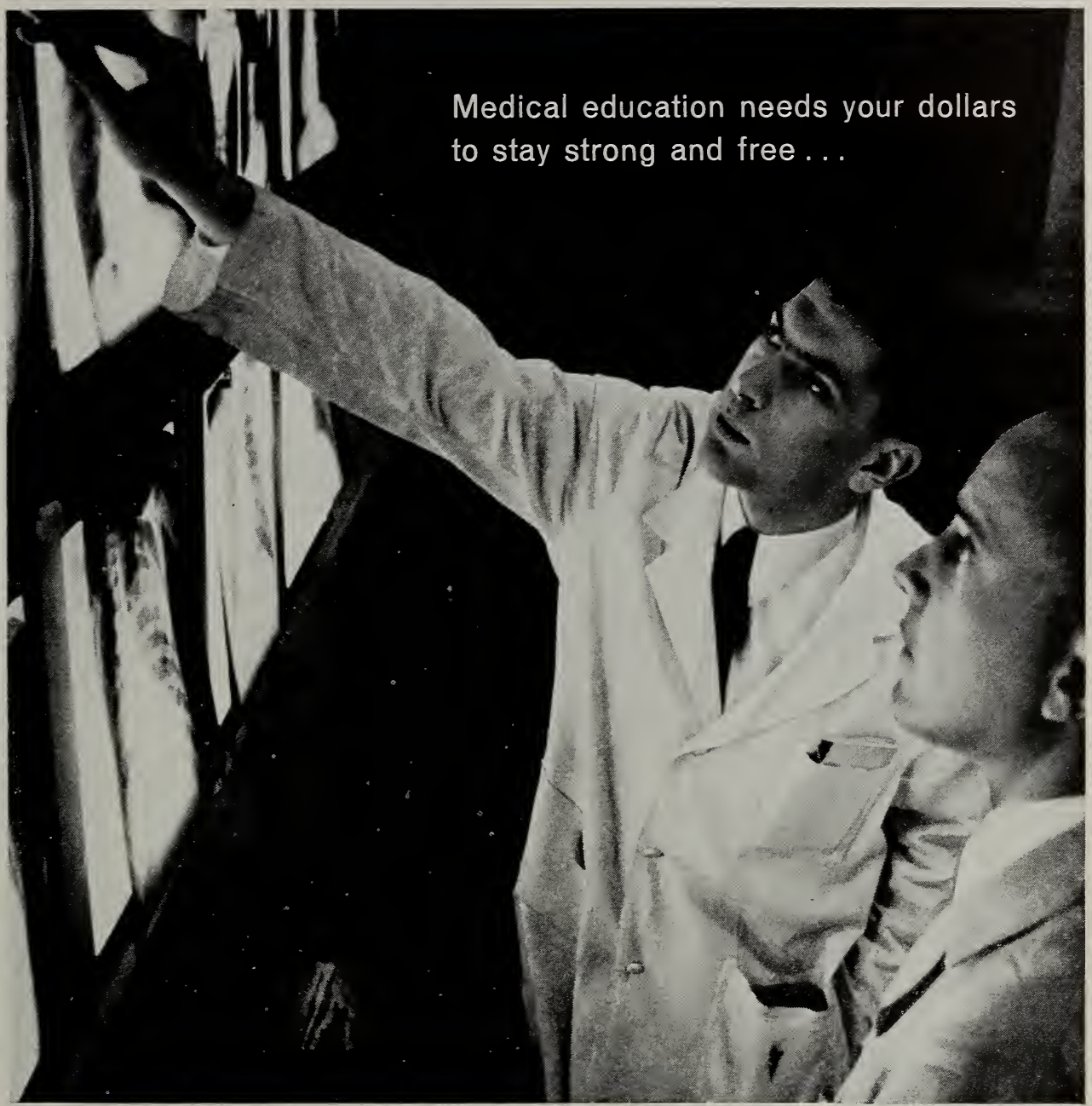
Eysenck, H. J. et al.: Smoking and Personality. *British Medical Journal* 1:1456, May 14, 1960.

SUBACUTE GRANULOMATOUS THYROIDITIS

The clinical picture of subacute granulomatous thyroiditis was first described by Quervain in 1904. The disease has shown a considerable rise in incidence, possibly because the correct diagnosis is made more frequently. Cause is not known. It may be caused by a virus infection, possibly by transmission from the upper respiratory tract. There is increasing evidence that subacute thyroiditis may be an auto-immune disorder, characterized by sensitization of the patient against his own thyroid gland.

Symptoms consist of fever, painful localized swelling of the thyroid gland and signs of mild hyperthyroidism. The most outstanding laboratory finding is a reduced radioactive iodine uptake associated with a normal or an elevated protein-bound iodine concentration. In severe cases the protein-bound iodine concentration may show a transient drop. This is associated with a stage of clinical hypothyroidism. Recovery is spontaneous. It can be accelerated in some patients by radiotherapy or administration of adrenocortical steroids.

Continued



Give to the
school of your choice
through AMEF

To train the doctors of tomorrow, the nation's medical schools must have your help today. It is a physician's unique privilege and responsibility to replenish his own ranks with men educated to the highest possible standards. *Invest in the future health of the nation and your profession. Send your check today!*

American Medical Education Foundation

AMEF

535 North Dearborn Street
Chicago 10, Illinois

Steinberg, F. U.: Subacute Granulomatous Thyroiditis. *Annals of Internal Medicine* 52:1014, May, 1960.

PULMONARY ALVEOLAR PROTEINOSIS

The authors report on a 28-year-old man, and a 36-year-old man with pulmonary alveolar proteinosis who were admitted to the Barton Memorial Division of Jefferson Hospital, Philadelphia. Both patients had dyspnea and cyanosis and had lost weight. Roentgenograms of the chest obtained from both patients showed an increased, rather diffuse density extending from the hili and occupying both midlung fields in one patient and most of the lung fields in the other. The first patient was hospitalized twice within 10 months for attacks of pneumonia which persumably responded to antibiotics. There was essentially no change in the chest roentgenograms in this 10-month period. The presence of dyspnea for a year before the first febrile attack lent further support to the evidence that these attacks were due to a secondary infection.

The second patient was febrile on admission and had a leukocytosis. Both the temperature and the white blood cell count returned to normal with the administration of antibiotics, without any change in the chest roentgenogram or in the degree of cyanosis. This also indicates that fever and leukocytosis are not necessarily related to the presence of pulmonary alveolar proteinosis, but are manifestations of a secondary infection.

Lung biopsies were performed in both patients. On microscopic examination sections of lung tissue characteristically revealed large groups of alveoli filled with proteinaceous material. In these sections the capillary bed appeared to be intact and functioning. Studies of pulmonary function were done in both patients to delineate the reasons for dyspnea and cyanosis. Both alveolar-capillary block and significantly increased venous admixture were found to be responsible for the cyanosis in these patients.

Fraimow, W., Cathcart, R. T., Taylor, C.: Pulmonary Alveolar Proteinosis. *Annals of Internal Medicine* 52:1177, June, 1960.

DIVERTICULITIS: INDICATIONS FOR SURGERY

Operation is required for diverticulitis when the colon becomes obstructed, when it perforates or when it forms a fistula into the bladder or the vagina. If complete obstruction or a perforation is present, the need for surgery is urgent. Apart from drainage of a large abscess, a proximal colostomy should be performed. Later, the patient will need a resection of the diseased colon and closure of his colostomy. The colostomy is made in the proximal part of the transverse colon so as to permit mobilization of the splenic flexure at the subsequent resection. If the inflammatory reaction surrounding the perforation or the fistula is extensive, it will take from four to six months to subside. The sigmoid can be resected more easily if the patient is advised to wait this length of time. If the inflammatory reaction has completely subsided, the colostomy may be closed at the time of the resection.

Even the treatment of choice cannot be applied routinely; carcinoma of the sigmoid must first be ruled out. If carcinoma cannot be excluded, the lesion must be resected two to three weeks after the colostomy, rather than after four to six months. To subject a patient with diverticulitis to an extensive cancer operation is unnecessary, and is associated with increased morbidity and mortality. Whereas 25 years ago the mortality of the surgical treatment of diverticulitis was 50%, it is now less than 2%. However, the morbidity of surgical treatment remains rather high. It can be reduced by earlier operation in patients with persistent or recurrent diverticulitis. Before a complication develops, it can be cured by a one-stage operative procedure with no increase in mortality.

Colcock, B. P.: Diverticulitis: Indications for Surgery. *Journal of Louisiana State Medical Society* 112: 203 June, 1960.

HYPOTENSION IN OBSTRUCTIVE JAUNDICE

In 350 patients with surgical jaundice, hypotension followed by uremia was the most common complication which led to death. A systolic blood pressure below 90 mm Hg for two hours or longer usually caused a rise in the blood urea nitrogen. Studies in dogs confirmed the clinical suspicion that the kidneys in the presence of obstructive jaundice are more sensitive to hypotension. Furthermore, hypotension occurred with very small blood losses in jaundiced dogs.

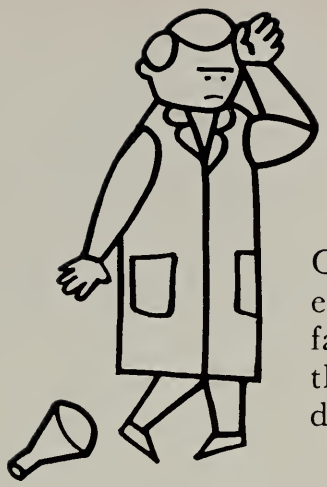
These findings strongly emphasized the need for preoperative blood transfusions and careful replacement of surgical and postoperative blood losses in the jaundiced patient. Through a program directed toward preventing hypotension, the surgical mortality in jaundiced patients has been decreased. The association of hypotension with uremia may help to clarify former concepts of the causes of death in patients with surgical jaundice.

Williams, R. D., Elliott, D. W., Zollinger, R. M.: Effect of Hypotension in Obstructive Jaundice. *Archives of Surgery* 81:334, Aug., 1960.

CASE AGAINST BUERGER'S DISEASE

Buerger, impressed by the presence of gangrene in young men, found certain features which he believed to be characteristic of a distinct entity to which he applied the term thromboangiitis obliterans. The clinical picture was dominated by symptoms referable to recurrent progressive peripheral arterial insufficiency. Lower extremities were involved more frequently than the arms and the ischemia often terminated in gangrene. The disease was particularly common in young Jewish male smokers; superficial and deep phlebitis was frequent. Skepticism concerning the identity of the disease has been expressed by a number of investigators.

The authors critically evaluated the nature of Buerger's thromboangiitis obliterans on the basis of data



One pharmaceutical research executive points up the importance of failures as guideposts to success in the search for new or improved drugs when he says:

"Failure is our most important product."

The pharmaceutical industry's investment in research has been growing much faster than the industry itself. Last year the prescription drug companies spent a record $197 million for research, a five-fold increase in the space of ten years. Such an investment is possible, of course, only when there are profits. • This growth in privately financed research has sent the volume of laboratory failures soaring. For two years in a row the pharmaceutical industry has tested more than 100,000 substances in the search for new medicines. Fewer than two per cent showed enough promise for clinical testing. Only a handful will ever be sold as prescription drugs. The odds against finding a product with therapeutic value probably exceeded 2000-to-1. • But year by year, as the failures mount, the successes also increase, putting new or improved medications at the disposal of the medical profession. And the public benefits through better health, specific cures, shorter hospitalization, longer lives. • This is only one part of the massive assault on disease that engages the health team headed by the medical profession and embracing hospitals, nurses, pharmacists, technicians, and colleges. It is an effort that could only take place in a society which encourages individual freedom and guarantees incentives to freedom of enterprise.

This message is brought to you in behalf of the producers of prescription drugs. For additional information, please write Pharmaceutical Manufacturers Association, 1411 K Street, N.W., Washington 5, D. C.

they obtained from different sources: the clinical records of patients with peripheral arterial occlusive disease; the examination of amputated limbs; autopsy and biopsy material from young patients with beginning arterial insufficiency; from hearts and amputated legs studied by special injection and dissection techniques; and from venous biopsy material.

They arrived at the conclusion that the condition known as Buerger's disease or thromboangiitis obliterans is indistinguishable from atherosclerosis, systemic embolization or peripheral thrombosis singly or in combination. Although the special form of phlebitis described by Buerger has been seen, the assumption that a specific arterial disease in association with a specific clinical syndrome exists when arterial obstruction is present in patients with this type of phlebitic reaction goes far belond the available facts. Thromboangiitis obliterans cannot be considered an entity in either the clinical or pathologic sense, and the term should be discarded.

S. Wessler et al.: Case Against Buerger's Thromboangiitis Obliterans. *New England Journal of Medicine* 262:1149, June 9, 1960.



"Yes, I know it's fine exercise, Frank, but in the future stay away from those heavy bowling balls!"

NECK DISSECTION FOR CERVICAL LYMPH NODE METASTASES

For many years the treatment of cervical lymph node metastases from oral carcinoma has been the operation of radical neck dissection. The so-called prophylactic neck dissection, formerly questioned, is now regaining popularity. A study has been done on 68 patients who have had radical neck dissection during the period 1950 to 1956, inclusive, with a minimum follow-up period of three years. The complications and mortalities were noted as were the number of pathological positive nodes that were found. The presence or absence of local recurrence of the primary tumor in the mouth at the time of death was also studied.

From this study the authors conclude that a more vigorous and radical attack should be directed toward the primary intra-oral tumor, particularly where there is no evidence of cervical lymph node metastases. Only after the primary lesion is well controlled should the full neck dissection be carried out.

Palmer, D., Martin, S. J.: Radical Neck Dissection for Cervical Lymph Node Metastases of Intra-oral Carcinoma. *Archives of Surgery* 81:233-236, Aug., 1960.

TOTAL THYROIDECTOMY FOR THYROID CARCINOMA

The occurrence of multicentric foci of carcinoma is the principal reason for performing total thyroidectomy for carcinoma of the thyroid. In our experience the over-all frequency of multicentricity was found to be at least 13%. In a group of total or near total thyroidectomies, the figure was at least 23%. In approximately half of the patients with multicentric foci, both lobes of the thyroid were involved. Multicentricity was especially a finding in a significant number of patients under the age of 20.

This evidence appears to justify total or near total thyroidectomy for most patients undergoing surgery to cure thyroid carcinoma. Preservation of parathyroid tissue is feasible for nearly all patients. If parathyroid tissue is not identified and preserved, it is usually preferable to leave a remnant of thyroid tissue in the region of the normal location on the side of the neck opposite the primary or predominant lesion.

Block, M. A., Horn, R. C., Brush, B. E.: Place of Total Thyroidectomy in Surgery for Thyroid Carcinoma. *Archives of Surgery* 81:236-244, Aug., 1960. ◄



Dollars Today—
—Doctors Tomorrow
American Medical Education Foundation
535 N. Dearborn Street, Chicago 10, Illinois
AMEF

New Preferred Blue Shield Certificates Made Available to Direct Pay Members

(One of a series of articles prepared by Blue Cross-Blue Shield)

Past articles in this series stressed the fact that during 1960 Blue Shield would make a maximum effort to push the preferred programs, both surgical and medical. We feel this protection is needed in most areas in the state, and that many of our problems would be solved if most members had this coverage.

Since 1954 we have sold nearly all accounts either the preferred or an equivalent special certificate, and have converted many accounts to the preferred schedule. Presently more than 40% of all account members have preferred or special, and we are making a strong effort to convert other accounts to the more realistic program that better matches present-day costs.

Now plans have been completed to make a new preferred Blue Shield certificate available to direct pay members. The medical profession has indicated interest in such a program, and many direct pay members have asked for a better Blue Shield program because they see the need and can afford such protection.

Starting in October and continuing for three months the offer to add this new coverage will be mailed with the regular billings to the more than 130,000 holders of direct pay certficates. This involves an estimated 275,000—members plus dependents.

The new preferred direct pay certificate was developed especially for this campaign. Benefits include:

Surgical, obstetrical and radiation therapy services paid for according to the Preferred Schedule of Indemnities.

Anesthesia, when administered in a hospital by a practicing physician other than the operating physician or his assistant, will be paid for on the basis of 20% of the preferred surgical allowance, with a $15.00 allowance for normal delivery.

For in-hospital medical care services Blue Shield will pay up to $15.00 for the first day, up to $10.00 for the second day, up to $4.00 for each of the next eight days, and $3.00 for each day thereafter for not more than 30 days for each hospital admission.

Payments up to $15.00 per contract year will be made according to the preferred schedule for x-ray services in the doctor's office for fractures and dislocations.

Quarterly fees for this new Blue Shield coverage will be $6.15 for a single membership, and $15.90 for a family membership.

This type of protection sets no dollar limit per six-month period, and no limit for the number of procedures covered. For example, Blue Shield recently paid $1,813.00 over a period of a few weeks for one member as a result of injuries received in an auto accident.

There will be no waiting periods for the added Blue Shield benefits on memberships that have been in effect 270 consecutive days.

Also, effective October 1 or soon thereafter, the above Blue Shield coverage will be made available to 19-year-olds continuing membership from their parent's preferred certificate, to former members returned from military service, and to members transferring from other states to an Indiana direct pay membership.

After the special campaign has ended, persons using the inquiry card now found in many physician's offices will be offered a choice of one of two memberships. One will be the membership that has been available in the recent past. The second is similar to the new direct pay certificate described above, with the chief difference that for in-hospital medical care services Blue Shield will pay up to $15.00 for the first day, up to $10.00 for the second day, up to $4.00 for each of the next eight days, $3.00 for each of

INDIANA STATE BOARD OF HEALTH

Monthly Report—September, 1960

Disease	Sept. 1960	Aug. 1960	July 1960	Sept. 1959	Sept. 1958
Animal Bites	561	795	626	601	448
Chickenpox	26	29	56	36	29
Conjunctivitis	62	65	59	91	37
Diphtheria	0	0	1	1	0
Dysentery, Unspecified	36	11	9	14	21
Impetigo	302	176	82	302	225
Infectious Hepatitis	43	54	25	12	11
Infectious Mononucleosis	9	10	16	5	6
Influenza	527	366	287	375	559
Measles (Rubeola-Rubella)	89	222	411	79	89
Meningitis, Meningococcal	1	5	3	1	2
Meningitis, Other	4	11	5	49	20
Mumps	39	67	111	40	45
Perstussis	6	11	36	81	155
Pneumonia	124	86	131	112	87
Poliomyelitis	49	32	11	55	33
Streptococcal Infections	296	385	267	182	250
Tinea Capitis	35	0	1	21	75

PREFERRED CERTIFICATES

Continued

the next 30 days, and $1.50 for each of the following 30 days, for each certificate year.

Blue Shield is making these preferred programs available on as wide a basis as possible. We know that programs cannot be forced on our membership, but we are putting a maximum effort into this important sales job.

We know that the preferred schedule, including the new increased in-hospital medical program, is doing a good job. It is now paying about 84% of the surgeon's total charges, with more than three-fourths of all claims paid in full. The addition of this coverage to a sizeable number of direct pay memberships will mark a significant step forward in achieving our goal—that of providing adequate surgical and medical protection for all the citizens of our state.

W. C. Huddlestone
Public Relations Division ◄



"I hope you fellows don't mind my getting up and tagging along with you; but I heard you mention a coffee break!"

Letters

to the editor

September 7, 1960

Dear Sir:

I would like to take this opportunity to thank you, members of the medical profession, and others in Indiana who cooperated so splendidly these past two years in our effort to defeat Forand-type legislation.

It would be my personal wish to be able to write to each member of your organization to express my appreciation for their individual cooperation in winning this important battle for American medicine, but I am sure you realize this task would be most difficult in the light of many persons who assisted us.

Certainly the physicians in your state must recognize the vast amount of time and effort spent by certain members of your Association.

Other organizations should not be overlooked. I read many friendly editorials in the Indiana newspapers. I recall the excellent meeting sponsored by your Association for some 200 officers of various organizations. I believe after the count is made, your state will lead all others in terms of the number of resolutions opposing the Forand-type legislation.

After each visit to your state, our field representative, Reuben Dalbec, reported the friendly cooperation he received from the executive office, and all with whom he visited.

Again, thanks for your help, and I hope you will kindly relay my personal gratitude to all in Indiana who helped bring about this decisive victory.

Sincerely yours,
F. J. L. Blasingame, M.D.
Executive Vice President, AMA.

To the Editor:

In January, 1943, I was stricken by coronary thrombosis followed by cerebral embolism, which resulted in right hemiplegia and complete aphasia. It was then, by using my left hand, that I devised 20 hand signs that became a universal one hand manual language, well known as the "Hand Talking Chart" which has proven to be a practical clinical aid. With the chart, aphasia patients impart their basic needs and desires, thus dispelling their fears and helping them to a "come back."

During the last 12 years, the chart has been supplied without charge to physicians and nurses through the kind cooperation of medical editors, nationally and internationally.

In 1954 the International Research Council was chartered as a worldwide medical confraternity for the dissemination of knowledge concerning aphasia associated with hemiplegia. The aims of the Council include: (1) establishment of a clearing house on this specialized subject—library data, medical books, publications, and reprints of articles written by Council members; (2) the continuance of free distribution of the "Hand Talking Chart."

With appreciation for your attention, I am

Sincerely,
Hamilton Cameron, M.D.
601 W. 110 St., Room 3-LL
New York 25, N. Y.

Dear Sir:

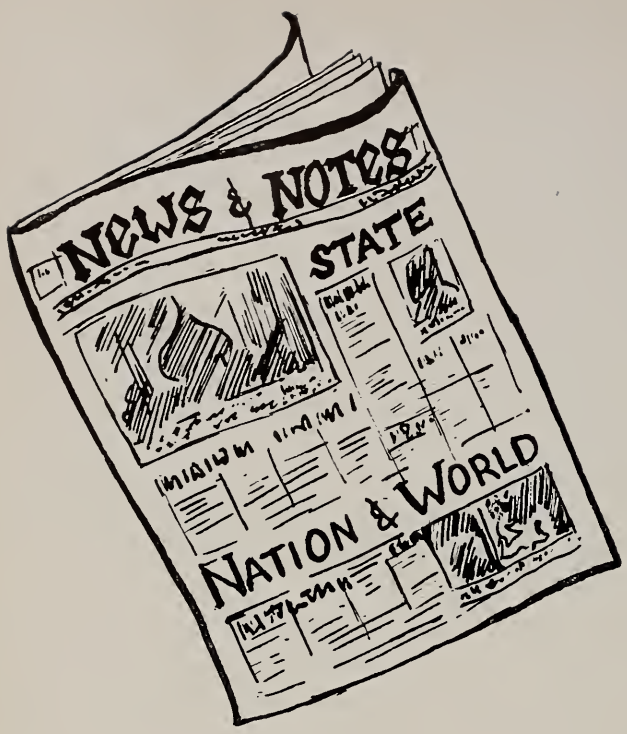
The editorial "Growth, Sales and Profits in Drug Industry" which appeared in the May issue of the *Journal of Indiana State Medical Association* has been read with interest by our staff. It is gratifying to us that you have considered it important to bring this timely discussion of drugs and the pharmaceutical industry to your many readers.

Sincerely,
Robert J. Benford, M.D.
Director of Medical Relations
Pharmaceutical Manufacturers Association

Dear Sir:

I was pleased at your thoughtfulness and generosity in making available space in the *Journal of Indiana State Medical Association* for the address that I gave for the Pharmaceutical Manufacturers Association. I hope that its contents are helpful to some of your readers. I would like to assure you and them that if there is anything I can do to supply additional information or answer questions please do not hesitate to let me know.

Sincerely yours,
Austin Smith, M.D., President
Pharmaceutical Manufacturers Association



Dr. Wood Named to AMA Council

Dr. Don E. Wood, Indianapolis, Chairman of the ISMA Executive Committee and chairman of the Commission on Legislation, has been appointed to the Council on Legislative Activities of the American Medical Association. He will become key contact man for several midwestern states, replacing Dr. Harlan English, Danville, Ill.

Hoosier Flying Physician Elected Head of National Group

Dr. Frank Coble, Richmond, has been elected president of the National Flying Physicians Association. Assisting him will be two other Hoosier physicians, Drs. Charles Loomis, also of Richmond, and Dan Urschel, Mentone.

Dr. Coble has been active in Flying Physicians since its inception. He was instrumental in initiating a disaster program, a nationwide plan to transport medical personnel and equipment into disaster areas by air transport.

Dr. Richard M. Nay, Indianapolis cardiologist, will head the Indiana Heart Association for 1961-62. Assisting him will be Dr. Charles Fisch, also of Indianapolis, vice-president.

Dr. Kirtley Named to Diabetes Post

Dr. Franklin B. Peck, Sr., Indianapolis, president of the American Diabetes Association has announced the appointment of Dr. William R. Kirtley of Indianapolis as the association's governor for the state of Indiana, for a three-year term.

County Societies' Conference To Spotlight Disaster Care

Disaster medical care will be the subject of an important national conference in Chicago on November 4-6. The occasion is the 11th County Medical Societies Conference. The feature of the meeting will be a report in full from the U. S. Public Health Service on health mobilization for disaster.

All physicians interested in civil defense and disaster medical care are invited and urged to attend. The meeting will be held in the Palmer House where a block of rooms is being held for reservations. Those who wish to attend should write the Palmer House direct for reservations.

College of Chest Physicians To Meet This Month

The annual interim session of the American College of Chest Physicians is scheduled for Nov. 26 and 27 at the Shoreham Hotel, Washington, D. C.

On the scientific program will be symposia on congenital bronchopulmonary disorders, role of steroid therapy in chest diseases and current therapeutic issues.

A highlight of the program will be fireside conferences on Sunday evening, November 27. Three round table luncheon discussions on both Saturday and Sunday will feature prominent speakers discussing various aspects of heart and lung diseases.

Ob-Gyn College Selects Director

Dr. Robert A. Kimbrough, Jr., of Philadelphia, is leaving active practice and several teaching appointments in that city to take over the newly created post of Medical Director of The American College of Obstetricians and Gynecologists, at its headquarters in Chicago. Dr. Kimbrough served for several years as a member of the American Board of Obstetrics and Gynecology.

Eli Lilly Announces Promotion of Four



Dr. Rice



Dr. Kohlstaedt

Raymond M. Rice, M.D., has been elected vice-president for medical affairs by the board of directors of Eli Lilly and Company. The board also elected General Counsel William G. Davis as secretary of the company.

Kenneth G. Kohlstaedt, M.D., succeeds Dr. Rice as executive director of medical research, a part of the company's research, development, and control function. Bill L. Martz, M.D., succeeds Dr. Kohlstaedt as director of the clinical research division.

Dr. Rice joined Lilly in 1936. He has served as executive director of medical research since 1955 and prior to that had held the positions of associate director of medical research and director of the medical division. In his new position Dr. Rice will have responsibilities for medical relations at the corporate level on a world-wide basis.

Davis, who was appointed general counsel and head of the Lilly legal division following the recent death of Walton M. Wheeler, Jr., now succeeds Mr. Wheeler as secretary.

Dr. Kohlstaedt moves up from director of the clinical research division, a position he has held since 1953. He was assistant superintendent of Marion County General Hospital when he joined the company in 1935. He has long engaged in research on problems of the heart, blood, and circulatory system.

Dr. Martz has been head of Lilly's clinical laboratories since 1956. He is a graduate of DePauw University and of the Indiana University School of Medicine. Like Dr. Kohlstaedt, his chief research interest has been disorders of the cardiovascular system.

Surgeons, Nurses, Medical Personnel Invited to Surgeons' Meeting

Surgeons, graduate nurses, and related medical personnel from all parts of the country are invited to attend the annual four-day Sectional Meeting of the American College of Surgeons in Philadelphia, March 6 through 9, 1961. Headquarters will be the Bellevue Stratford, Ben Franklin, and Sylvania Hotels, with some sessions scheduled at leading hospitals in the city.

In length and scope this scientific meeting approaches that of the annual Clinical Congress of the College. The program will include hospital clinics, panel discussions, symposia, scientific papers, industrial exhibits, and medical motion pictures in general surgery sessions and in the specialties of obstetrics and gynecology, ophthalmology, otolaryngology, urology, orthopedic surgery, plastic surgery, pediatric surgery, and thoracic surgery.

Wyeth Labs Fellowship Applications Close November 30

November 30 will be closing date for Wyeth Laboratories' 1961 Pediatric Residency Fellowship applications.

The pharmaceutical firm is offering 20 two-year grants to encourage qualified doctors to pursue postgraduate training in pediatrics. Each grant carries an annual stipend of $2,400. This year's awards, effective July 1, 1961, will be announced in February.

Eligible for fellowships are U. S. or Canadian citizens with doctors degrees in medicine. They must be interns, physicians who recently completed internships, in military service or U. S. Public Health Service tours.

Fellowships will be awarded on the basis of applicants' interest in pediatrics, character, conscientious and able performance of duties and academic competence.

Those receiving Wyeth grants must serve a residency in pediatrics in a hospital properly accredited by the residency review committee of the Council on Medical Education and Hospitals of the American Medical Association, the American Board of Pediatrics, and the American Academy of Pediatrics.

Applications should be submitted to Dr. Philip S. Barba, University of Pennsylvania, Philadelphia 4.

Invest in the future health of the nation and your profession



Give to medical education through AMEF

To train the doctors of tomorrow, the nation's medical schools must have your help today. It is a physician's unique privilege and responsibility to replenish his own ranks with men educated to the highest possible standards. *Medical education needs your dollars to stay strong and free. Send your check today!*

American Medical Education Foundation
535 N. Dearborn St., Chicago 10, Ill.

NEWS & NOTES

Continued

$300 Goiter Essay Award

The Van Meter Prize Award of $300.00 is again offered to the essayist submitting the best manuscript of original and unpublished work on "Goiter—Especially its Basic Cause" by the American Goiter Association, Inc.

Studies may relate to any aspect of the thyroid gland in all of its functions in health and disease.

The award will be made at the annual meeting of the Association, May 3-6, 1961, at Philadelphia. The winning essayist will take part in the program.

Competing essays, covering either clinical or research investigations, should not exceed 3,000 words and must be presented in English. Duplicate copies, double spaced, should be sent to the Secretary, John C. McClintock, M.D., 702 Madison Ave., Albany 8, N. Y., by Jan. 1, 1961.

Ob-Gyn Written Exam Scheduled

American Board of Obstetrics and Gynecology Part I written Examinations will be held in various cities of the United States, Canada and Military centers outside the U. S. on Friday, January 13, 1961.

Reopened candidates are required to submit case reports for review 30 days after notification of eligibility. No reopened candidate may take the written examination unless the case abstracts have been received in the office of the executive scretary.

Further information may be obtained from Dr. Robert L. Faulkner, 2105 Adelbert Road, Cleveland 6, Ohio.

Most magazine editors are affable people who like to accommodate subscribers. One editor, however, felt the following letter was asking too much:

"Dear Sir: Last year you printed an article, at least I think it was in your magazine, that interested me very much, but I have forgotten what it was. I lost my notes on the subject and can't find the magazine. Will you send me another copy of same, if it was your magazine?"

—*Oral Hygiene*, reprinted in *Quote*, July 3, 1960.

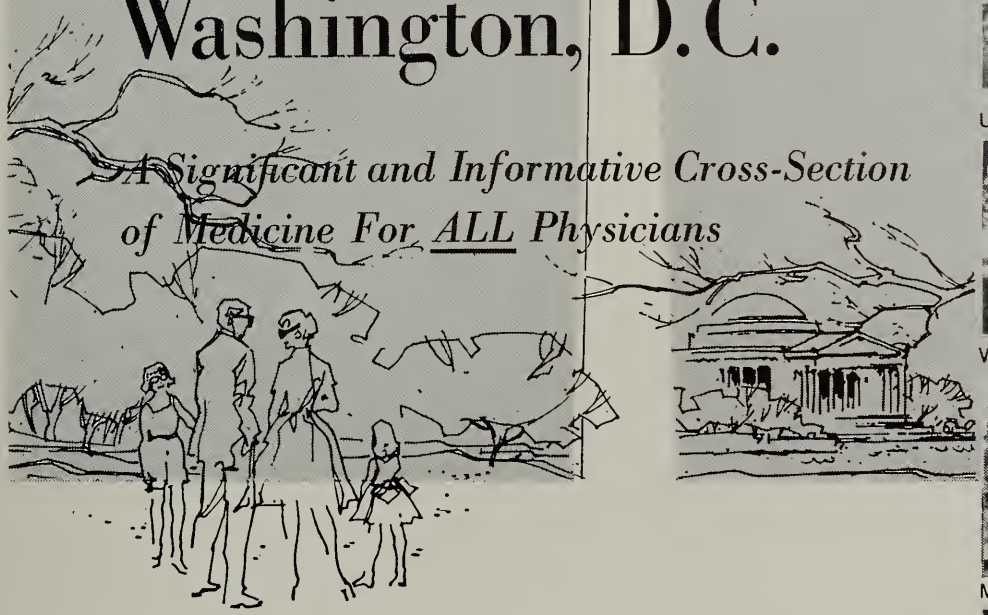
AMA

14th CLINICAL MEETING

November 28, 29, 30
December 1

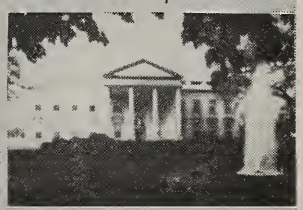
Washington, D.C.

A Significant and Informative Cross-Section of Medicine For ALL Physicians





United States Capitol



White House



Mount Vernon



Lincoln Memorial



Smithsonian Institution



OUR NATION'S historic capital city will be the setting for the American Medical Association's 14th Clinical Meeting November 28 through December 1.

The program—planned to interest and inform every physician—features the latest medical developments presented in panel discussions, symposiums, round table sessions, lectures, closed circuit telecasts and motion pictures. Many scientific and industrial exhibits will be on display.

AMERICAN MEDICAL ASSOCIATION

535 North Dearborn Street, Chicago 10, Illinois

Deaths . . .

Walter N. Culmer, M.D.

Dr. Walter N. Culmer, 84, who practiced medicine in Bloomington for 50 years, passed away Aug. 30 in Indianapolis, where he had lived for four years after retirement.

An ear, nose and throat specialist, Dr. Culmer was a pioneer in the fight against tuberculosis and helped to establish a sanitarium near Bloomington.

He was a graduate of the University of Louisville, class of 1900. Dr. Culmer served in World War I, and shortly after that time, was certified by the American Board of Otolaryngology.

Jack R. Glosson, M.D.

A 41-year-old Clay City physician, Dr. Jack R. Glosson, died Sept. 22 in an automobile accident.

Dr. Glosson was commander of the 122nd Tactical Hospital of the Indiana Air National Guard, and was recently promoted to Lieutenant Colonel. He was also medical coordinater of the Clay County Civil Defense program.

Dr. Glosson was a graduate of the Indiana University School of Medicine, class of 1943.

Arthur W. Hull, M.D.

An Elkhart anesthesiologist, Dr. Arthur W. Hull, passed away Aug. 27 at the age of 68.

Dr. Hull, who had practiced in Elkhart since 1925, was chief of anesthesiologists at Elkhart General Hospital. He was a 1924 graduate of the Indiana University School of Medicine.

Bernard J. Larkin, M.D.

Dr. Bernard J. Larkin, professor emeritus of Ophthalmology at the Indiana University School of Medicine, passed away Oct. 5 in his Indianapolis home.

Dr. Larkin retired from practice in January, 1960. He was former chief of staff, Department of Ophthalmology, at Marion County General Hospital, and had been chief of staff at St. Vincent's Hospital. He was also on the staff of Methodist and Indiana University hospitals and a consultant at VA hospital.

Dr. Larkin was a graduate of St. Louis University, class of 1912. He was a member of the American College of Surgeons and the American Academy of Ophthalmology.

Abe H. Leff, M.D.

A 40-year old Indianapolis physician, Dr. Abe H. Leff, passed away early in October at his home.

Dr. Leff had practiced general medicine and specialized in internal medicine in Indianapolis since 1945. He was a graduate of the Indiana University School of Medicine, class of 1943.

Clarence R. VanArsdall, M.D.

A recently retired Terre Haute physician, Dr. Clarence VanArsdall, 61, passed away Aug. 26 in Indianapolis.

Dr. VanArsdall had practiced in Terre Haute since 1925 until his retirement in June. However, at the time of his death, he was still serving as county medical commissioner, a post he held 10 years.

Dr. VanArsdall received his medical degree from Indiana University in 1924. He served in the Army Medical Corps during World War II, and while in the European Theatre was decorated with the Operations Ribbon and one battle star. He served three terms as coroner of Vigo county.

Elmer E. Wood, M.D.

A pioneer Columbus, Ind. physician, Dr. Elmer E. Wood, passed away Sept. 16 at the age of 89.

Dr. Wood, a senior and 50-year ISMA member, practiced 50 years before retiring in 1949; he was one of a fraternity of 12 pre-1900 doctors in Columbus.

The last survivor of the Franklin College class of 1893, Dr. Wood served five terms on the college's board of directors. He helped establish the Bartholomew County Hospital in 1916. ◄

County Society and District News

Adams

Twelve members of the Adams County Medical Society met at Decatur Sept. 13 for a business session.

Clay

Nine members of the Clay County Medical Society met at Brazil Sept. 20 to hear Dr. Charles Moon speak on "Health Organization of Political Education."

Elkhart

Speakers at the Oct. 6 dinner meeting of the Elkhart County Medical Society were Dr. J. M. Carter: "Keeping Antibiotics Out of Milk" and Dr. J. J. Fishler: "What Happens When the Veterinarian's Patient Bites the Doctor's Patient?"

Floyd

Dr. Marion Beard spoke on "The Use and Abuse of Blood Transfusions" at the Sept. 9 meeting of the Floyd County Medical Society, held at New Albany. Twenty-five members attended.

Fountain-Warren

Ten members of the Fountain-Warren Medical Society met at Attica Sept. 1 to discuss plans for their annual fall road show.

Lake

Dr. Theodore VanDellin, Medical Editor of the *Chicago Tribune* and president of the Chicago Medical Society, discussed medical communications at the Sept. 14 meeting of the Lake County Medical Society. There were 73 members present.

Laporte

Dr. Maurice M. Albala, Chicago, spoke on "The Diagnosis of Anemias" at a Sept. 20 meeting of the Laporte County Medical Society at Michigan City. There were 33 doctors present.

The group discussed medical organizations at an Aug. 30 meeting, held in Laporte.

Montgomery

Twenty-five coaches and trainers from Montgomery County schools and Wabash College were guests at the third annual coaches conference presented by that county's medical society, Sept. 15 at Crawfordsville.

Dr. Loyal Coombs, Purdue University, discussed "The Athlete as an Individual Rather than a Specific Injury."

Orange

Eight members of the Orange County Medical Society met at Mitchell Sept. 6 for a general business session.

Perry

Members of the Perry County Medical Society made plans for a November diabetes drive at their Sept. 6 meeting.

Vanderburgh

Members of the Vanderburgh County Medical Society met Oct. 11 at Evansville Boehne Hospital for dinner and a business meeting.

Wayne-Union

Forty-one members of the Wayne-Union Medical Society met at Richmond Sept. 13 to hear a discussion of accident studies, presented by a representative of the Indiana State Police.

Wells

Dr. Donald A. Covalt, Associate Director of the Institute of Physical Medicine and Rehabilitation at New York University-Bellvue Medical Center, spoke at the 14th annual clinical conference of the Wells County Medical Society, Oct. 12 in Bluffton.

Twenty-two doctors and 16 nurses from Wells County heard Dr. Covalt discuss "Rehabilitation and the Hemiplegic Patient." ◄

Association News

EXECUTIVE COMMITTEE

September 11, 1960

Roll call showed the following present: Don E. Wood, M.D., chairman; Wendell E. Covalt, M.D.; Earl W. Mericle, M.D.; Guy A. Owsley, M.D.; Maurice E. Glock, M.D.; Okla W. Sicks, M.D.

Frank B. Ramsey, M.D., editor of *The Journal;* Robert Hollowell and Ralph Hamill, attorneys; James A. Waggener, executive secretary.

The statement of income and budget balances as of Aug. 31, 1960, and the Treasurer's report were approved on motion of Drs. Owsley and Mericle.

Membership Report

Number of members as of Sept. 1, 1959	4,221
1960 members as of Sept. 1, 1960:	
Full dues paying	3,602
Interns	30
Residents	172
Council Remitted	42
Senior	389
Military	35
Honorary	1
Total 1960 members as of Sept. 1, 1960	4,270
Gain over last year	49
Number of members Dec. 31, 1959	4,256
Number of AMA members as of Sept. 1, 1959	4,094
1960 AMA members:	
Dues paying	3,462
Exempt, but active	672
Total 1960 AMA members as of Sept. 1, 1960	4,134
Gain over last year	40
Number of AMA members as of Dec. 31, 1959	4,210
Number who have paid state dues but not AMA dues in 1960	123

Legislation

The chairman of the Commission on Legislation reported on the recent activities of his commission and for the information of the committee read a letter of appreciation from the American Medical Association for the support given the recent controversy on the Forand-type of legislation.

Annual Convention, French Lick, Oct. 2, 3, 4 and 5, 1960

The committee approved by consent the final review of the arrangements for the French Lick meeting and also the amount of exhibit space sold.

Annual Convention, Indianapolis, 1961

By consent the dates of Oct. 24, 25 and 26, 1961, at the Murat Temple, were approved.

Organization Matters

Upon motion of Drs. Mericle and Owsley the Council is to be requested to recommend to the House of Delegates that the Bylaws be changed to permit the selection of dates and locations of annual meetings at least five years in advance.

A letter from Dr. Edward B. Smith, addressed to the president, setting forth the desires of the Pathology Department of Indiana University to conduct a research project was approved on motion of Drs. Covalt and Owsley, and the editor of *The Journal* was requested to prepare an article for *The Journal* on this proposed project.

Mr. Hollowell reported that in a conference with the attorney of the State Hospital Association, it was his understanding that the Hospital Association had accepted his suggestions for revisions in their publication, "Hospital Guides for Release of Information."

New Business

On motion of Drs. Mericle and Glock the Executive Committee is to recommend to the Council and the appropriate commission that appropriate resolutions be prepared for presentation to the House of Delegates calling upon the State of Indiana to implement a needy aged assistance program as adopted by Congress.

Dr. Mericle read a letter from Rogers, Slade & Hill for the information of the committee, and the committee agreed that Dr. Mericle should answer the letter informing Rogers, Slade & Hill that the Association is not interested in their proposal.

The secretary read a letter from the Blue Shield Plan concerning a new group rating method they were adopting, and the secretary was instructed to discuss this with Mr. Saylor to learn the reasons why such a plan is being instituted.

There being no further business the committee adjourned to meet again at 10:00 a.m., Central Standard Time, Sunday, Oct. 2, 1960, in the Hoosier Jr. Room, French Lick-Sheraton Hotel, French Lick, Ind.

for every phase of cough... comprehensive relief

AMBENYL® EXPECTORANT

AMBENYL EXPECTORANT quickly comforts the coughing patient because it is formulated to relieve all phases of cough due to upper respiratory infections or allergies. Combining Ambodryl®—potent antihistaminic; Benadryl®—the time-tested antihistaminic-antispasmodic; and three well-recognized antitussive agents, AMBENYL EXPECTORANT:

• soothes irritation • quiets the cough reflex • decongests nasal mucosa • facilitates expectoration • decreases bronchial spasm • and tastes good, too.

Each fluidounce of AMBENYL EXPECTORANT ◈ contains:

Ambodryl® hydrochloride (bromodiphenhydramine hydrochloride, Parke-Davis)	24 mg.
Benadryl® hydrochloride (diphenhydramine hydrochloride, Parke-Davis)	56 mg.
Dihydrocodeinone bitartrate	1/6 gr.
Ammonium chloride	8 gr.
Potassium guaiacolsulfonate	8 gr.
Menthol	q.s.
Alcohol	5%

Supplied: Bottles of 16 ounces and 1 gallon.

Dosage: Every three or four hours—adults, 1 to 2 teaspoonfuls; children ½ to 1 teaspoonful. 27160

◈ Exempt narcotic

PARKE, DAVIS & COMPANY
Detroit 32, Michigan

PARKE-DAVIS

The Journal of the INDIANA STATE MEDICAL ASSOCIATION

December 1960

Office of Publication:
1019 Hume Mansur Building, Indianapolis, Indiana

$1.00 per copy
except Yearbook
$5.00 per year

Contents

SCIENTIFIC

Coroners' Symposium:
Masquerades: Homicide, Suicide, Accident or Natural Death, Frank P. Cleveland, M.D., Cincinnati, Ohio....2181
Gunshot Wounds, Herbert P. Lyle, M.D., Cincinnati, Ohio....2185
Program for Indiana Coroners, Richard A. Myren, Bloomington....2191
Pheochromocytoma and Neurofibrosarcoma in a Patient with Neurofibromatosis, Harley P. Palmer, M.D., Indianapolis....2197
The Case of the Four-Sided Triangle, Arnold Lieberman, M.D., New York, N. Y....2202
Pathfinder: Diagnostic Uses of Radioisotopes, Wei-Ping Loh, M.D., Gary....2209
Electrocardiogram of the Month: Wolff-Parkinson-White Syndrome Simulating Ventricular Tachycardia, Charles Fisch, M.D., Indianapolis....2211

EDITORIALS

Few Oldsters Need Help....2216
Enforcement Program Saves Lives....2216
Readiness is a Desire for Perfection....2217
Aged Have Choice of 288 Health Insurers....2217
Editorial Notes....2218

SPECIAL FEATURES

Influenza Immunization, Leroy E. Burney, M.D., Surgeon General, U.S.P.H.S....2220

1960 CONVENTION

1960 Convention Story....2257
50-Year Club Response, Herman Baker, M.D., Evansville....2262
Lake County G.P. Named President-Elect....2263
Past President's Message....2264
President's Address, Earl W. Mericle, M.D., Indianapolis....2266
President-Elect's Message, Guy A. Owsley, M.D., Hartford City....2271
Scientific Award Plaques....2278
Index to House of Delegates Proceedings....2279

REGULAR FEATURES

Month in Washington....2160
Fourth Estate....2166
Journal Medical Essay Contest....2196
President's Page....2222
Woman's Auxiliary Reports to ISMA....2226
Progress and Blue Shield (One of a series)....2232
Wanted: Physicians, Locations....2234
About Our Cover....2238
News Notes....2240
Evansville Assistant, Doctor-Boss Named to National Offices....2240
Dr. Baker Honored for Role in Rehabilitation Center....2240
Bluffton Physician New President of Clinics Group....2240
Board of Health Report....2243
Future Meetings, Seminars, Courses....2250
Deaths....2254

BUSINESS

County, District News....2255
Commission Meeting: Medical Economics and Insurance, Sept. 11, 1960....2308
Executive Committee: Oct. 2, 1960; Oct. 5, 1960....2310
The Council:
Oct. 2, 1960....2311
Oct. 5, 1960....2315

EDITORIAL AND ADVERTISING INFORMATION

All articles must be typewritten, double-spaced with margins of one inch.

Photographs should be printed on glossy paper. Negatives cannot be used.

Illustrations are desirable. Selection of illustrations submitted at discretion of editor and editorial board members. Cost of color illustrations must be shared by the author.

Contributors are responsible for all statements made in their articles. The editors and editorial board members may not be in agreement with all views expressed by authors, but it is desired to give all authors as great latitude as possible. However, the right is reserved to reduce in length or reject any article.

Articles are accepted for publication with the understanding that they are submitted for exclusive publication in THE JOURNAL of the Indiana State Medical Association.

Communications dealing with editorial matter should be sent to Frank B. Ramsey, M.D., Editor, 1802 North Illinois Street, Indianapolis 2, Indiana. All other communications should be sent to THE JOURNAL of the Indiana State Medical Association, 1019 Hume Mansur Building, Indianapolis 4, Indiana.

Advertising rates will be furnished on request. Copy must be received by the 5th of the month preceding month of issue. (Scientific manuscripts must be received at least two weeks earlier if geared for a specific issue.)

Entered as second class matter January 25, 1933, at the Postoffice at Indianapolis, Indiana. Copyright, 1960, by the Indiana State Medical Association. Published monthly at 1019 Hume Mansur Bldg., Indianapolis 4, Indiana.

"Well, I'll send the culture to the lab, and we should hear from Bacteriology in a day or two. Now, how shall we treat her cystitis while we're waiting?"

"The chief usually orders AZOTREX. *The azo dye is an excellent urinary analgesic and the sulfamethizole and tetracycline are likely to take care of most of the bugs you find in the urinary tract. If necessary, you can switch to something else after you get the lab findings. But it probably won't be necessary."*

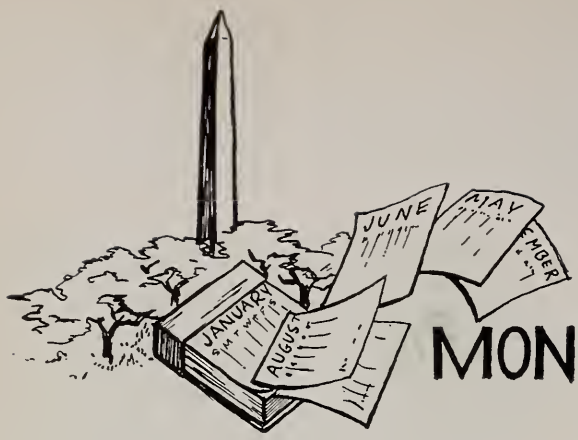


Azotrex®

Each AZOTREX capsule contains: TETREX® (tetracycline phosphate complex) equivalent to tetracycline HCl activity...125 mg.; sulfamethizole . . . 250 mg.; phenylazo-diamino-pyridine HCl . . . 50 mg. **Supply:** Bottles of 24 and 100.

BRISTOL™

BRISTOL LABORATORIES
Div. of Bristol-Myers Co.
SYRACUSE, NEW YORK



This summary of what is happening in Washington is prepared by AMA's Capital office and airmailed to *The Journal* on the ninth of each month preceding month of issue.

MONTH IN WASHINGTON

Washington, D. C.—Election of Senator John F. Kennedy as President made it probable that the issue of providing health care for the aged under Social Security again will be raised in Congress next year.

Kennedy will go into the White House pledged "to the immediate enactment of a program of medical care for the aged through Social Security." His intentions present a serious challenge to the nation's physicians who have vigorously opposed use of the Social Security system to provide health care for the aged.

Kennedy's program would provide what he described as "a life policy of paid-up medical insurance" for older persons. "It would provide them hospital benefits, nursing home benefits and x-rays and laboratory tests on an out-patient basis," he said in his campaign for the Presidency.

He said the Kerr-Mills legislation enacted into law last summer is inadequate. The medical profession supports this federal-state program to provide health care for needy and near-needy aged persons. In approving the Kerr-Mills program, Congress rejected the Social Security approach espoused by Kennedy and union labor leaders.

Kennedy's medical program also included: federal grants for construction, expansion and modernization of medical, dental and public health schools; federal loans and scholarships for medical students; federal grants for renovating older hospitals; increased federal financial support for medical research, including basic research and expansion of federal programs for rehabilitation of handicapped or disabled persons.

FDA EMPLOYES CLEARED

Food and Drug Administration employes have been cleared of conflict-of-interest charges brough up in the Senate Antitrust and Monopoly Subcommittee's investigation of the drug industry.

A three-member investigating group appointed by Arthur S. Flemming, Secretary of Health, Education and Welfare, examined the financial records of 900 FDA employes. The special investigators then reported:

"On the basis of all the evidence before us, it is our judgment that there are no present employes of the FDA whose sources of personal income are incompatible with their government employment."

The investigators continued to analyze "a mass of fact and opinion" in connection with charges that there has been too close a relationship between some FDA employes and drug companies which they check for conformance to government regulations.

Continued

ALL OVER AMERICA!

KENT with the MICRONITE FILTER IS SMOKED BY MORE SCIENTISTS and EDUCATORS

than any other cigarette!*



KING-SIZE, REGULAR-SIZE OR CRUSH-PROOF BOX

THIS does not constitute a professional endorsement of Kent. But these men, like millions of other Kent smokers, smoke for pleasure, and choose their cigarette accordingly.

The rich pleasure of smoking Kent comes from the flavor of the world's finest natural tobaccos, and the free and easy draw of Kent's famous Micronite Filter.

If you would like the booklet, "The Story of Kent", for your own use, write to: P. Lorillard Company—Research Department, 200 East 42nd Street, New York 17, New York.

For good smoking taste, it makes good sense to smoke KENT

*Results of a continuing study of cigarette preferences, conducted by O'Brien-Sherwood Associates, N.Y., N.Y.

A PRODUCT OF P. LORILLARD COMPANY · FIRST WITH THE FINEST CIGARETTES · THROUGH LORILLARD RESEARCH

© 1960, P. LORILLARD CO.

The investigators anticipated that their final report would show the possibility of organization or procedural improvements in the FDA.

The charges were triggered by disclosure at the Subcommittee investigation that Dr. Henry A. Welch, Director of the FDA's Antibiotics Division, had received $287,000 over eight years as a writer and editor for antibiotics publications. After the disclosure, Flemming ousted Welch from the government post.

The Federal Children's Bureau reported that the infant death rate in the United States has declined since 1958 but still shows the effect of a 1957-'58 setback.

There was a steady decline in U.S. infant deaths during the 1950's but increases in 1957 and 1958. Since then, the infant death rate has headed downward again but still hasn't made up the lost ground, even though the provisional rates for 1959 (26.4 deaths under one year per 1,000 live births) and the first half of 1960 (25.9 per 1,000) showed improvements.

In 1915, when data were first gathered on infant mortality in this country, the rate was 99.9 per 1,000. By 1940, this had been cut to 47, and by 1950 it had been reduced to 29.2.

An all-time low of 26 was registered in 1956. It edged up to 26.3 in 1957 and 27.1 in 1958.

According to the 1959 United Nations Demographic Yearbook, nine other countries reported lower infant mortality rates than the United States in 1958. They were: Sweden 15.8, Netherlands 17.2, Australia 20.5, Norway 20.5, Switzerland 22.2, United Kingdom 23.3, Denmark 23.4, New Zealand 23.4 and Finland 24.5.

Russia reported a rate of 81 in 1950 and 40.6 in 1957, latest year for which data were reported.

FLU IMMUNIZATION ADVISED FOR SOME

Persons with heart and blood vessel diseases have been urged to consult their physicians about routine vaccination against influenza.

In a joint statement, the American Heart Association and the National Heart Institute of the U.S. Public Health Service said that "evidence of the past three years abundantly confirmed that dangers of influenza are much greater for patients with heart or lung disease than for others." The risk was described as "particularly high for those with lung congestion due to heart disease."

The joint statement added that three recent influenza epidemics had "again emphasized the fact that individuals with cardiovascular or pulmonary disease are more susceptible to the hazards of influenza than is the general population." The epidemics were in the fall of 1957, the spring in 1958 and early this year.

The increased risk was shown both by more severe illness and by higher fatality rates among patients with heart and blood vessel disease, the statement said.

The association and the federal agency said influenza virus vaccine had been shown "of defnite value" in preventing the disease. Side reactions were reported as "extremely few." ◄

a broad spectrum non-narcotic analgesic

Trancoprin, a new analgesic, not only raises the pain perception threshold but, through its chlormezanone component, also relaxes skeletal muscle spasm[1-6] and quiets the psyche.[2,3-5,7]

The effectiveness of Trancoprin has been demonstrated clinically[8] in a number of patients with a wide variety of painful disorders ranging from headache, dysmenorrhea and lumbago to arthritis and sciatica. In a series of 862 patients,[8] Trancoprin brought excellent or good relief of pain to 88 per cent of the group. In another series,[9] Trancoprin was administered in an industrial dispensary to 61 patients with headache, bursitis, neuritis or arthritis. The excellent results obtained prompted the prediction that Trancoprin "... will prove a valuable and safe drug for the industrial physician."[9]

Exceptionally Safe

No serious side effects have been encountered with Trancoprin. Of 923 patients treated with Trancoprin, only 22 (2.4 per cent) experienced any side effects.[8,9] In every instance, these reactions, which included temporary gastric distress, weakness or sedation, were mild and easily reversed.

Indications

Trancoprin is recommended for more comprehensive control of the pain complex (pain → tension → spasm) in those disorders in which tension and spasm are complicating factors, such as: headaches, including tension headaches / premenstrual tension and dysmenorrhea / low back pain, sciatica, lumbago / musculoskeletal pain associated with strains or sprains, myositis, fibrositis, bursitis, trauma, disc syndrome and myalgia / arthritis (rheumatoid or hypertrophic) / torticollis / neuralgia.

Dosage

The usual adult dosage is 2 Trancoprin tablets three or four times daily. The dosage for children from 5 to 12 years of age is 1 tablet three or four times daily. Trancoprin is so well tolerated that it may be taken on an empty stomach for quickest effect. The relief of symptoms is apparent in from fifteen to thirty minutes after administration and may last up to six hours or longer.

How Supplied

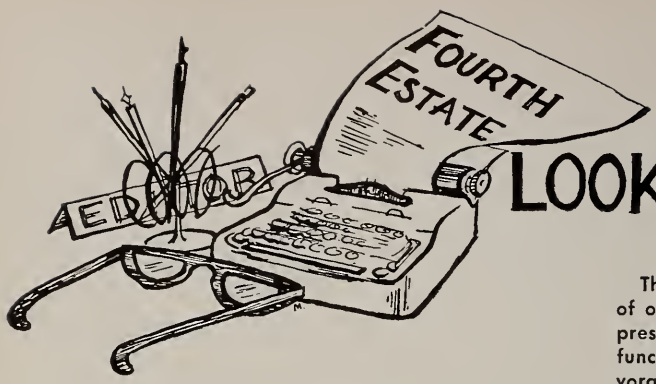
Each Trancoprin tablet contains 300 mg. (5 grains) of acetylsalicylic acid and 50 mg. of chlormezanone [Trancopal® brand]. Bottles of 100 and 1000.

Trancoprin Tablets / non-narcotic analgesic

References: 1. DeNyse, D. L.: *M. Times* 87:1512, Nov., 1959. 2. Ganz, S. E.: *J. Indiana M. A.* 52:1134, July, 1959. 3. Gruenberg, Friedrich: *Current Therap. Res.* 2:1, Jan., 1960. 4. Kearney, R. D.: *Current Therap. Res.* 2:127, April, 1960. 5. Lichtman, A. L.: *Kentucky Acad. Gen. Pract. J.* 4:28, Oct., 1958. 6. Mullin, W. G., and Epifano, Leonard: *Am. Pract. & Digest Treat.* 10:1743, Oct., 1959. 7. Shanaphy, J. F.: *Current Therap. Res.* 1:59, Oct., 1959. 8. Collective Study, Department of Medical Research, Winthrop Laboratories. 9. Hergesheimer, L. H.: An evaluation of a muscle relaxant (Trancopal) alone and with aspirin (Trancoprin) in an industrial medical practice, to be submitted.

Winthrop LABORATORIES, New York 18, N. Y.

Trancoprin and Trancopal (brand of chlormezanone) trademarks reg. U.S. Pat. Off.



LOOKS AT MEDICINE

This section of THE JOURNAL is devoted to the presentation of opinions which appear on the editorial pages of the public press, and which are of interest to the medical profession. Its function is to review comments which may be favorable or unfavorable to medicine. Members are invited to submit editorial clippings for this column.

The Next President's Problems

As this is written, we do not know who will be the next President of the United States. But whoever he is, we cannot say we envy him the problems he faces.

This is the best country in the world, and it is better than it has ever been before. Whatever else may be said about President Eisenhower, he has provided good government and the heritage of a rich, going concern. That, in fact, is the big challenge for his successor. What will he do with the heritage?

He inherits, in particular, two incalculable benefits: The economy, where the inflationary thief has been caught; and the handling of foreign affairs, by which the peace has been kept.

Foreign affairs have received most of the attention in this campaign, but it has not been sufficiently noted just how difficult keeping the peace has been in these years when a fresh war crisis seemed to erupt at least every year. It has taken remarkable cool-headedness, judgment, maturity and diplomacy to stay out of war without new surrenders to Communism. These qualities President Eisenhower has displayed in abundance; we can only hope the same will be said of the new President.

For what confronts the country is not any idiotic problem of "prestige." What faces it is a ruthless enemy with a long view and many masks. The enemy seemingly chooses to lie dormant in the closing months of the Eisenhower era. But he has made it clear he will be active again once the inauguration is past. A new war threat may await, perhaps in Berlin, perhaps elsewhere.

But a war threat is at least a clear threat, if a President has the wisdom to meet it wisely. What is possibly more dangerous is the insidious enemy's other face, which he assumes on occasion to bemuse the unwary. And it is unfortunately true that there are many people in this world, and in this country, whom no amount of painful experience can teach to be wary.

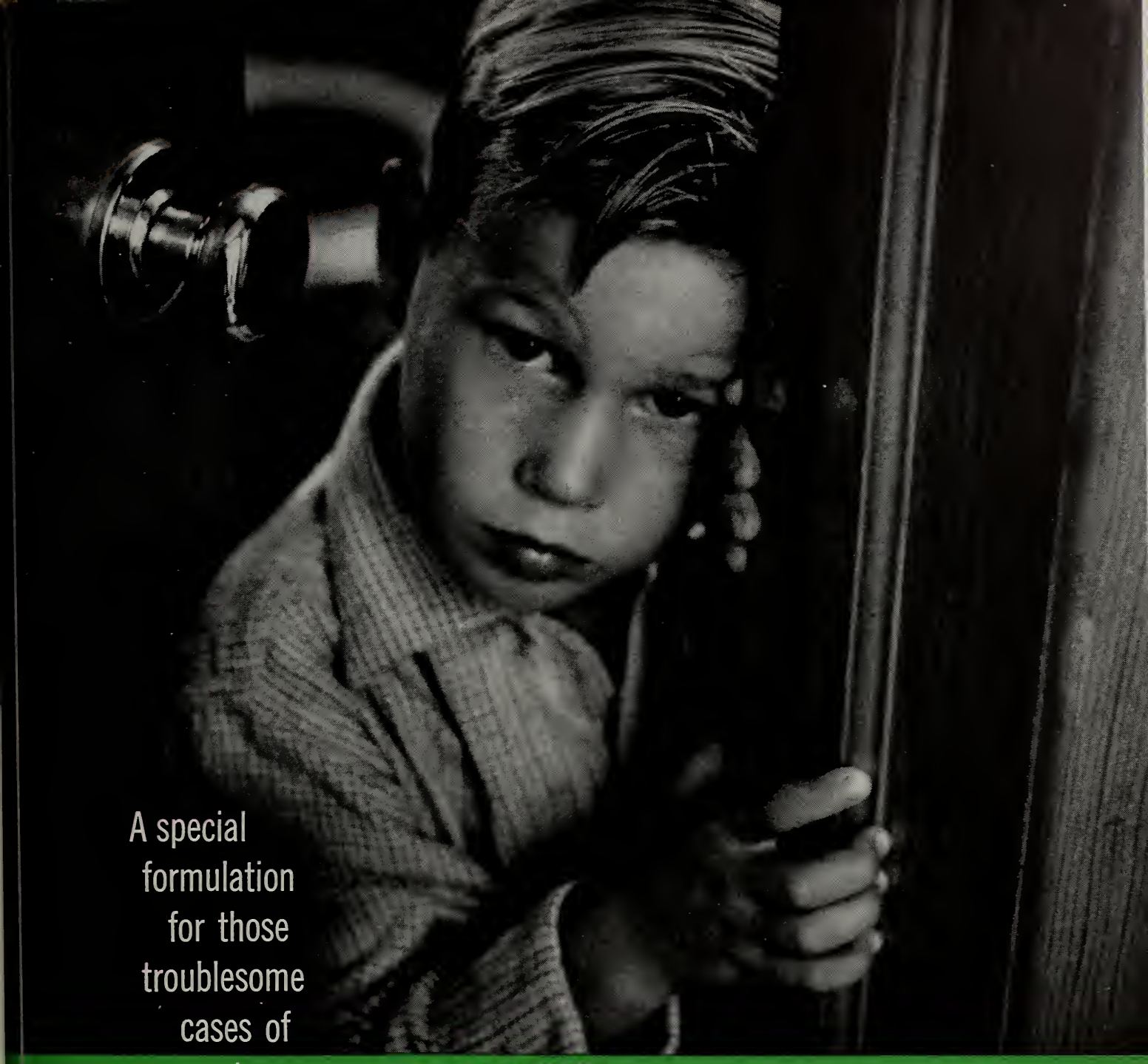
So it is, we fear, that the U.S. will be under rising pressure from the Communists but also from the fellow-travelers, the neutralists, the varieties of pacifists. Under pressure to make a false peace by making fresh surrenders. Under pressure also to fall for grandiose and totally unrealistic schemes for saving the world by trying to buy it.

The new President will be under intense pressures at home as well. There is nothing new in that, except perhaps in degree. We are, unhappily, a pressure-group political society, and as some aspects of our society become more complex the pressures multiply. For years, reason has not been permitted a say about our farm policy. Latterly the cry of the ignorant, of whom many are well-educated, has been that we can have any kind of crazy Federal "welfare" scheme anyone happens to think up, and hang the cost.

That is inflation. There could hardly be a safer prediction that the incoming President will be under enormous pressure to inflate, and often it will be presented in the most persuasive-sounding rationalizations.

If he succumbs to the inflation pressure, especially now after President Eisenhower has halted that curse, he will be playing the cruelest joke on the people who elected him whose lives he has so much power to affect. And if he succumbs, he need not worry about America's position in the world, for it will disappear.

Continued



A special formulation for those troublesome cases of acute nonspecific diarrhea

DONNAGEL®-PG

Donnagel® with paregoric equivalent

Provides greater assurance of more comprehensive relief in acute self-limiting diarrheas through the time-tested effectiveness of two outstanding antidiarrheals—DONNAGEL and a paregoric equivalent. *Tastes good, too!*

Each 30 cc. (1 fl. oz.) of DONNAGEL-PG contains:

Powdered opium U.S.P. (equivalent to paregoric 6 ml.)	24.0 mg.
Kaolin	6.0 Gm.
Pectin	142.8 mg.
Natural belladonna alkaloids	
hyoscyamine sulfate	0.1037 mg.
atropine sulfate	0.0194 mg.
hyoscine hydrobromide	0.0065 mg.
Phenobarbital (¼ gr.)	16.2 mg.

SUPPLIED: Pleasant-tasting banana flavored suspension in bottles of 6 fl. oz.

Also available:

DONNAGEL® with NEOMYCIN—for control of bacterial diarrheas.

DONNAGEL®—the basic formula—when paregoric or an antibiotic is not required.

A. H. ROBINS CO., INC. Robins
RICHMOND 20, VIRGINIA



FOURTH ESTATE

Continued

The problem, in short, is how to preserve a nation that stands at the height of its power and prosperity. That is a very different problem from how to revive a nation war-ruined or depression-shocked. But the greatness of this country is also its great hope today, for it has reached its greatness despite much mismanagement over the long years. We are confident it can survive some more mismanagement, if need be, but we hope the attempt will not be made.

The test of courage for the next President will be, as always, to hold firm for sanity when the pack is running toward folly.

Wall Street Journal
Nov. 9, 1960

Who's Hiding The Law?

Bits and pieces of what might be a medical-care-for-the-aged law continue to dribble down from the bureaucrats in Washington. State officials have now found that the law which Congress is said to have passed contains a no-lien provision.

This is still another point where the might-be medical care law varies from existing federal and Hoosier statutes. Indiana law permits the state to obtain a lien against the estate, if any, of a welfare recipient in order to recover part of the tax money spent for monthly aid payments. Last year, Indiana got back more than $1,000,000 from these legal claims against welfare recipients who died.

Previously, Hoosier welfare officials found out that the might-be law slaps a padlock of secrecy on records and abolishes any residence requirements. Indiana law leaves the welfare books open and fixes residence requirements for eligibility.

Yet, State Welfare Director Albert Kelly still doesn't know what other provisions there are in this slippery statute. Kelly can't even get a copy of the law from federal officials, even though he made a special trip to Washington for that purpose.

Did the late Congress write a law, or not? The bobtailed session convened in August and ended on the second day of September. More than 40 days have passed, and still no one in Indiana has an official copy of the act. Supposedly, Congress can pass no law unless it has been printed in full so that members of the House and Senate will know what they are voting for or against.

There is no real reason for concern, perhaps. After all, this medical care bill, if anyone ever finds it, will only cost the nation a couple of billion dollars a year, according to Jack Kennedy. Perhaps Senator Kennedy knows where the law is. The Democrats controlled Congress when it was passed.

When Congress goes back to Washington in January, a diligent search should be begun for this might-be law. When, as and if it is found, there can no longer be any doubt that the statute needs drastic revision or repeal.

Indianapolis Star
Oct. 14, 1960

Prime Criteria

The new bill providing financial aid to elderly people for meeting health costs was something of a compromise. It couldn't, and didn't, please everyone. But, of top importance, it met the prime criteria of informed authorities within and without the government—notably the Administion itself, and the American Medical Association—that any plan should be voluntary and tailored to fit those who need it.

Equally important, the bill does not provide for indiscriminate hand-outs. The states will actively participate, not only financially but in administering the law. That means that basic decisions will be made at the local level where they should be made. Local officials have a far

for chronic bronchitis

Tetrex® capsules

The Original Tetracycline Phosphate Complex

U.S. PAT. NO. 2,791,609

effective control of pathogens...with an unsurpassed record of safety and tolerance



SUPPLY: TETREX Capsules—tetracycline phosphate complex—each equivalent to 250 mg. tetracycline HCl activity. Bottles of 16 and 100.

TETREX Syrup—tetracycline (ammonium polyphosphate buffered) syrup—equivalent to 125 mg. tetracycline HCl activity per 5 ml. teaspoonful. Bottles of 2 fl. oz. and 1 pint.

BRISTOL LABORATORIES, SYRACUSE, NEW YORK
Div. of Bristol-Myers Co.

BRISTOL™

Continued

better knowledge of local needs than Washington bureaucrats.

However, no one should think, just because Congress has passed a bill and the President has signed it into law, that the controversy is over. There is strong political agitation, in this critical election year, for a very different and infinitely more costly kind of measure. It would provide federal medical payments for everyone drawing Social Security benefits — which simply means that an arbitrary age, and not need, would be the criteria. The cost is estimated at something like $2 billion a year to begin with—and some say this might ultimately rise to as much as $8 billion.

Worst of all, the proposal would establish a precedent which could inexorably lead to government-bossed medicine or even socialized medicine. Remember that old adage about the camel who got his nose in the tent—and then soon took over the whole tent?

Onarga, Ill., Leader-Review
Oct. 13, 1960

Thoughts for Voters

In case the trials of voting are getting you down today, we offer a couple of cheery thoughts culled from the news.

Girls in a London shampoo firm struck for a "beer break" and won. It seems beer goes into the shampoo, and the girls had been putting inside some of what should be used outside. Now they will get a special barrel for internal use, with a half pint free at lunch. Obviously this opens up a new era in labor negotiations, and a much more delightful one.

Then there is the American scientist who won the Nobel Prize for a bubble bath. To be sure, it's an atomic bubble bath, but it still has a nice frothy sound, especially since it was invented by a bachelor. (Incidentally, where are all the Russian scientific Nobel Prize winners?)

Finally, there is the other scientist who has discovered that the end of the world will come on Friday, November 13, 2026. At first glance this may not sound especially cheerful, but that would be a superficial view. First, it is still some way off. Second, contrary to many gloomy scientists, Doomsday will come not because we have run out of food and other resources but because there will be so many people we will have run out of space. Surely squeezing is more fun than starving.

Besides all that, the prediction can be classified as unlikely. A nation that can survive this campaign will probably still be here 66 years hence. Even the candidates will be only in their early hundred-teens.

Wall Street Journal
Nov. 8, 1960

Improve Road Markers!

The constant urgings we get to drive with care must go on and on. We have to assume that this basic safety message sinks in with many drivers.

But if among those who present this message there is any yearning for more concrete endeavors, let them mount a comprehensive drive to have state, county and city traffic engineers review the placing of every road marker and every foot of white guide line in the United States.

For there are thousands of miles of poorly placed center guide lines and untold thousands of road signs which are so badly located as to be more dangerous than useful.

Who has not seen the puzzled driver jockeying at a turn or intersection, trying to read a sign set too close to the division in the road to permit anything but a last minute snap decision?

If you were to count the signs thus fixed, plus all those stuck behind posts, obscured by trees, bearing legends far too small to read except at very close range, they'd easily come to 50 to 100 in a good day's driving.

As for the guide lines, they are supposed to tell the driver when it is unsafe to pass on a two-lane roadway. The marks are intended to bar passing on hills, curves, at intersections and other places where for one reason or another "sight distances" are limited.

The plain fact is that the "no passing" indication often is given where it is clearly safe to pass, while the "passing" indication—the dotted line—often is painted on a highway where to pass is to court a head-on collision.

Anyone who doubts the irresponsibility of these designations—always referred to so soberly in state vehicle code manuals—hasn't taken a very good look at them.

Continued

NaClex®

benzthiazide

a new diuretic with an unsurpassed faculty for salt excretion



as salt goes, so goes edema

A basic principle of diuresis is that "increased urine volume and loss of body weight are proportional to and the osmotic consequences of loss of ions."[1]

Robins' new NaClex is a potent, oral, non-mercurial diuretic that helps reduce edema through the application of this fundamental principle. It limits the reabsorption of sodium and chloride in the renal proximal tubules (*with a relative sparing of potassium*). The body's homeostatic mechanism responds by increasing the excretion of excess extracellular water. Thus the NaClex-induced removal of salt leads to a reduction of edema.

a unique chemical structure

NaClex (benzthiazide) is a new molecule which provides a "pronounced increase in diuretic potency"[2] over its antecedent sulfonamide compound. Compared tablet for tablet with current oral diuretics, it is unsurpassed in diuretic potency.

twofold value

NaClex produces diuresis, weight loss, and symptomatic improvement in edema associated with various conditions. It also has antihypertensive properties and may be used alone in mild hypertension or with other antihypertensive drugs in severer cases.

For complete dosage schedules, precautions, or other information about NaClex, please consult basic literature, package insert, or your local Robins representative, or write to the A. H. Robins Co., Inc.

Supply: Yellow, scored 50 mg. tablets.

References: 1. Pitts, R. F., Am. J. Med., 24:745, 1958. 2. Ford, R. V., Cur. Therap. Res., 2:51, 1960.

A. H. ROBINS COMPANY, INC.
RICHMOND 20, VIRGINIA

It is not an exaggeration to say that a motorist, alert to every reasonable demand of safety, could conclude that the men who place the signs and paint the highway guide lines in all too many areas do not themselves know the simplest elements of driving.

We can talk about safety. We can design better highways and better cars. But if we can't learn to mark them properly, we will be opening the way—inexcusably—for accident trouble.

Kokomo Tribune
Oct. 20, 1960

Distributing Doctors

The United States system of medical care is without question one of the finest in the world. An important reason for this is that we have a comparatively high number of doctors in proportion to population. This does not alter two salient facts—that the number of doctors relative to total population is less than it once was, and that there is a serious problem of distribution of doctors.

Expansion of medical training facilities is under way. This expansion is not taking place as rapidly as it should, but there is at least a glimmer of hope that the number of doctors per 100,000 population can gradually be increased. The problem of distribution is both less difficult and more so.

It is less difficult because far less complicated and expensive than the business of building medical schools and finding able men to staff them. But the problem of distribution of doctors is troublesome because the cities are generally much more attractive to young doctors than small towns or rural areas. There is more demand for specialization in the cities, and big hospitals also are a drawing card. As a result, many a small town or rural community finds it hard to attract a good doctor and keep him interested.

One promising way of helping such communities is exemplified in Minnesota, where the state Academy of General Practice has just established a loan fund for medical students who will agree to practice for a time in certain communities. It is expected that about 20 students will be aided by the program each year, and they will not be required to repay the loans if they practice in small communities for a few years. Such a program is by no means the whole answer to the problem of doctor distribution, but it is a practical step toward that end.

Terre Haute Star
Oct. 9, 1960

Trouble in Medicine

There are too few doctors in the United States to provide everyone with the excellent care the medical profession is capable of providing under optimum conditions. Not enough new doctors are being added each year even to maintain the present ratio of doctors to population. There has recently been a decline in both the number and the quality of young persons seeking a medical career.

These closely related facts coupled with the rising cost of medical education and the lack of sufficient training facilities, are of deepening concern. Corrective steps are being taken, but more must be done if a crisis is to be averted.

There is nothing either alarmist or speculative in this. Dr. Ward Darley, executive director of the Association of American Medical Colleges, has noted that there are doctor shortages "in several areas of medicine—anesthesiology, pathology and radiology among them." He also says that, although never before "had we ever found it necessary to conduct a program to attract students . . . it is necessary now." A pamphlet for this purpose has been published by his group, together with the American Medical Association. Among other things, it attacks the "popular misconception" that only top students can enter medical school and notes that in recent years "the actual college grade average of freshmen medical students has been approximately A—17%, B—66%, C—17%."

Plans are afoot to set up more medical scholarships, and to shorten the period of education for able students. Various medical schools, including those of Chicago University, the University of South Dakota and the State University of Iowa, are striving to attract more students. These and related efforts may avert a greater doctor shortage. The public interest is notably involved in what is being done.

Terre Haute Tribune
July 17, 1960

Continued on page 2176

as it calms anxiety!

Smooth, balanced action lifts depression as it calms anxiety... rapidly and safely

Balances the mood – no "seesaw" effect of amphetamine-barbiturates and energizers. While amphetamines and energizers may stimulate the patient *–they often aggravate anxiety and tension.*

And although amphetamine-barbiturate combinations may counteract excessive stimulation–*they often deepen depression.*

In contrast to such "seesaw" effects, Deprol's smooth, *balanced* action lifts depression as it calms anxiety–both at the same time.

Acts swiftly – the patient often feels better, sleeps better, within a few days. Unlike the delayed action of most other antidepressant drugs, which may take two to six weeks to bring results, Deprol relieves the patient quickly – often within a few days. Thus, the expense to the patient of long-term drug therapy can be avoided.

Acts safely – no danger of liver damage. Deprol does not produce liver damage, hypotension, psychotic reactions or changes in sexual function–frequently reported with other antidepressant drugs.

Bibliography *(13 clinical studies, 858 patients)*: **1.** Alexander, L. (35 patients): Chemotherapy of depression – Use of meprobamate combined with benactyzine (2-diethylaminoethyl benzilate) hydrochloride. J.A.M.A. 166:1019, March 1, 1958. **2.** Bateman, J. C. and Carlton, H. N. (50 patients): Meprobamate and benactyzine hydrochloride (Deprol) as adjunctive therapy for patients with advanced cancer. Antibiotic Med. & Clin. Therapy 6:648, Nov. 1959. **3.** Beerman, H. M. (44 patients): The treatment of depression with meprobamate and benactyzine hydrochloride. Western Med. 1:10, March 1960. **4.** Bell, J. L., Tauber, H., Santy, A. and Pulito, F. (77 patients): Treatment of depressive states in office practice. Dis. Nerv. System 20:263, June 1959. **5.** Breitner, C. (31 patients): On mental depressions. Dis. Nerv. System 20:142, (Section Two), May 1959. **6.** Gordon, P. E. (50 patients): Deprol in the treatment of depression. Dis. Nerv. System 21:215, April 1960. **7.** Landman, M. E. (50 patients): Clinical trial of a new antidepressive agent. J. M. Soc. New Jersey. In press, 1960. **8.** McClure, C. W., Papas, P. N., Speare, G. S., Palmer, E., Slattery, J. J., Konefal, S. H., Henken, B. S., Wood, C. A. and Ceresia, G. B. (128 patients): Treatment of depression – New technics and therapy. Am. Proct. & Digest Treat. 10:1525, Sept. 1959. **9.** Pennington, V. M. (135 patients): Meprobamate-benactyzine (Deprol) in the treatment of chronic brain syndrome, schizophrenia and senility. J. Am. Geriatrics Soc. 7:656, Aug. 1959. **10.** Rickels, K. and Ewing, J. H. (35 patients): Deprol in depressive conditions. Dis. Nerv. System 20:364, (Section One), Aug. 1959. **11.** Ruchwarger, A. (87 patients): Use of Deprol (meprobamate combined with benactyzine hydrochloride) in the office treatment of depression. M. Ann. District of Columbia 28:438, Aug. 1959. **12.** Settel, E. (52 patients): Treatment of depression in the elderly with a meprobamate-benactyzine hydrochloride combination. Antibiotic Med. & Clin. Therapy 7:28, Jan. 1960. **13.** Splitter, S. R. (84 patients): Treatment of the anxious patient in general practice. J. Clin. & Exper. Psychopath. In press, April-June 1960.

Deprol®

Dosage: Usual starting dose is 1 tablet q.i.d. When necessary, this dose may be gradually increased up to 3 tablets q.i.d.

Composition: 1 mg. 2-diethylaminoethyl benzilate hydrochloride (benactyzine HCl) and 400 mg. meprobamate. **Supplied:** Bottles of 50 light-pink, scored tablets. Write for literature and samples.

WALLACE LABORATORIES / *Cranbury, N. J.*

CD-2843



FOURTH ESTATE

Continued from page 2172

Pep Pills and Crime

Bootleg operations "more dangerous than the narcotics traffic" are taking place every day with amphetamine sulfate — commonly known as "pep pills," reports the October *Reader's Digest,* in an article condensed from *Today's Health,* published by the American Medical Assn.

Author Lin Root says that the growing use of the pep pills can be blamed for a mounting rise in juvenile crime and highway accidents.

Like other useful drugs, amphetamine has a Jekyll-and-Hyde" character benign when used under physician's care, the drug is a menace when taken irresponsibly.

Irresponsible use has been on the increase since 1949, when original patents on amphetamine expired. More than 150 companies are grinding out the pills at a rate of 75,000 pounds—enough for 7,000,000 five-milligram pills—a year. More than two-thirds of these pills are sold illegally, at truck stops, service stations, roadside diners.

More frightening, the illegal traffic is branching out to schools, where thrill-seeking teenagers are gulping the pills, then going out to commit crimes. Says one youngster: "Thrill pills are worse than marijuana, because after you take them you feel you can pull off any kind of job."

Most noteworthy of the recent pep pill tragedies was the death in Rome of an Olympic bicycle racer after a dose of the stimulant.

Mrs. Root suggests various ways of controlling the pep pill traffic in her article. But until these suggestions are adopted, she says, "the only hope lies in wider understanding of the truth about amphetamine sulfate."

Kokomo Tribune
Oct. 7, 1960

Doctor Shortage Worse

Doctors are losing the race to keep ahead of the population growth and cannot even maintain the status quo.

Among college graduates, those financially able to continue their education and training for six more years are inadequate to the need. The U.S. now has a smaller ratio of doctors to the general population than at any time since its infancy, and the number of medical students shows only a minor increase.

Increasing population not matched by an increase in the number of doctors is not the only factor contributing to a decline in satisfactory medical treatment. The average American, as a result of health awareness campaigns, now sees his family physician twice as often as did his parents. Hospitals are experiencing similar problems, with inadequate nursing and technician staffs, a declining number of interns and beds filled with patients who in years past were not considered ill enough to be admitted to a hospital.

Medicine is not an unattractive profession, but the initial outlay required is prohibitive enough to prevent all but a few of those who would like to make a career in medicine from doing so. The obvious solution to the problem lies in the financing of a medical education. Aside from government interference and subsidy, which should be the last resort, there are many ways in which aid can be given to a young man or woman indicating interest in a medical career.

Many communities, particularly small towns which would otherwise be unable to attract adequate medical personnel, combine their resources to offer a doctor inducements ranging from a community-purchased office or clinic to a guaranteed annual income. Large corporations and farm organizations have provided similar incentives in communities where there was no doctor.

Many business firms, frequently not related to the field of medicine, annually make a grant for medical scholarships. Foundations, trusteeships and private individuals do the same. But it costs an average of $47,000 to educate and equip the average doctor who does not specialize; $20,000 more for those who qualify for a specialty.

Hammond Times
Sept. 14, 1960

◄

The Journal of the INDIANA STATE MEDICAL ASSOCIATION

Supervised by THE COUNCIL

Volume 53 — December 1960 — Number 12

Coroners' Symposium:
The following three papers were included in a program sponsored by the Indiana Commission on Forensic Sciences during the Indiana Coroners' Association meeting, May, 1960, at Indianapolis.

"Masquerades:" Homicide, Suicide, Accident or Natural Death

*FRANK P. CLEVELAND, M.D.**
Cincinnati, Ohio

A PRIMARY FUNCTION of the coroner's office that is of most importance to the general community welfare is investigation of deaths of persons within the county. To the coroner is given the responsibility of ascertaining whether a given death results from homicide, suicide, accident or natural causes. Generally, state statutes (defining the functions of the coroner) place major emphasis upon investigation of deaths that occur as the result of violence where a crime has been committed or is suspected. However, there is a broad category of cases, the circumstances being unknown at the time of death, wherein it is mandatory that a thorough investigation be made. Only when all facts have been determined can the coroner come to a final resolution of the problem.

Homicidal violence may be simulated by other types of death or may simulate death from natural causes. Even when there is positive physical evidence of violence, the situation, which may appear to be a homicide, can prove ultimately to be accidental or suicidal in character. This problem is resolved only through cooperation of responsible agencies, namely the coroner, the prosecutor and the police.

In many instances a death has to be evaluated where there may be a combination of both violence and natural causes. Thus, it must be determined whether the violence contributed to the death and how much the natural disease contributed.

At the outset it must be pointed out that not every case can be solved. A large number of cases which require investigation are those in which victims are recovered from rivers or other bodies of water. When the body is in the fresh state, it may be entirely reasonable to ascertain cause of death from drowning. However, it is impossible to establish from the postmortem examination whether the person jumped, was pushed or fell into the water.

In these cases often the suicidal nature is determined by indirect means. Careful and thorough interrogation of relatives or friends can uncover a mental condition with pre-disposition

* Associate Professor of Forensic Pathology, Director of Research, The Kettering Laboratory in the Department of Preventive Medicine and Industrial Health, College of Medicine, University of Cincinnati.

to the commission of suicide. In other instances one may find on the body certain definitive evidence that points to homicide. Many of the cases are solved by first establishing identity of the individual. Such a process may constitute an insurmountable problem, particularly in the instances where the body is badly decomposed.

Body Dismemberment

Occasionally cases arise wherein there is dismemberment of the body. This may result from impact with river vessels or even prior to deposition of the parts in the water. In occasional situations it is quite obvious that dismemberment could have been accomplished only by a human agent. So it is totally wrong to conclude upon the recovery of a dismembered body, that one is dealing with a homicide. Each situation is an individual one and must be handled on its own merits.

There are a number of natural diseases which under certain circumstances may mimic death as the result of homicide. In such situations the postmortem examination can clearly establish cause of death and immediately stop any unwarranted investigation or accusations of homicide. Situations have been observed wherein one or more individuals are found dead within a dwelling and have on the exterior of the body considerable evidence of injury prior to death.

Conditions where there is hemorrhage either into the brain or about it often produce symptoms causing the individual to be irrational or to lose consciousness. The subject falls once or many times, sustaining injury. In some cases many such injuries may have occurred prior to complete unconsciousness and subsequent death. When the body is found there is considerable disturbance of the normal arrangement of furniture within the dwelling and significant external evidence of injury. Without postmortem examination it would be entirely possible to conclude that death resulted from violence. However, the postmortem examination clearly establishes the primary disease that led to the situation as it was found.

Hemorrhages Can Simulate Violence

Other examples appearing to be homicide are those wherein there is hemorrhage about the brain, resulting from a defect in one of the arteries about the base of the brain. This defect, properly termed "aneurysm," is at a point where the vessel is weak and develops bulging of the wall which under normal conditions may rupture at any time. Not infrequently such a rupture occurs under circumstances that lead observers and investigators to believe that the death is the result of violence. The aneurysm frequently ruptures when an individual is intoxicated or when the individual has gotten into an argument terminating in some type of physical disagreement. During the course of the altercation a blow is struck, the victim collapses and after a period of unconsciousness expires.

Witnesses to the occasion have observed the infliction of an injury and have noted the immediate proximity of death following such injury. On the basis of observations alone, there is adequate evidence that would sustain a conviction for homicide in a court of law. Without a postmortem examination, such miscarriage of justice has and will continue to occur. The responsibility for preventing such a miscarriage of justice dwells in the integrity, knowledge and experience of the investigating officers, a conscientious prosecutor and an inquiring coroner. If the latter fails to perform his duty, that of initiating a postmortem examination, the prosecutor is left to try the suspect on the substance of the police investigation which establishes eyewitness testimony to the occurrence of physical injury followed by death. Having this in mind, it should be mandatory in such cases and many other analogous types of death that a postmortem examination be performed by a responsible, well-trained individual in the field of forensic pathology.

Accidental Death vs. Homicide

Frequently accidental death assumes all appearances of homicide. In a recent case a young woman was found dying when her husband returned from work. A call made to the life squad was of no avail, after which police were called for investigation of the death. To all investigators the appearance was characteristic of severe injuries inflicted by blows to the body. There were large areas of injuries upon the face and scalp, the latter being obscured by the long hair of the victim. There was generalized swelling of the facial features almost to the point of non-recognition. Within the apartment there was evidence of some degree of violence having taken place.

The body was lying on the floor; beneath it there were considerable stains emanating in the

region of the pelvis and also staining the articles of clothing present upon the body. The large area of injury upon the face was covered by considerable serosanguineous crusts. On the door of a cupboard adjacent to the body about 18 inches from the floor, there were adherent to the surface many strands of hair. The hair was literally glued to the door by some of the same serosanguineous exudate that emanated from the body. Within the same room there were broken items of china. The shoes of the deceased were found in different areas.

The entire apartment presented an appearance of great disorder. The suspect upon interrogation by the police appeared confused and could not give adequate explanation for the circumstances. During the course of the interrogation, the suspect told a number of stories which were proven to be lies by the subsequent investigation, by interrogation of other persons and by the facts ascertained from postmortem examination.

Placing maximum emphasis upon the postmortem examination as an unprejudiced, impartial, objective, scientific procedure, one must take the facts as they exist and fit them into the jigsaw puzzle that comprises the investigation. It is inconceivable to take a situation and then try to fit the facts to the situation. Rather, the facts must be ascertained and then the situation and circumstances evaluated, finally determining what evidence constitutes a true situation. Using this as a guide, police agencies can then with a knowledge of truth proceed along the lines that are necessary.

Having convinced the investigating officers that the injuries upon the body were in reality not inflicted by external physical violence, but rather from external pressure upon the various portions of the body and were analogous to the bed sores or properly termed "decubitus ulcers" of the seriously ill or unconscious patient, the investigation proceeded along the proper channels.

Carbon Monoxide in Blood

Chemical examination of the blood from the victim provided the explanation for unconsciousness. There was a significant concentration of carbon monoxide within the blood of the victim. It suddenly became apparent to all persons involved that the suspect was in reality confused and completely unable to explain all of the circumstances. It was subsequently established that the suspect himself was unconscious for a period of five days, also suffering from carbon monoxide poisoning and having varying degrees of temporary and complete amnesia for certain events.

Assuming that these facts were true, there must have been a source for the carbon monoxide. An examination of the apartment revealed that the heating was provided from a hot water system. The cooking appliance used natural gas, analysis of which showed absolutely no carbon monoxide. The final object of the search proved to be a refrigerator, the mechanism of which was activated by the burning of natural gas. Use of an apparatus for detecting the presence of carbon monoxide revealed that when the refrigerator was performing under normal conditions, the level of carbon monoxide was in the order of 200 to 300 ppm., and when the refrigerator was functioning under the stress of needing to cool the interior, the concentration of carbon monoxide from the exhaust reached the magniture of 1000 or more ppm.

At this time there existed sufficient evidence to establish beyond any doubt that the death of the victim was accidental. In order to further clarify the situation, further investigation established that the victim and her husband had lived within the apartment for only a period of two weeks, that the previous occupants of the apartment had had their own refrigerator, and being of sufficient age, they had moved to a new location for retirement. Thus, the owner of the building now having a vacant apartment decided the best course of action was to rent the vacant apartment as a furnished apartment and therein placed furniture which was currently at his disposal.

Among the items available was a gas burning refrigerator that had not been used for a period of several years. It was placed in the apartment, was found to function satisfactorily in terms of cooling the interior, and the unsuspecting victim and her husband moved in, living there a week without any indications of potential danger. The week during which the unfortunate series of events began was one during which the environmental temperature fell and it was necessary for internal comfort to close the windows of the dwelling, thereby setting up a situation that ultimately culminated in the death of one individual and investigation of the survivor for possible homicide.

On frequent occasions, there are deaths which appear to be accidental when they are reported. However, investigation very quickly points to the probability of suicide. Very early after the occurrence of the death, friends and relatives are convinced that the death could have resulted from accident or homicide. The postmortem examination combined with the investigation confirms only the theory of suicide. Many times physical evidence from the scene and from the clothing support the official conclusions. The major problem confronting all persons concerned whether friends, relatives or police is the reason for such action by the deceased. The background of the person generally, is as follows: the individual is well educated, having graduate and post-graduate degrees; he has a responsible position and a good income; the family life is happy; there are no financial or medical problems. Psychiatrists and forensic pathologists have made and are continuing to gather data about such cases in an attempt to understand the reasons for such an action. Suicide is the only conclusion which can be reached by the enforcement agencies, but understanding is still lacking.

Homicidal Poisoning

Another type of crime, homicidal poisoning, frequently escapes immediate detection often for long periods of time. Many of the poisons used by persons committing this type of crime produce symptomatology that very closely resembles natural disease. The individual who is the victim is known by friends and relatives and acquaintances to be ill, generally for a significant period of time, so that when death finally occurs, it is no surprise. The illness has existed, the patient's condition is well-known and, on interrogation, everybody has expected him to die, but had no idea as to when death might occur.

Another interesting feature of this problem is that when the victim, perhaps prior to his death, is brought to medical attention and cared for in hospital facilities, again the symptoms so resemble that of natural disease that the patient is put under treatment for the symptoms and the actual condition remains undiagnosed. If the patient recovers, it is attributed to medication and therapy that he received during hospitalization. If he expires, then it is an unfortunate incident of death from the suspected disease.

Unless a postmortem examination is performed, the exact cause of death may well be buried with the body. Even with postmortem examination it is not at all uncommon to have ascertained the condition of all of the organs of the body and still be unable to explain why the individual has died. If the person performing the autopsy has experience in forensic pathology he is more likely to suspect poisoning. At this point, unless further investigation is made in the form of analysis of the organs of the body for the presence of poison, the nature of the death may go undiscovered and the culprit remain undetected.

In general, it is possible to state without equivocation that homicidal poisoning is one of the most difficult types of cases with which the police and pathologists have to deal. For it is essential that one recover from the organs of the body a quantity of poison that is sufficient to constitute a lethal dose. Many times analysis of tissue will reveal traces of minor quantities of a given substance which in adequate amounts could be fatal and yet which may normally be present either as the result of taking of a tonic or medication.

In conclusion one must constantly be aware that homicide may masquerade as a natural, suicidal or accidental death or that natural death may masquerade as suicide, accident or homicide. It is only through the tenacity of the police investigator and the inquiring approach of the coroner employing the talents of the forensic pathologist that the true situation will be elucidated for the protection and welfare of our community. ◄

Gunshot Wounds

Diagnoses are complicated, but quite helpful

*HERBERT P. LYLE, M.D.**
Cincinnati, Ohio

THE OFFICIAL investigation of a dead body bearing gunshot wounds poses the same general problems to the investigators as do all cases involving violence, namely:

1. The determination of the cause of death
2. The determination of the instrumentality producing the injury (manner)
3. The forming of an opinion as to the intent or absence of intent to produce bodily injury by the person or persons applying the injuring instrumentality (mode)
4. The determination of the relationship between the injury and the death.

The proper completion of the death certificate in the case requires the coroner to state not only the cause of death but also the manner and mode.

The investigation of gunshot wound deaths embodies not only medical knowledge but knowledge of police sciences also. The practical application of police science technics will usually be performed by technicians skilled in that particular field.

The investigation must answer several questions:

1. How many wounds are there?
2. What are the exact locations of the wounds?
3. What is the appearance of each wound and the area adjacent to it?
4. Is it a wound of entrance or exit?
5. What course did the projectile follow in the body?
6. Was the course of the projectile altered by any body structure?
7. Was there more than one projectile in the single wound?
8. What was the order of infliction of multiple wounds of entrance?
9. Did the wounds incapacitate the person?
10. What distance did the projectile travel before wounding?
11. Could the wounds have been self-inflicted?
12. What additional information and evidence is there to assist the firearms identification technician and other investigators?

In order for the coroner to answer these questions, he should make full use of the varied kinds of assistance available to him. To do this he must not only conduct his part of the investigation so that those assisting will have the evidential material they need, properly collected, identified and preserved but he must know what assistance he needs and where it is available. Therefore, a brief discussion of some of the fundamentals relating to firearms and ammunition is in order.

Types of Firearms

The firearm ordinarily used by the civilian population may be produced commercially or may be homemade. The barrel may be short or long, with smooth or rifled bore. Arms designed to propel projectiles by use of compressed air or gas from cylinders must be considered as well as the usual type in which gas is formed by the burning of gunpowder.

The type of firearm predominating in a particular area may vary depending upon the den-

---

* Coroner, Hamilton County, Ohio. Presented in August, 1959 at Cincinnati, Ohio—reprinted from *Proceedings of The National Association of Coroners, 1958-1959.*

sity of population and the predominating sporting use of firearms. Hand guns are found in all areas.

Projectiles

The homemade "zip gun" may use anything from a bolt head to conventional ammunition.

The compressed air and CO_2 gas arms employ spherical projectiles, usually ranging in diameter from 0.18 (BB) to 0.22 (F) inches.

The smooth barreled commercial arms are for the most part shotguns today although the "Flovert" and squirrel gun may still be encountered. The spherical projectiles from these arms range from 0.04 (dust) to 0.71 (10 gauge ball) inches in diameter.

The rifled barrel arms consists of hand guns and rifles. The projectile sizes in hand guns vary from 0.22 to 0.455 inches in diameter, and in rifles from 0.22 to 0.45 inches. The projectile is greater in length than diameter. The form of the nose varies from the flat nose "wad-cutter" to the sharp pointed nose. Hollow nose projectiles may also be encountered.

The projectile is usually composed of an alloy of lead and zinc. Some bullets have a harder metal cupro-nickel or Gilding metal (copper and zinc) jacket over the lead alloy core. Soft-point or mushroom projectiles are jacketed bullets with soft lead points, or unjacketed bullets with hollow noses. Lead alloy bullets may have a very thin coating of lubricant or metal plating applied to the outside.

Projectile Propellants

Modern ammunition combines the gas-producing material used to propel the projectile in a single unit with the igniter and the projectile, the shotgun shell or cartridge of hand guns and rifles.

The gas-producing materials are gunpowders, usually the smokeless type, less frequently the semismokeless and infrequently black powder alone.

The chemical and physical differences between these powders may be of assistance in investigation procedures. The usual compositions and physical characteristics follow:

Black powder is composed of potassium nitrate (75%), sulfur (15%) and carbon (charcoal, 10%). The residues of black powder combustion include several compounds one of which is potassium nitrite.

Black powder grains are irregular in shape and have a glossy appearance.

Smokeless powders may be either single or double base. The single-base powder is composed of cellulose nitrate. The double-base powder contains glycerol nitrate in addition to the cellulose nitrate. Stabilizing substances are usually added. Nitrites are one of the residues of smokeless powder combustion.

Smokeless powder grains may be coated with graphite. A particular make of smokeless powder has grains of uniform size and shape. The shapes of the grain differ: disc, diamond, rectangular, tubular or doughnut.

Semismokeless powder is a combination of black powder (85%) and smokeless powder (single base, 15%).

All powders produce nitrites in the residues. Black powder produces less gas and more flame and soot. Smokeless powders require a more powerful igniter (primer). Corrosive primers are still frequently used with semismokeless powders.

Propellant Igniters

A combination of materials is placed in the base of cartridge and shell cases to ignite the propellant. These igniters consist of a substance that will explode when its container is struck a sharp blow by the firing pin of the firearm, an oxidizing material and fuels. Rimfire ammunition may employ ground glass as an abrasive in the combination.

Early primers contained potassium chlorate which proved to have a corrosive effect upon the metal of the firearm. This substance has been omitted from the primers of smokeless powder.

Smokeless powder primers today usually contain barium nitrate as the oxidizer. The fuel may be antimony sulfide in either new or old-style primers. The explosive ingredient is usually lead azide. The composition of primer materials varies among manufacturers; however, the metallic elements usually found in primer residues are antimony, barium and lead.

Interior Ballistics

The term "ballistics" refers to the science of the motion of projectiles. It does not refer to firearms identification.

Internal ballistics has to do with the motion of the projectile within the firearm and the forces which influence that motion.

Ignited gunpowder burns rapidly, forming large quantities of gas. One grain of smokeless powder will generate 800 to 900 ml of gas. There are 3.6 grains of powder in an S&W or Colt Special .38 cartridge. This amount of powder completely burned would yield about 2,900 ml of gas. The case of the cartridge in greatest diameter is 0.38″ and the length from base of the cartridge to the base of the projectile is 1.125″. It can readily be seen that, upon firing, a tremendous pressure is built up and exerted in all directions. The case is forced against the cylinder wall or barrel and back against the breech. These structures are unyielding. The pressure against the weakest point is the pressure toward the mouth of the case where the projectile is mounted. The pressure against the base of the projectile forces it from the case into and through the barrel and out of the muzzle.

At the time the projectile is forced from the muzzle, gases and other materials blown out of the muzzle billow out and are dispersed in a cone-shaped area.

Some gases may escape ahead of the projectile if the fit between the projectile and barrel is not tight.

Gases may escape from the space between the cylinder and barrel of revolvers. Auto-loading pistols with loose fitting slides may show leakage from the chamber through the cartridge ejection port.

Various materials are carried with the escaping gases. Metal may be sheared from the projectile as it is forced against the lands and grooves of the barrel or as it jumps from the cylinder into the barrel of a revolver with improper alignment.

Metal from cartridge cases may be present as well as metallic substances from primer residues.

Partially burned and unburned powder grains are usually carried by the gases, as is soot from the burned carbon and graphite of the powder grains.

Metal particles lodged in the barrel from previous firing and rust and oil from cleaning materials may also be present in the gases.

Flame from the burning gases is present.

The amounts of these various substances as well as the distances they may be found from the muzzle vary within limits. These limits depend upon the type and amount of gunpowder, the size and weight of the projectile, the fit between the projectile and the barrel, the length and caliber of the barrel, and the type of firearm.

These limits may be of importance to the investigator attempting to determine the distance from which an arm was fired.

The heavier the material the further it may travel from the muzzle. The projectile is carried the greatest distance.

Shotgun wadding is made of cardboard, cork composition, felt and various patented compositions. These wads may be carried as far as 50 feet.

Heavier particles from the projectile may be carried varying distances. Smaller particles of metal and unburned powder grains are seldom found more than 24 inches beyond the muzzle of a hand gun, 30 inches from a rifle.

Powder residues and soot are seldom found beyond 12 inches from the muzzle. Flame may extend from six to eight inches from the muzzle.

In all cases test firings with the firearm in question and similar ammunition are necessary to correlate distance findings.

Velocity of the Projectile

The velocity of a projectile in feet per second as it leaves the muzzle of a firearm is the muzzle velocity. Velocities of 1200 f/s or less are termed low velocities. Velocities of more than 1200 f/s are high velocities. The muzzle velocities of most pistols and revolvers with standard ammunition range from 500 to 1200 f/s.

The velocity of the projectile as it travels through the air is decreased to a certain extent by air resistance. The amount of this slowing depends upon the weight and shape of the projectile and upon the distance traveled.

The path followed by the projectile through the air is known as the trajectory.

The considerations just mentioned are termed *exterior ballistics*. The action and effects of the projectile when it strikes a target are *terminal ballistics*. Wound ballistics are terminal ballistics.

Wound Production

The effects that a projectile produces when it strikes the human body depend upon several factors.

1. The energy transmitted. This energy is measured in foot-pounds and depends upon the mass of the projectile and its velocity. The mass of a projectile is its weight in pounds divided by the acceleration of gravity (32.16

f/s). Grains divided by 7,000 equals pounds. The formula is:

$$\text{Energy} = \frac{\text{Mass} \times \text{Velocity}^2}{2}$$

2. The diameter of the projectile
3. The shape of the point (nose) of the projectile
4. The stability of the projectile (gyroscopic)
5. The resistance of the tissues.

Military experience has established approximate striking velocity values for the average type of 110 to 230 grain missiles encountered in combat. About 250 f/s is required to penetrate skin. Muscle and other deeper tissues require 750 to 1500 f/s.

The area of distribution of energy at contact is the square of the diameter of the projectile. The shape of the nose of the projectile influences the resistance to penetration.

The area of the projectile that contacts the body surface is determined by the stability of the projectile. A tumbling projectile may strike sidewise or at an angle to the nose and in this way may influence the nature of the entrance wound.

The resistance of the tissues under the skin to penetration, their elastic properties, is an important factor in wound production.

In wound production we are dealing with two forces: the disruptive force of the projectile and the retentive force of the body tissues. The amount of energy and the velocity and direction of its transmission by the disruptive force as related to the density of the body tissues acted upon are the chief factors.

Wounds produced by high velocity projectiles show the effects of an explosive, expansile action many times the diameter of the projectile and producing widespread tissue destruction far beyond the actual line of passage of the projectile.

The primary injury in wounds produced by low velocity projectiles is confined to the tissues directly in the path of the projectile.

Secondary missiles may arise from fragmentation of the projectile, metal objects carried into the body by the projectile, fragmentation of bone by the projectile. These secondary missiles may produce additional wound tracts.

Classification of Wounds

Wounds may be classified as:

1. Nonpenetrating
2. Penetrating
3. Perforating
4. Mutilating

The nonpenetrating wounds are grazing wounds or contusions produced by a projectile of very low velocity. The grazing wounds show abrasion of the skin and often contusion. There is no regular appearance. The findings about the wounds vary in relation to the distance to the firearm muzzle from the body.

Penetrating wounds represent wounds of entrance only with the projectile at the end of the tract within the body.

Perforating wounds exhibit entrance and exit wounds. These are through and through wounds with or without deflection of the missile in its course through the body.

Mutilating wounds present loss of anatomic parts, extensive tissue loss or marked disfiguration. They are usually caused by tight contact of the muzzle with the skin overlying the skull or by muzzle's being placed in the mouth.

Entrance Wounds, Single Projectile, Exit Wounds

The relationship between the size of the entrance wound and exit wound may show the following variations:

A. Small entrance, small exit. The wound tract is usually a through and through tunnel. High velocity, small arms cause this type of wounding.

B. Small entrance, large exit. Small arms at close range produce this type.

C. Large entrance, small exit. Contact wounds over the skull produce this wound relationship.

D. Large entrance, large exit. Tumbling and deforming projectiles may produce this type.

The projectile may enter the body by way of the nostril, ear canal or other natural surface opening so that no obvious entrance wound will be seen on external examination. Closed eyelids may hide an entrance wound through the globe.

Entrance wounds may be further classified according to the distance of the muzzle of the firearm from the body surface.

1. Contact wounds.
   a. Tight.

The gases, flame, and solid particles from the muzzle blast may be blown into the projectile tract. The skin may show no smudging or tattooing. The projectile contact ring will be present and show the typical abraded ring about the skin defect with or without fouling. The muzzle pattern of the firearm may be present on

the skin. The skin performation may be small and regular or it may be large and irregular, depending on the elasticity of the underlying structures. Wounds over the skull frequently exhibit a stellate splitting of the skin.

b. Partial or loose contact.

In addition to the features mentioned, burning, smudging and at times a small amount of tattooing all close to the skin defect may be present.

2. Close range wounds—six to eight inches.

Wounds in which the muzzle is within six to eight inches of the body surface are termed close range. Powder grains and metallic fragments may be imbedded deeply in the skin. Smudging from the soot of the smoke is present. The amount of soot depends upon the type of powder, caliber and length of the barrel.

The pattern of the sooting may show asymmetry in relation to the skin perforation. The denser deposit will be in relation to the sight of the firearm. Flame from the burning gases may burn the tissue and hair.

The usual projectile contact ring is present along the margins of the skin defect where the superficial skin layers are abraded. Soot and in some instances lubricant from the projectile may be transferred to the contact area. The shape of the skin defect will vary, depending on the angle of entry of the projectile.

3. Intermediate distance wounds—18 to 24 to 30 inches.

The longer barreled firearms project solid particles farther. Hand guns 18 to 24 inches from the body surface will cause no burning or smudging. Powder particles and small metallic fragments will be absent or widely distributed and not deeply embedded. The projectile contact ring will be present upon the skin margins. The skin defect may be regular or asymmetrical.

4. Distance range wounds. More than 24 to 30 inches.

Distance range wounds are those produced when the muzzle of the hand gun is more than 24 inches or the rifle more than 30 inches from the body surface. Residues and the smaller particles are absent. Larger metallic particles such as pieces from the projectile may be found. The abraded contact area is found on the wound margins. The shape of the wound may be regular or irregular.

Exit wounds

Exit wounds are characteristically larger than entrance wounds except in some contact wounds. They are frequently irregular in shape and must be differentiated from stab wounds.

Multiple exit wounds may be present from a single entering projectile when the projectile splits or bone fragments constitute secondary missiles.

Splitting of the skin without actual loss of tissue may occur. The edges of the skin may be approximated.

Projectile contact rings when present will be found on the inner side of the wound.

Skull wounds show a cone-shaped deformity or defect with the apex of the cone pointing in the direction whence the projectile came.

"Splash Back"

Projectiles whose velocity exceeds 2000 f/s impart considerable energy to the tissues. The tissues are forcibly displaced from the projectile tract in a radial direction. There is a somewhat explosive effect, temporary cavities are formed along the projectile tract, the size of the cavity depending on the energy of the projectile and the elasticity of the tissue. Tissue may extrude from the entrance wound simulating the appearance of an exit wound. The skin may rupture, leaving a large gaping wound at the site of entrance.

The structures involved in and displaced by the temporary cavitation show damage similar to that produced by explosive or hollow-point projectiles.

Shotgun Wounds

Entrance wounds

Single-ball shot shells will exhibit characteristics that have been mentioned except for tumbling. Deformity of the ball will produce irregularly shaped entrance wounds.

The distribution of the pellets from multiple shot loads will be modified by the choke and length of the barrel. The firing of test patterns is needed for proper evaluation of the pattern found on the body except in contact or very close wounds.

Wadding may be found in the wounds or wad marks upon the body surface.

Investigation

The investigation of gunshot wounds requires the application of the fundamental knowledge that has been discussed.

It is also necessary to apply the principles of proper collection, identification and preservation of evidence. The firearms identification technician may well ask many coroners whether he and his staff are helping or are part of the problem. This goes for other investigators too.

Class and individual characteristics of recovered projectiles may be mutilated or destroyed by mishandling. A necessary part of cooperation requires an understanding as to the proper collection, identification and preservation of evidence. If you are not sure how your technicians need evidence marked, by all means come to an immediate understanding.

Earlier in this discussion several questions to be answered by the investigation were listed. Many of these questions are for the coroner's office:

How many wounds are there? What is the exact location and appearance of each wound? What course did the projectile follow in the body and was its course altered?

The opinion as to whether or not the wound would incapacitate the person must be formed cautiously.

The determination of whether a wound is an entrance or exit wound will depend to a very large extent upon the investigation of the body by the coroner's office.

Clothing bearing projectile holes must be carefully preserved for further investigation.

The determination of the sequence relationship between wounds may be assisted by the securing of powder grains from each entrance wound for comparison with powder types of fired cases in the cylinder of a revolver.

The relationships of intersecting fracture lines in the skull must be known in multiple wound cases to determine sequence.

Within limits, the distance the projectile traveled before wounding should be determined by the characteristics of the entrance wound as compared to test firings.

The protection of the hands of the deceased in cases of suspected self-inflicted wounds may be easily accomplished by merely securing paper bags over them. Dermal nitrate or the newer tests developed by Dr. Harrison and Mr. Gilroy[1] may be employed. This latter method is based upon the detection of primer residues rather than nitrates.

The whole investigation adds up to careful, thorough, meticulous external examination and autopsy. The attention to detail is the secret. Intelligent cooperation between the coroner's office and the police investigators and technicians will yield the results that the security of the individual and community require.

REFERENCES

1. Harrison, H. C., and Gilroy, R.: Firearms Discharge Residues, *J. For. Sci.* 4:184-199, 1959.

6760 Greenfield Drive
Cincinnati 24, Ohio ◄

CORRECTION

The third sentence of the second paragraph of the article entitled "Vaccinia Immune Globulin Used for Vaccinia of Eyelids" by Robert William Harger, M.D. and Lucian A. Arata, M.D., page 1321, Volume 53, *JISMA* (July), 1960, which appeared originally as "One pint of blood provides the equivalent of five cc gamma globulin (1.69 mgm per cc)" should be changed to read "One pint of blood provides the equivalent of five cc gamma globulin (169.0 mgm per cc)."

A constructive criticism of the coroner system in Indiana

Program for Indiana Coroners

*PROF. RICHARD A. MYREN**
Bloomington

MY ASSIGNMENT for this meeting is to discuss what Indiana coroners might do through this Association to improve operations in the several coroner offices of the state and to change, for the better, the prevailing public attitude toward coroners. In attempting to carry out that assignment, I will discuss four points: statement of the problem, exploration of the need for facts, uses to which needed facts could be put once obtained and elaboration of some of the problems which can be anticipated in connection with any proposed legislative program.

Statement of the Problem

Indiana's coroner system was established in essentially its present outlines in 1852. The only important substantive change in the operation of the office since that time has been abolition of the coroner's jury, which occurred in 1879.[1] This is not a situation peculiar to Indiana but is characteristic of this county office across the land.[2] In many states, the office of coroner operates under essentially the same legal structure today as it did in England at the time the settlers of the United States borrowed their governmental scheme from the mother country.

When established by one of the kings of England probably shortly before the advent of the 13th century, the office of coroner was given the task of independent investigation of suspicious deaths. The office was also responsible for assuring that unclaimed goods washed up on the shores from wrecks at sea, that fishes that happened to flounder onto the shore, and that discoveries of precious metals were handled in the king's best interest. Profits from the sale of these gifts from the sea went directly into the king's coffers as did precious metals that might be found. Criminal homicide also increased the king's revenue because all of the goods of murderers, including the weapons with which they committed their crimes, were forfeited to the crown. A strong suspicion on the part of the king that the county sheriff, the officer responsible for collecting these revenues, was allowing at least a part of the profits to be siphoned off on the way to the royal treasury resulted in the establishment of the office of coroner to safeguard these revenues.[3]

This ancient history of the office of coroner is now of little other than academic interest. More sophisticated revenue sources are now relied upon for governmental support. The one remaining function of the coroner is the investigation of suspicious deaths. But in carrying out that duty, the coroner has a jurisdiction which parallels that of other modern law enforcement agencies. This is the source of one of the problems related to the coroner's office of today. Does he make a contribution to the protection of life which is commensurate with the cost of maintaining his essentially duplicating investigative efforts?

Another source of dissatisfaction which plagues the coroner of today is his inability under the law to investigate deaths attributable to contagious disease and industrial hazard.[4] Greater information than is currently available is needed in both of these areas. If the coroner

* From the Department of Police Administration, Indiana University. Currently on leave as Consultant on Law Enforcement Programs, Children's Bureau, Department of Health, Education and Welfare, Washington 25, D. C.

were able to investigate such deaths in a manner similar to his investigation of deaths in which foul play is suspected, the information necessary for control would become available.

This restriction in the law which limits the investigation of coroners to those deaths which are suspicious from the beginning also precludes the discovery of an appreciable number of clever criminal homicides. Enough such cases are discovered by accident to make it obvious that systematic investigation of every unexplained death would turn up many more.[5]

Still a fourth source of criticism of present operation of the Indiana coroner system is the problem of financing difficult investigations. A common complaint is that the coroner does not have the money at his disposal when he needs it. A recent study commission found this to be the case "in many counties" in Indiana.[6]

Perhaps the most frequently heard comment on the Indiana coroner system is that the corooners are concerned primarily with the medical determination of cause of death which most of the incumbents, even if physicians, are unqualified to make, working alone. It is argued that this is a job for a medical specialist, the forensic pathologist.

These criticisms may be summarized as duplication of existing services, limitation of jurisdiction to a scope too narrow to meet current needs, incompetence to make the specialized medical determination required of them and inadequate arrangements for financial support.

Most of these problems can be traced directly to official and public apathy. Malfunctioning of the coroner system is difficult to detect. The dead are buried and gone. Other law enforcement agencies are investigating criminal homicides. This makes it difficult to arouse interest in modernization, in keeping the legal structure of the coroner system up to date. The office of sheriff is even older than that of coroner, yet the sheriff is an admittedly indispensable officer of the county today. He has kept that position because his duties have continually changed with the times. The legal structure of the office has frequently been overhauled to meet changing conditions and to take advantage of newly developed governmental technics. The coroners of Indiana have a problem today because they have refused to face problems in the past.

Need for Facts

Although it is relatively easy to discover that the coroner system of Indiana is in trouble, it is not so easy to discover the exact nature and scope of the factors contributing to that problem. More facts are needed. There is an obvious immediate need for an accurate picture of the system as it is operating today.

Who are the coroners of Indiana? What is their background of training and experience which fits them for the office? How many deaths are occurring in each county each year? How many of these are being investigated? Of those investigated, how frequently are autopsies performed on the bodies of the deceased? How many cases are being closed with no determination or with an unsatisfactory determination of cause of death? What is the direct cost of the office to the county, both on a per case and a per capita basis? Who are the coroners who seem to be doing an outstanding job? What practices do they follow which might be useful to other coroners? What do the men in the offices believe to be their most serious handicaps? What is the exact legal and financial structure within which the system must operate?

These are questions for which there should be answers. These are questions to which there can be answers. Most of this information is in the hands of the coroners themselves. Some could be obtained from the State Board of Accounts. Some could be obtained from the State Board of Health. In cases where cooperation was not forthcoming, imaginative investigation would turn up other sources for at least intelligent estimates.

This description of current operations should be supplemented by an evaluation of current needs. What would be the increase in case load if contagious disease and industrial hazard were added to the jurisdiction of the coroner? What would be the increase in cost? What additional facilities and services would be needed, if any? Are there needs other than in the fields of criminal homicide, contagious disease and industrial hazard which might be satisfied through a revamping of the office of coroner? Some of the spade work in this area has already been done by the Forensic Sciences Study Committee appointed pursuant to an act of the 1957 General Assembly. The formation in recent years at the state level of the Toxicology Laboratory and

the Commission on Forensic Sciences also raises the problem of correlating the operations of the county office of coroner with these state offices. In addition, it is possible that a careful exploration would disclose other resources at the state level which county coroners could utilize to advantage.

This need for facts can be satisfactorily met only with a well-correlated study under the direction of some person well-grounded in research technics. It may be that such a person could be found in one of the state colleges or universities for whom this study would serve some professional purpose. An inquiry might be made to the Bureau of Government Research at Indiana University as to possible assistance.

Uses for Survey Facts

Facts obtained in a survey such as the one recommended could be used for at least four purposes: education of coroners as to the difficulties which might be encountered in the execution of their duties; education of coroners as to operating improvements which can be made within existing legal structures; education of the public as to the proper role of the office of coroner and as to the legal limitations on his operations; and education of the legislature as to needed changes in the laws relating to the office of coroner.

One of the uses to which the results of a study could be put would be the writing and publishing of a manual for coroners which would be available to any new coroner when he took office. This manual could explain the constitutional and statutory provisions pertaining to the office and recommend technics of practice and administration which have been proven in use in Indiana. It could also warn as to some of the difficulties which are encountered and how these have been met by previous coroners. In this regard, the Indiana Coroners' Association could follow the lead of the Indiana Sheriffs' Association which has published, in conjunction with Indiana University, a manual of law and practice.

If such a manual were written or, less effective to be sure, even if one were not written, the materials collected during the study could serve as the basis for periodic study conferences for coroners. Both law and practice in those jurisdictions where the operation of the coroner seems to meet with particular success could be discussed by the study workers.

If previous studies can serve as a guide, tremendous opportunities for improvement in the operation of our existing coroner system would be discovered even without the aid of new legislation. It is seldom, for example, that the onerous job of recordkeeping is given the attention that it deserves through the years. Devising a set of standard report forms to be published by the association with complete instructions for their use in an accompanying booklet would probably be both a profitable venture for the association and a significant contribution to more effective operation of the office. The same could be said for a pamphlet describing available services frequently needed by a coroner. Such a pamphlet would outline the situations in which specialized services are needed, list the sources from which they are available across the state and estimate the probable cost to the county. These are but examples of improvements which could be made by the association without new legislation if the needed information were available.

This information could also serve as the basis for a concerted constructive public relations program on the part of the association. Any citizen knows that if he hires a carpenter to work with a hand saw and hammer more work will be accomplished than if the man has power tools. The same is true with the county coroner. He operates with all the handicaps of outmoded legal and financial tools. He also operates without a clear mandate as to the social purpose which he is to serve. Pointing up these shortcomings with facts to stand behind the assertions would lead to a realization that in many cases the coroner is doing as good a job as the tools given to him by the people will allow.

A similar approach could be taken with the legislature if it were decided that legislation is needed to revitalize the office of coroner. Backed by factual information from the survey, the association could campaign for changes in the legal structure of the office in a manner which the legislature could not and would not wish to ignore. Legislators are interested in making worthwhile changes in the laws, but they have enough well-considered proposals made to them at each session so that they are not going to waste their time on proposals which are not well thought out and documented.

Selling a Legislative Program

One of the eventualities that usually follows from a thorough study of any long neglected and dark corner of the law is a need for change in the legal structure. This can be accomplished only by legislation. Persuading a legislature to make these changes requires a selling job. In this particular kind of selling, there are certain technics of proven effectiveness which it would be well to keep in mind.

Perhaps the first rule in promoting a legislative program is that it must be taken to the legislature by some group interested in the change. There are relatively few programs which spring from the collective brow of any legislature without pressure from some outside source. It is certainly true in this regard that the squeaking wheel gets the grease. For this reason, many groups such as this association have found it advisable to hire a legislative counsel to assist them in formulating and selling their program to the legislature. Those associations which have a full-time executive secretary to assist their members may rely on him for this service during the legislative sessions. Even where individual association members have the know-how, time and inclination to assist in pushing the program through the legislature, central direction from paid personnel can assist in making given resources count the most. In sum, the program must be taken to the legislature, and taken there effectively.

Such a program must always be based on fact. No program can expect to sail the legislative sea without opposition. None is more sensitive to a current of opposition to any program than the legislator to whom it is presented. If he was not acutely aware of community sentiment and how to appraise it, he would not be in public office. A legislative program can overcome opposition only if it is soundly based on fact. The factual survey must pinpoint the probable sources of opposition to the effort and have the answer for these critics. Anticipation of opposition is half the battle in meeting it.

Get an Early Start

Another secret of success with legislative programs is an early start. The research should be done and the program formulated prior to the elections which determine the composition of the legislature. The content of the program should be presented to those legislators who are known to be returning as soon as it is established, and to newly elected senators and representatives immediately after the election. The proposals should be presented in the form of bills as early in the session as possible, on the first day if this can be arranged. They should be followed effectively through the legislative hopper by knowledgeable guides who can identify times and occasions on which an organized presentation in support is needed. In addition to identifying and meeting opposition, persons who are uncommitted must be identified and convinced.

In addition to having a sound program based on fact which meets probable opposition in advance, the supporting group must show that it is helping itself and that the new legislation will be effectively utilized if provided. This is where the selling of the information from the study to the coroners themselves becomes important. It is also wise to separate those proposals which require appropriations for implementation from those which do not, since laws which cost no money are never as unpopular as those which do. Still another successful device is the use of permissive legislation which enables but does not command a county to make certain changes. Probably the most important strategy consideration of all, however, is to go slowly, at least at first. Complete and comprehensive changes in governmental structure are seldom made, except in areas where dramatic public support can be mustered. As mentioned above, this is improbable, if not impossible, when dealing with the coroners' law.

A practical program based on fact well presented to the legislature early in the session in the form of enabling legislation, where this will do the job, has an excellent chance of success. Neglect of any of these factors is asking for trouble. Nor should any group be disheartened if less than its full program is accepted at the session of the legislature when first presented. Repeated submissions may be necessary. One might guess that an average program is before at least three sessions of the legislature in some form or another prior to complete realization. Continued effort is the price of progress.

Summary

In closing, I would like to say that Indiana coroners share the problems which have been faced by coroners all over the United States

and in England as well. These problems arise from decades, even centuries of neglect of the office. To deal with these problems, facts are required. Facts are needed to clarify the coroners' own position, to present that position to the public, to accomplish such reforms as are possible within the framework of existing law and to sell the legislature on changes in the law where needed. There are a few rather simple, common sense rules to remember in attempting this selling job on the legislature. But the bright side of this picture is that coroners in several states have demonstrated that, when they have the facts, they can do much for themselves and can persuade the public and the legislature to do for them that which is beyond their personal control.

REFERENCES

1. For a discussion of the legal structure of the office of coroner in Indiana today, see Note, 31 *Indiana Law Journal* 296 (1956).
2. Detailed studies of particular state systems include Minnesota Legislative Research Committee: *The Coroner System In Minnesota* (1954); Myren: *Coroners In North Carolina* (1953); Blair: *The Office of County Coroner In Kansas* (1953); Johnson: The Wisconsin Coroner System, 1951 *Wis. L. Rev.* 529; Breyfogle: The Laws of Missouri Relating to Inquests and Coroners, 10 *Mo. L. Rev.* 34 (1945).
3. See generally, Menhennitt: Coroners and Coronial Inquests, 1 *Res Judicata* 109 (1936); Langbein: Jury of Presentment and the Coroner, 33 *Col. L. Rev.* 1329 (1933); Schultz: *The Coroner's Office,* American Academy of Political and Social Science Pub. 713 (May 1913).
4. *Ind. Ann. Stat.* § 49-2904 (Burns 1951).
5. From the wealth of literature on this subject, see the following articles dealing particularly with the Indiana situation: Davis: What Kind of Help Does the Indiana Coroner Need?, 50 *J. Ind. State Med. Assn.* 1252 (1957), and Smith: Does the Indiana Coroner Need Help?, 49 *J. Ind. State Med. Assn.* 1457 (1956).
6. "Report of the Forensic Sciences Study Commission," Indiana Legislative Advisory Commission Report to the 1959 Indiana General Assembly, pp. 107-109 (1958). ◄

Denatured Language, Hard Reading

In the rush to publish, padding and jargon are often employed to make up for a paucity of content. Inadequate attention is given to the meaning of words, and the influence of careless speech in daily life casts a long shadow on much scientific and technical writing.

This does not mean that technical terms should not be used. On the contrary, there is a legitimate use for a specialized vocabulary that can be employed for precise and economical communication by experts in a given field. This is one reason for the use of mathematical language in certain branches of science.

The fact is that technical terminology is like all language in that most words have several meanings or shades of meaning, that these tend to change in the course of time and that new words or old words with new meanings are bound to come on the scene. Any editor must learn to accept this fact of life.

At the same time, such recognition cannot be used to excuse sloppy writing that results from fuzzy thinking, or from the employment of denatured language acquired from textbooks and learned treatises, or from a combination of these factors. The editors must endeavor to offset the corrupting effects of such influences, for as Sheridan stated so succinctly and forcibly: "Easy writing's vile hard reading."—George Rosen: Editorial Viewpoints. *International Record of Medicine,* July, 1960. Reprinted in *U. S. Armed Forces Medical Journal,* Vol. 11, No. 11.

The Journal of the Indiana State Medical Association

MEDICAL ESSAY CONTEST

for

Interns and Residents of Indiana Hospitals

During the intern and resident year of 1960-61 The Journal is sponsoring a medical essay contest open to interns and residents of hospitals in Indiana. The subject matter will be limited to clinical experience observed primarily in the teaching hospital of the author. Presentations may contain up to 4,000 words and preferably should be illustrated with clinical pictures, graphs or tables.

A first prize of $100.00, a second price of $75.00 and a third prize of $50.00 will be awarded. All entries are eligible for consideration for publication in The Journal.

Manuscripts will be judged by a prize award committee selected by the Editorial Board of The Journal and by the Dean, Indiana University School of Medicine.

Manuscripts should be prepared in accordance with the specifications outlined on the masthead page of The Journal.

Entries must be submitted prior to May 1, 1961.

The manuscript itself is to be identified only by the title. The author's name must not appear in the manuscript. Instead, a special title page bearing the title and the author's name and address should accompany the paper. Mail entries to Mr. James A. Waggener, 1021 Hume Mansur Bldg., Indianapolis 4.

Second Award Winner
Journal Essay Contest

Pheochromocytoma and Neurofibrosarcoma In a Patient with Neurofibromatosis

*HARLEY P. PALMER, M.D.**
Indianapolis

THE TENDENCY of pheochromocytoma to occur in patients with neurofibromatosis (von Recklinghausen's disease) is well recognized. Glushien, Mansuy and Littman[1] found 17 such cases in the literature and reported one additional case in 1953. A review of the literature from 1953 to 1959 by Chapman, Kemp and Taliaferro[2] revealed 17 more cases including three of their own. These latter authors found an incidence of 25% of neurofibromatosis in patients having a pheochromocytoma.

The phenomenon of malignant transformation to neurofibrosarcoma occurs in 10-15% of persons afflicted with neurofibromatosis.[3,4] Further, one-half of the cases of neurofibrosarcoma occur in patients with von Recklinghausen's disease.[5]

No additional case reports of pheochromocytoma occurring with neurofibromatosis were found in the literature since those of Chapman et al.[2] The purpose of this paper is to report another such case in a patient also suffering from the malignant counterpart of a neurofibroma. Embryologic basis and some of the clinical applications of this association of lesions will be discussed.

* From the departments of pathology, Marion County General Hospital and Indiana University School of Medicine. Second award winner *Journal* Medical Essay Contest, 1959-60.

Case Report

A 51-year-old Negro female complained of a sensation of heaviness in the lower abdomen and of pain in the coccygeal region of four weeks duration upon entering the hospital. The coccygeal pain had become intense and had radiated into the right leg by the time of hospitalization. She stated that she had not had a bowel movement the two weeks prior to this examination, and denied bleeding from the vagina and rectum.

She was last seen 11 years previous to the current admission at which time she was treated for recently acquired syphilis. At that time her blood pressure was recorded as 130/80 on several occasions, and there was noted a mass in the region of the right broad ligament of the uterus approximately the "size of a hen's egg." Microscopic study of several of the skin tumors, over a period of six years, revealed neurofibromas compatible with von Recklinghausen's disease.

There was no family history of neurofibromatosis recorded. The patient's mother and brother were living and apparently in good health. Her father and two sisters had died of unknown causes, and one sister had died of tuberculosis.

Elevated Blood Pressure

Physical examination revealed a moderately obese Negro female with skin lesions typical

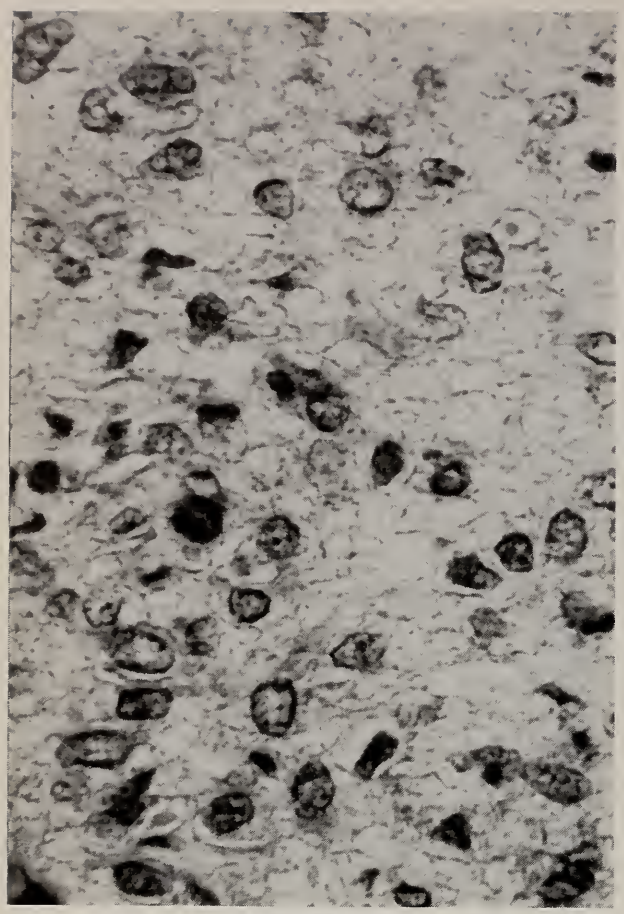


FIGURE 1
NEUROFIBROSARCOMA. Note cellularity, nuclear variation and the mitotic figure. H. and E. X 575.

of neurofibromatosis. Significant findings upon physical examination were limited to the heart, blood pressure, abdomen and pelvis. In spite of an elevated blood pressure, the heart was not enlarged. There was a soft, systolic murmur heard at the aortic valve area. The abdomen was moderately obese and no masses were palpated, but there was tenderness to deep palpation in the right lower quadrant. On pelvic examination a mass was believed to be present in the right pelvic fossa. Rectal examination revealed the presence of fecal impaction. Neurological examination was not remarkable.

The temperature was normal, the pulse 88, respirations 22 and the blood pressure was 220/120.

Examination of the blood revealed a hemoglobin of 12.2 gm per 100 ml, a red-cell count of 3,990,000 and a white-cell count of 5,800 with a differential of 66% neutrophils, 33% lymphocytes and one percent monocytes. The Kahn test was negative and the Klein test was doubtful. Routine urinalysis was not remarkable.

An x-ray examination of the abdomen was not noteworthy.

An exploratory laparotomy was performed on the third hospital day. A smooth, glistening, retroperitoneal tumor was found to be firmly attached to the right sacro-iliac region and loosely adherent to the rectum. It measured 4.5 cm in diameter. A small portion of the mass was removed for microscopic study.

Prior to the administration of anesthesia her blood pressure was 208/128. Thirty minutes after beginning ether anesthesia and five minutes after placing the patient in Trendelenburg position, her blood pressure dropped to 100/90 and it remained at this level throughout surgery even though the administration of whole blood was begun at this time.

Develops Adynamic Ileus

The patient's temperature ranged from 102-103° F. throughout her postoperative course. On the second postoperative day she developed adynamic ileus which was partially relieved by the introduction of a Miller-Abbott tube and enemas. Five hours before her demise, on the fourth postoperative day, she complained of extreme nervousness, inability to sleep and severe weakness. Blood pressure was not recorded at this time, but the pulse was 160 per minute and the respirations were labored at 36 per minute. She then lapsed into coma and died.

At the autopsy the skin tumors were again noted. Weight of the heart was 390 gms, and the wall of the left ventricle was slightly hypertrophied. Lower lobes of the lungs contained a moderate amount of frothy, hemorrhagic fluid. The peritoneal cavity contained approximately 500 ml of serosanguineous fluid. Retroperitoneal tissues of the pelvis were bloodstained. The previously described pelvic mass had eroded into the bones of the sacro-iliac region. Its origin from any recognizable structure could not be demonstrated. The left adrenal cortex enclosed a mass, 1.5 cm in diameter, which was dry, granular and of rusty-orange color on its cut surface. The brain was not examined, but a postmortem spinal fluid examination was normal.

Microscopically, the pelvic tumor was composed of areas of spindle-shaped cells with a tendency to palisading of nuclei alternating with areas of cellularity showing nuclear variation and a rare mitotic figure (Figure 1). There were several areas of necrosis noted in



FIGURE 2
NEUROFIBROMA of the skin. H. and E. X 60.

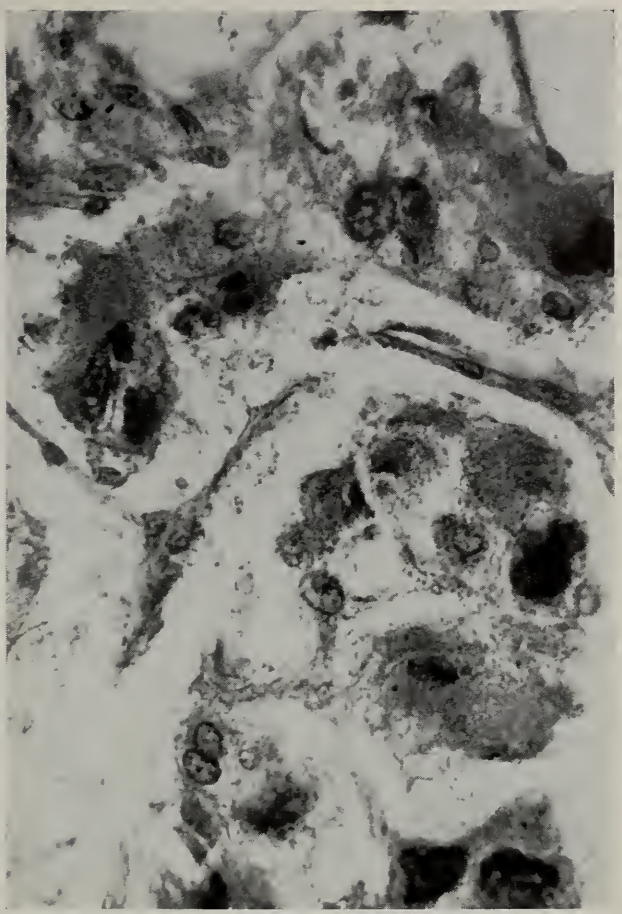


FIGURE 3
PHEOCHROMOCYTOMA. Note the bizarre nuclei, cytoplasmic granules and the delicate connective tissue septae. H. and E. X 425.

the tumor. Microscopic sections of a skin tumor were compatible with a neurofibroma (Figure 2). Microscopically, the adrenal tumor compressed the surrounding adrenal cortex. It was composed of islands and sheets of large cells with eosinophilic cytoplasm and often bizarre nuclei. These groups of cells were separated by vascular, delicate strands of connective tissue. Many of the cells contained fine, brown granules within their cytoplasm (Figure 3).

Discussion

Incidence of pheochromocytoma occurring in patients with neurofibromatosis is striking. Glushien et al.[1] and Hollenhorst,[7] in separate papers, reported the incidence as 5-10%. Later series by Cahill et al.[6] and Chapman et al.[2] revealed an incidence of 20% and 25% respectively. If individuals with incomplete or "abortive" forms of neurofibromatosis were included in these series, the incidence would be even more striking. "Abortive" forms of the disease include patients with café-au-lait spots[4] and patients with only neurofibromas of the eyelids.[9]

Glushien et al.[1] found that pheochromocytoma occurred in or about the left adrenal in 13 of the 18 cases he reported. For this reason, he emphasized surgical exploration of the left side of the abdomen in patients with a suspected pheochromocytoma and von Recklinghausen's disease. However, the left adrenal was affected in only five of the 18 subsequent cases reported. In the 36 cases reported to date the left adrenal was involved in 19 cases, the right adrenal in 13 instances and both adrenals in three cases. It was not stated which adrenal was affected in one case report. The right adrenal is affected in 60% of the patients not having neurofibromatosis,[8] and perhaps this shall not differ appreciably in patients with neurofibromatosis as more case reports are accumulated.

Neurofibromatosis, Sturge-Weber syndrome, von Hipple-Lindau's disease and tuberous sclerosis have been grouped together as the neurocutaneous syndromes by several authors. This classification is justified since all are congenital, probably all are familial and the major lesions

of each involve structures of ectodermal origin. However, lesions also occur in mesodermal derivatives (kidneys and pancreas) in Lindau's disease. Further, pheochromocytoma is of ectodermal origin and is probably familial in certain instances.[10, 11, 12]

The primitive brain and spinal cord begin as the neural plate which invaginates, fuses and forms the neural tube by the fourth embryonic week.[13] The neural crest lies between the neural plate and the general ectoderm before the neural tube is formed. When the neural tube is anatomically separated from the general ectoderm the neural crest lies between the neural tube and the overlying general ectoderm. The cells of the neural crest give rise to ganglion cells, supportive neural tissue and the chromaffin cells of the adrenal medulla.[14]

By the seventh embryonic week the future chromaffin cells of the adrenal have migrated from the primitive ganglia of the coeliac plexus, and have begun to invade the already formed cortical primordium. These chromaffin cells lie in the center of the adrenal gland at the end of fetal life. Thus, a defect in the primitive neuroectoderm could account for the association of the neurocutaneous syndromes with one another and with pheochromocytoma.

Association of pheochromocytoma with von Hipple's disease was first proposed by Glushien et al.[1] in 1953. These authors reported two such cases, and Chapman et al.[2] reported a third case and reviewed a probable fourth case in 1959. Pheochromocytoma in association with other neurocutaneous syndromes has not been reported, but perhaps will be as physicians become more aware of this association of entities.

All physicians are aware of the classical manifestations of a pheochromocytoma. Besides the paroxysmal hypertension, diaphoresis, tachycardia, severe headache and palpitation, acute abdominal pain is observed in 10-15% of patients[15] during a hypertensive crisis. It has been repeatedly emphasized that 70% of the patients with an active pheochromocytoma have a sustained, chronic type of hypertension rather than the classic paroxysmal hypertension. Of the 50 cases of pheochromocytoma reported by Green,[16] 37 of the patients suffered from a chronic type of hypertension.

Besides the usual complications of hypertension, patients with pheochromocytoma often develop clinical shock.[17, 18] Apgar and Papper[18] reviewed the literature in 1951 and observed that the operative mortality in patients with unsuspected pheochromocytomas was 50%. In addition, they found that 15 of the 16 that died, did so within 48 hours of surgery in a state of irreversible circulatory collapse following an episode of acute pulmonary edema.

Signs of Shock Before Death

Although no blood pressure reading was recorded, our patient manifested signs of clinical shock shortly before death, and this appeared to be the immediate cause of her death. Moderate pulmonary edema found at autopsy lends support to this hypothesis. Further, the extreme nervousness, weakness and inability to sleep that this patient experienced five hours before death may have represented a hypertensive crisis followed by the pulmonary edema, shock and death.

With this severe degree of hypertension, it is of interest that the heart was only slightly enlarged. One must conclude that she suffered from either a paroxysmal type of hypertension or a sustained, chronic hypertension of relatively recent onset.

In this patient, the question arises whether the mass palpated in the right side of the pelvis 11 years prior to the final admission was a neurofibroma that underwent malignant transformation. It is logical to assume that this sequence of events did occur.

When patients with either a complete or incomplete neurocutaneous syndrome develop hypertension, pheochromocytoma should be suspected. Also, whenever elective surgery is planned in such patients, a careful search for the presence of a pheochromocytoma should be undertaken.

It is noteworthy that neurofibromas of intercostal nerves may produce bilaterally symmetrical rib notching simulating that seen with coarctation of the aorta.[19] With no other evidence of coarctation in such individuals, the presence of a pheochromocytoma should be considered in the differential diagnosis.

Summary

A case of pheochromocytoma associated with neurofibromatosis is reported. This is believed to be the 36th such case in the literature. Malig-

nant transformation of a neurofibroma was also observed in this patient.

The possible association of pheochromocytoma with other neurocutaneous syndromes is re-emphasized.

Some of the clinical implications of this association of entities are discussed.

ACKNOWLEDGMENT

The author gratefully acknowledges the assistance of Mr. Robert Albright, clinical photographer, Marion County General Hospital, and the encouragement received from P. V. Evans, M.D. and T. A. Stump, M.D.

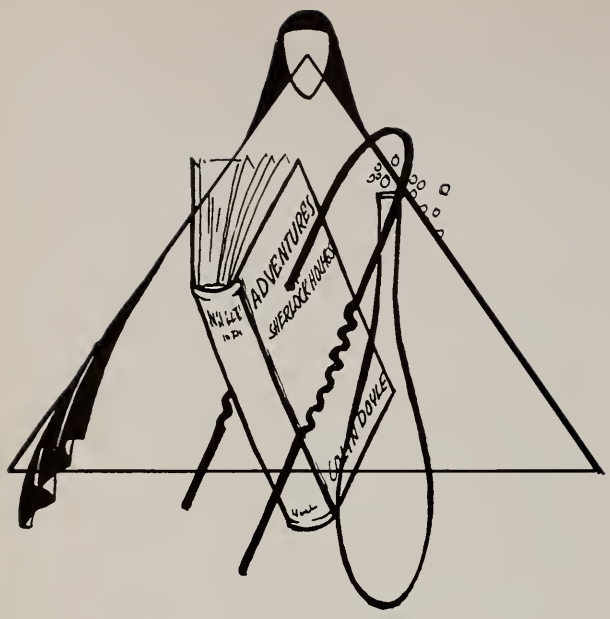
REFERENCES

1. Glushien, A. S., Mansuy, M. M., Littman, D. S.: Pheochromocytoma: its relationship to the neurocutaneous syndromes. *Amer. J. Med.* 14:3, 1953.
2. Chapman, R. C., Kemp, V. E., Taliaferro, I: Pheochromocytoma associated with multiple neurofibromatosis and intracranial hemangioma. *Amer. J. Med.* 26:6, 1959.
3. Hosoi, K.: Multiple neurofibromatosis (von Recklinghausen's disease), with special reference to malignant transformation. *Arch. Surg.* 22:258, 1931.
4. Penfield, W., Young, A. W.: The nature of von Recklinghausen's disease and the tumors associated with it. *Arch. Neurol. & Psychiat.* 23:320, 1930.
5. Smith, E. B., Beamer, P. R., Vellios, F., Schulz, D. M.: *Principles of Human Pathology.* Ed. 1, New York, Oxford University Press, 1959, p. 1123.
6. Cahill, G. F., Monteith, J. C.: The use of dibenamine and norepinephrine in the operative treatment of pheochromocytoma, report of two cases. *New England J. Med.* 244:657, 1951.
7. Hollenhorst, R. W.: The ocular changes associated with pheochromocytoma. *Amer. J. Med. Sc.* 216: 226, 1948.
8. Smithwick, R. W., Greer, W. E. R., Robertson, C. W., Wilkins, R. W.: Pheochromocytoma: a discussion of symptoms, signs and procedures of diagnostic value. *New England J. Med.* 242:252, 1950.
9. Yakovlev, P. I., Guthrie, R. H.: Congenital ectodermatoses (neurocutaneous syndromes) in epileptic patients. *Arch. Neurol. & Psychiat.* 26:1145, 1931.
10. Greenberg, R. E., Gardner, L. I.: Pheochromocytoma in father and son: report of eighth known affected kindred. *J. Clin. Endocr. Metab.* 19:3, 1959.
11. Cone, T. E., Jr., Allen, M. S., Pearson, H. A.: Pheochromocytoma in children. *Pediatrics* 19:44, 1957.
12. Cone, T. E., Jr., Recurrent pheochromocytoma, *Pediatrics* 21:994, 1958.
13. Arey, L. B.: *Developmental Anatomy.* Ed. 6, Phil. and London, W. B. Saunders Co., 1954, p. 680.
14. Hamilton, W. J., Boyd, J. D., Mossman, H. W.: *Human Embryology.* Baltimore, 1952, Williams & Wilkins Co.
15. Healey, Frank H., Jr., Mekelatos, C. J.: Pheochromocytoma and neurofibromatosis. *New England J. Med.* 250:11, 1958.
16. Green, D. M.: Pheochromocytoma and chronic hypertension. *JAMA* 131:1260, 1946.
17. Clinico-Pathologic Conference. *Amer. J. Med.* 19:6, 1955.
18. Apgar, V., Papper, E. M.: Pheochromocytoma; anesthetic management during surgical treatment. *Arch. Surg.* 62:634, 1951.
19. Holt, J. F., Wright, E. M. The radiologic features of neurofibromatosis. *Radiology* 51:647, 1948. ◄

How to Avoid Malpractice Suits

The material appearing in the medical journals not only keeps doctors up to date; it may also have the effect of increasing the doctor's medicolegal liability. A court may reason that if the dangers of a particular procedure have been reported in the medical literature, then the reputable physicians in the locality should know of such dangers and a physician who uses such a procedure must be guilty to malpractice. . . . Such articles not only increase the possibility of a lawsuit, they also make such suits harder to defend.

Medical journals are a two-edged sword. They cannot cease publication merely because they are a possible benefit to dissatisfied patients, however. In the long run, the profession and the public are best served by honest and unbiased reporting in the medical press. The lesson of importance for all physicians, though, is *read your medical journals!*—George E. Hall: A Vicious Medicolegal Circle. *The New Physician,* Nov. 1958. Reprinted in the *U. S. Armed Forces Medical Journal,* Vol. 11, No. 11.



The Case of the Four-Sided Triangle

*ARNOLD LIEBERMAN, M.D.**
New York, N. Y.

THE PRINCE of the Church was in possession of the essential facts when he gave this terse summary to the case; however, it might be less confusing to present the tale as it actually unfolded.

It was somewhat flattering to learn that a physician requesting consultation with me was one of New York's truly "big names." I had been in Manhattan for only a short time. He was cordial, brisk and to the point: "This patient's employer says he has known you since way back; he wishes to have you called. The case has bizarre features; we both might learn; the fee will be maximal; how about seven o'clock tonight?"

Promptly at seven, we were closeted together going over the folder of the case. Nicholas Frigovich had been born in Cairo, Egypt some 35 years ago; single; graduate of Beirut University in chemical engineering. He had been working in Cairo earning a scanty living doing odd jobs for an Aramco subsidiary. John M. Gardener, the present employer, had met Nick at this plant, hired him, and taken him along when he went back to the States. Nick appeared to have made himself indispensable. Until two weeks ago, he had been in rugged good health: at that time, he began to have some blurring of vision and dull, diffuse, protracted headaches. At first, the patient thought he was suffering from just a severe cold; rhinorrhea, mild dyspnea and lassitude lent credence to the supposition.

Symptoms Worsen

Instead of abating, the symptoms worsened; the rhinorrhea became very distressing; profuse salivation developed; breathing became so difficult that, at times, the patient almost panicked into a fear of suffocation. The employer was very solicitous: it was he who insisted on Frigovich going to see the doctor in his office.

"Who is this employer?"

"Why, Mr. Gardener says he knows you very well: He is an industrial chemist who made a fortune with his own company marketing stuff he has invented and patented—insecticides, fertilizers and such."

A very thorough examination had shown no abnormalities. True, the pupils tended to be constricted but homatropine dilated them readily and the fundi were absolutely normal. The dyspnea did not seem to originate from the heart or lungs; all x-rays and the E.K.G. were within the normal ranges; all the usual and unusual laboratory tests checked out entirely humdrum. The man had been reassured firmly, given an R_x for a mild anti-histaminic and dismissed.

---

* One of a series of case reports. Dr. Lieberman formerly practiced in Lake County, Ind.

That very evening, the doctor had to make an emergency call on Frigovich. Nicky had a sudden convulsion, foaming at the mouth and choking. Mr. Gardener had turned on the powerful ventilator blowers, pulled out Nicky's tongue, wiped off the drooling saliva and done other chores while waiting for the physician. Nick had both vomited and lost control of his sphincters. First the patient had babbled in Arabic but had recovered rather rapidly from his semicomatose, limp state. He was taken to the hospital via ambulance.

Nothing Abnormal

The doctor was emphatic in telling me that there was no evidence whatever of heroin, marijuana, mescaline, alkaloids, heavy metals or anything else even remotely abnormal. There were no vials, hypodermic needles or any suspicious appurtenances. No! there was no odor of anything excepting the fragrance from a bouquet of flowers Mrs. Gardener had sent the patient. Oh, yes! Mr. Gardener was married to a woman younger than himself—"quite a lovely lady."

In the famous institution to which Frigovich had been taken, all conceivable tests were undertaken; repeated E.E.G's, spinal taps, myelographs, pneumoencephalograms, electrolyte balance studies, poisons mundane and exotic, photometric and tracer isotope tests, immunoelectrophoretic investigations for aberrant amino-acids—everything checked out as being normal.

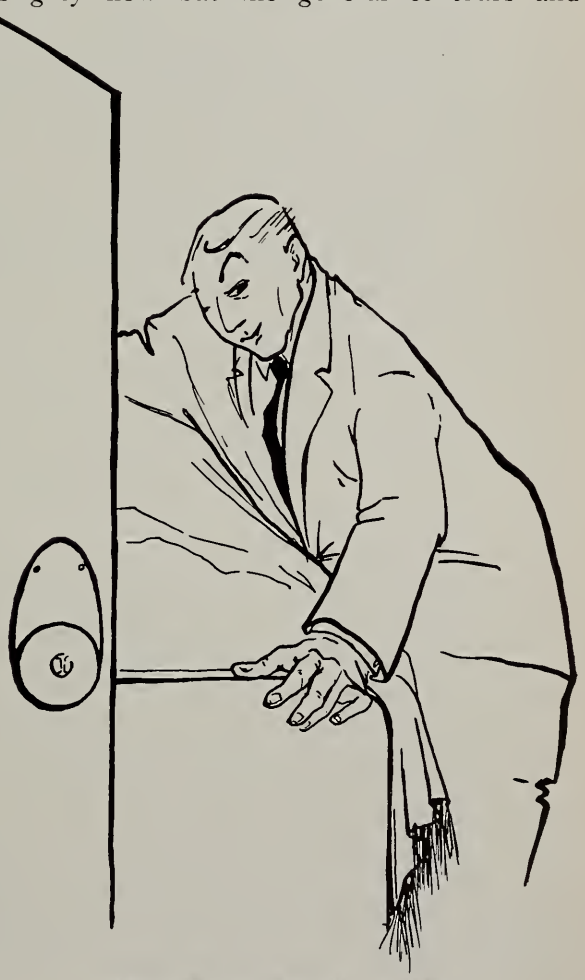
After ten days' snooping and probing by a bevy of certified 'ologists, Frigovich was discharged. This had been just the day previous to my being called. While the patient's condition was excellent, physically speaking, there was some vague talk by him about "them" trying to get him; this had led the psychiatrists to consider early paranoia or schizophrenia but the attending physician was unshaken in his conviction that there had to be a *real* reason for the violent seizures that he had been privileged to see. Certain cerebral growths just could be the underlying cause; however, he felt that such things as periodic familial paralysis, all known myopathies and neuropathies, all imaginable poisonings, cerebral aneurysms and such—had been ruled out. In short, the doctor was sorely puzzled and made no bones about it.

At the penthouse apartment we were escorted directly to the patient's bedroom. Nick Frigovich was a fleshy, ruddy-cheeked, rather untidy person lying propped up on a couple pillows. He seemed apprehensive but neither acutely or chronically ill. The luxuriant, curly hair and a very flashy, hooked nose went with thick, sensuous lips which had a hint of lipstick on them; a touch of mascara and the shaved eye brows gave him a rather *pretty* look even if there was no denying the intelligence in the grave eyes.

Just as the introductions were being completed, the patient's employer bustled in from the other door leading to the laboratory. First, he went over to the bed and embraced Nicky quite effusively; then he turned full face to me with, "Hello, there; long time no see."

Halitosis Foul as Ever

The feed-back neurons of my memory did a pin-pointing flash-back. This was the Czech World War I refugee, 10 years my senior, who had sat next to me in the general chemistry course I had taken as a freshman in college. At that time, he had been a rather sallow, dyspeptic little runt with a dank lock of hair hanging over a streaked, greasy forehead. It was grey now but the general contours and



Hello there; long time no see!

build were unforgettable. At that time, I had been a very naive youngster of 17 who did not quite grasp why that splendid student had always been repellent to me. Now, I was very much older, maybe more aware of the depravities which had instinctively made my hackles rise when he had sidled next to me—oh, so many decades ago. Of course, the creature before me was Jan Milosadovic; the voice had authority in it but the harsh, Czech rasp was unmistakable and—by Jove: the halitosis was as foul as ever.

Jan spoke again, "Oh, yes: You knew me as Jan Milosadovic. You must approve the neat translation, John Merry Gardener; quite clever of me, don't you think?" Gardener—Jan, that is—relaxed into a chair while the two doctors went over the patient. Sotto voce, I asked the attending physician, "Is the patient's rectal sphincter snug?"

"HIS (pointing to the patient) is; THAT one's I don't know about, but we agree on our guesses, I take it;" this was said under his breath into my ear.

The physical examination turned up nothing new; there was the formidable sheaf of reports on the patient that I wished to peruse. As we were preparing to leave, Jan spoke to me directly, "Oh, doctor: Let me show you around my diggings; I won't detain you long!" It was impossible to refuse.

Jan led me directly into the laboratory. It was huge, of baronial hall vastness, crammed with the usual desks, rows of bottles, granite sinks, fancy balances, safety hoods, spectrophotometers, a massive little safe for isotopes, miniature cracking set-ups—also, several cages with rats and one with a couple of canaries. Noticing my obvious surprise at the lavish layout, Jan oozed satisfaction even as he gloated; "A lot better than that junk in old Kent, N'est-ce pas?"

As we were going by his personal work bench, I could not help noticing an almost full, paraffin sealed vial bearing a multicolored marking, thus: F—P—OR. Just as I was reaching for a closer look, Jan rasped, "Be careful how you handle things here: Don't you know any better?"

The positive hatred in his sudden command alerted every fiber of my body. What gave? Anyway, why had I been called at Jan's desire? What grudge had this psychopath been nursing the better part of a lifetime? It behooved me to be very wary: very stupid, slow—and listen with both ears. Very mildly, I replied, "I trust you'll forgive me; I've been away from chemistry these many years. The label is colored most conspicuously OR and that made me think, quite naturally, of the Operating Room; I did not know that you were making things for surgery."

I Have Postively Hated You . . .

Jan had been eyeing me narrowly as I blathered along mustering my most invincible, blatant ignorance, "You mean—oh, yes; OR, Operating Room. Of course; and to think that all these years I have positively hated you for getting that four-year scholarship in chemistry!"

It was my turn to be genuinely surprised, "But, Jan: You got that Masaryk fellowship that carried you all the way through! You had no need of anything else!"

"I know! I know! But just the idea of any of you strutting Americans beating me at anything at all just galled me; after all, I am the GREAT Milosadovic!" His super-ego required that I should comprehend my abysmal inferiority vis-a-vis his own intellect, then he asked, "By the way have you ever read *The Adventure of the Devil's Foot?* Conan Doyle, the author, was only a medico, like you, but he did touch a very interesting area in that tale. . . ."

Jan continued to rant and rave—and became ever more enlightening. We wound up in his suite at the other exit from the laboratory; there was a wash room off his bedroom. With an apologetic, "May I?" I went in and locked the door before he could change his mind. Keeping the water running, I opened the medicine cabinet. In addition to the usual paraphernalia, there were a couple 5 cc syringes; on the shelf by them was a 30 cc vial of saline and a tiny bottle of hypodermic tablets; the label read: atropine, 15 mg. Somehow, that is what I expected, even the dosage figured.

Jan resumed his patter of egocentric boasting even as he guided me to the outside corridor.

Just then, the entrance across the hall started to open and a strikingly beautiful, mature but still youthful woman began to emerge. As she saw me, she gasped and began to withdraw. This infuriated Jan; in loud, harsh, guttural Czech, he berated her with words on the gutter

level, then quickly changed to English and imperiously called her out.

Haughtily, he introduced her as his wife, Francine Gardener. I trust I was convincingly clumsy as I bowed over her hand in the reputedly most awkward Yankee manner. As I sneaked a fleeting upward look, I saw her looking at her husband; was it fear and loathing in addition to the submissiveness that I saw? Her English was execrable and I feigned knowledge of no other language; Jan was helpful and escorted me to the elevator after Mrs. Gardener had retired to her suite. He continued extolling to his audience (me) the enormous significance of his work — of the as yet underestimated greatness of JAN MILOSADOVIC!

Back in my office, I made a bee-line for the nice new 2d edition of Drill's *Pharmacology in Medicine;* I had received the book recently for the purpose of reviewing it; it had been used just the week before when I had been called to see a case of insecticide poisoning caused by improper use of *Sarin.* That is why that bottle on Jan's work bench had meant so much to me. Chapter 59 confirmed precisely what I had remembered from my reading.* SARIN, F-p-cH(cH)$_2$, was spelled out in all its grim detail; Jan had merely been using the usual chemical shorthand when he had written F—P(=O)—OR. I was now, also in a better position to peruse the truly elegant work of Nachmansohn on pyridine-2-aldoxine methiodide, the neutralizer of the cholinesterase poisons. Every military martinet hugging "security secret" to his bosom ought to be made to read about how a great scientist, by "mere" doodling, could write a hypothetical formula, postulate the expected properties, prepare the compound—and find exactly the properties he had predicted!

Lethal End for Me? . . .

Having had the fantastic luck of being the recipient of Jan's garrulity at the very time when Sarin was very fresh indeed in my mind—there still was a question of *why?* Was Jan being merely nasty when he had had me called in as a consultant? Could he be, perchance, planning a lethal ending for me also? The atropine in that enormous dosage on the ready? Of course! That painted assistant? Ugh! But it figured; the beauteous Mrs. Gardener? A glaring misfit in that menage—obviously.

Instead of fretting, I proceeded to call long distance a very private number; my old-time boyhood friend answered on the other end. I skipped the amenities and asked bluntly as to what I could be told without benefit of security clearances re my charming patient. In short order, a call came back, "Arnie, I'm on a debugged line; we have very little on Gardener even if some items are—shall we say—curious. How did he ever get a Jew for a consultant? He is a virulent Nazi from away back; he was palsy-walsy with Roehm and his pals around Hitler; he fled Germany when Roehm's gangsters were being liquidated; he is welcome in Madrid and very chummy with the Arab League crowd.

Still, he is an American citizen; you know his former name? Oh, fine. He did get married to an Egyptian-born Czech woman; we have very little on her; she leads a very secluded life; she seems to be a very pious type, goes out with her maid to Roman Catholic affairs, visits convents—that sort of thing. Yes! He has clearance for highly classified work on gases; I'm told he is a positive genius in that line—made a stack of dough from some patents he took out: insecticides, fertilizers and chemical gadgets. Just one word of caution: We don't trust him one blessed bit—don't you either! Be deucedly careful!"

Before leaving, I spoke quietly to my senior nurse, "Do you think you could get some 15 mg tablets of atropine, some decontamination outfits and — mebbe — be prepared for some sudden—ah! shall we say startling emergencies?" It was a good thing that she had known me from way back and was used to my vagaries.

My sound sleep was disturbed before breakfast time by an urgent call from the attending physician; he was about as excited as a well-bred Ivy Leaguer can get. "Fifteen minutes ago, I had an emergency call from upstairs; just as I got there, our patient was breathing his last!

* While for reasons that should be apparent, the actual persons, locale and actions portrayed have been so distorted that any resemblence to persons living or dead can be denied vigorously. The reader could benefit by reading: (1) Scientific American, Nov., 1959, p. 75 on; "Poisons" by Elijah Adams. (2) Harper's Magazine, June, 1959, lead article on Biological and Chemical Warfare by General Jacques Rotschild. (3) John G. Hubbell "Let us Face the Truth About Gas and Germ Weapons," Reader's Digest, Aug., 1960.

The most frightful series of clonic and tonic convulsions and then he just went limp—right before my eyes! I insisted on a postmortem. Mr. Gardener was very co-operative; he seemed quite upset over the loss of his assistant."

Neurological Speculation

As I listened calmly (I really could not pretend surprise over the expected), he went on, "We'll look for alkaloids, cyanides, and what have you, but I'm thinking . . ." He went into an exquisite neurological speculation.

Apropos of nothing at all, I asked in the politest tone I had, "Did you try giving Nick 10 to 15 mgs of atropine?" The other end of the wire had professorial pity for my abysmal ignorance. "The dose is *one-tenth* of a milligram for children and adults in proportion! And, no; I had no time in which to give the patient anything."

"Of course, doctor; You are so right; One more things, however; Did you ever read Conan Doyle's "The Adventure of the Devil's Foot?"

The good man's courteous manner was fraying rapidly, "Never had time for him; Good-bye, doctor" Well, I *tried* to tell him . . .

As I was dressing, the whole series of grotesque events paraded before my mind. Why did Jan kill his "love"? Why the bravado of flaunting the "perfect crime" before the best known internist in the metropolis? Why was I dragged in? The more I cogitated, the more queasy did I get. Any recipe for a long life meant giving a wide berth to the malevolent John Merry Gardener—that seemed a certainty.

That very evening, this admirable resolution was shattered; a frantic voice on the telephone was begging me to come up and see Mrs. Gardener immediately. It was the maid; the doctor downstairs was out; Mr. Gardener was locked in his suite and would not come out; Mrs. Gardener was in bed moaning with terrible pain; would I please come right away? The urgent terror sounded too genuine for any acting—I said I'd come. First, I called my associate and told him *exactly* what to do if I did not call every hour; my wonderful nurse had ready the stuff I had requested—she accompanied me as I tooled the car to the too familiar address.

We found Mrs. Gardener in bed, writhing with pain. My nurse helped me with a rapid diagnostic survey; it was simple enough: Mrs. Gardener herself guided us to the source of her agony: a hairpin had been inserted into the urethra—just a trifle too far. It had become wedged in sideways and neither the woman nor her maid could get it out. Perineal inspection also revealed an almost intact, obviously virginal hymen. It was over easily; a rather heavy dose of sodium amytal relaxed the previously incoherent patient; the urethra was greased with a little anesthetic ointment; the gadget was grasped, manipulated and slid out without tearing any membranous tissues.

Made a Lot of Promises . . .

As the patient relaxed, she began to gasp out her tale in clear, coherent Czech. "Jan brought me here; made a lot of promises; he told me that he had to have a wife for the sake of appearances; he had no use for women. That is why I was placed across the hall while Frigovich was always with him. Sometimes, Jan would come in and fondle me; then he would rush to Nicky; that is how I started using that hairpin for relief—you understand! Nicky, however, liked women, too; Jan suspected it and was terribly jealous; said he'd kill Nicky if he ever found him dallying around, but Nicky thought Jan was just talking. . . ."

"Well, a couple weeks ago, Nick barged into my room; he'd been drinking; he started getting very familiar when Jan walked in. I've never before seen Jan foam with rage. And that is when things started happening to Nicky. One evening, Jan had forgotten to shut his door and I could see him pick up a vial, real careful like, and carry it to Nick's room. Jan had the ventilators going full force and he wore gloves and a mask. He sprinkled the liquid on flowers which were in a vase, thrust the vase into Nicky's room and quickly closed the door. I did not dare linger and observe further. Yes: The flowers I was supposed to have sent."

Mrs. Gardener paused in her droning speech, sat up in bed and became more emphatic. "This very morning, Jan came in, told me Nicky was dead and told me I'd better behave or be ready to join him. I have a duplicate key to Jan's apartment; he never knew that. I waited this evening until he had gone to bed; I spied on him—made sure he had fallen asleep. Then I sneaked into the lab. on the other side, picked up the gloves and mask just as I had seen Jan do, took the vial and carried it and a beaker with me to Jan's bedroom. I splashed the stuff on

his blankets even as he was snoring, ran back to the lab, jerked off the mask and gloves as I replaced the glassware—and dashed madly back to my suite and locked myself in. I heard Jan screaming and that made me real excited—you know. The butler and his wife are off for the week-end; besides Jan and me, there is only my maid. I just had to abuse myself—you know—and then it got real quiet like: I dared sneak across and there was Jan on the floor clawing for air and then—all of a sudden-like—he was limp DEAD."

Got All Excited Again

Neither my nurse nor the maid had understood Czech but we were all almost hypnotized by her manner of speech. Mrs. Gardener was beginning to get drowsy with the relief from pain and the cumulative sedation; still, she resumed, "Again I fled to my room; my eyes were smarting but not too bad. I knew I was free of Jan and I got all excited again and so I wiggle-waggled that hairpin again—and the rest you know." Mrs. Gardener closed her eyes and drifted off to sleep.

I told the nurse that there was a dead man across the hall; I was helped into the decontamination suit and mask; the enormous ventilators were turned on; the atropine was readied—just in case; gingerly, I flipped on the light switches and walked in. The animals were dead in their cages; the deadly *Sarin* vial stood there half empty—my gloved hand cautiously replaced it on the shelf. I continued into Jan's room. Contorted "like a bundle of rags," he sprawled grotesquely: he must have awakened even as the cholinesterase of his body was being bound inexorably by the fumes of the nerve gas. He had helped in its synthesis; he had killed with it; now, Nemesis was guiding the shears of Atropos to cut *him* down.

The medicine cabinet still held the atropine paraphernalia Jan had not had time to reach; on an impulse, I slipped it all into my pocket; the dead man I did not touch. Out in the hall again, I got out of my gear, packed it away and shut the blowers. Just then, the door bell rang and the attending physician came in. It was a relief to tell him that the maid had called me when she had failed to contact him. Mrs. Gardener had been hysterical; I had given her a sedative; she was sound asleep, as he could verify. Mr. Gardener was definitely dead; I had not touched the body, as it was quite clearly a coroner's case. I had subbed for the family physician; now I was turning the entire matter back into his most capable hands. My words were chosen with care; much I left out but all I said was true and easily verifiable. I did not—as yet—deem it my duty to report on Mrs. Gardener's speech or the matter of the hairpin.

The good doctor was almost flustered; this second death destroyed all his diagnostic speculations. There was nothing for him to do at the moment—he merely glanced at the sleeping patient, and hurried off saying he had a very ill man whom he could benefit at the hospital.

Just as the nurse and I were at the front door on our way out, the maid rushed up: Mrs. Gardener was awake; she appeared to be strangely different; we all trooped back. Indeed, Mrs. Gardener was awake: she was calm, collected and speaking slowly in musical, very idiomatic French.

"Francine has been a very bad, bad woman; she has been doing many bad (mauvais) things. Now, the blessed Lord Jesus himself has just spoken to me and told me what to do; I know exactly."

Neither my nurse nor the colored maid understood French; yet there was a quality about Francine's speech—an eery weirdness—that made both the women involuntarily cross themselves. This climax to the sodium amytal sedation almost shocked me into numbness; were we looking at the second of "The Three Faces of Eve"? How badly was she hallucinating? Very soothingly, in my execrable French, I asked, "Who am I talking to?"

Blessed by a Vision

"I am Sister Penitentia, who has just been blessed by a vision of the Lord Himself; I will expiate with charitable deeds and upright living the heinous sins of the dead Francine Gardener. And—who are you?"

Was it my responsibility to send her to a psychopathic ward for observation? Quite obviously, the recent harrowing events had been blotted out of the conscious mind of—ah!—Sister Penitentia. I might be abetting murder; but I was not the physician in charge; also, the coroner people would be on the scene soon. And then I had a genuine inspiration; *Sister* Penientia! Back to the phone I went. I called a grateful patient who was an assistant district

attorney and an influential Catholic to boot. He listened carefully as I asked him to get me an appointment with the monsignor of his diocese. Why? I had a most grave problem of morals and faith; also, would the assistant D.A. be so good as to be present also? There was a most perplexing, delicate legal thing clamoring for an answer. My patient was fully convinced of the gravity of my plea being made in the middle of the night.

"The Cardinal himself is seeing me later this morning. Meet me at ten in my office; we'll go together."

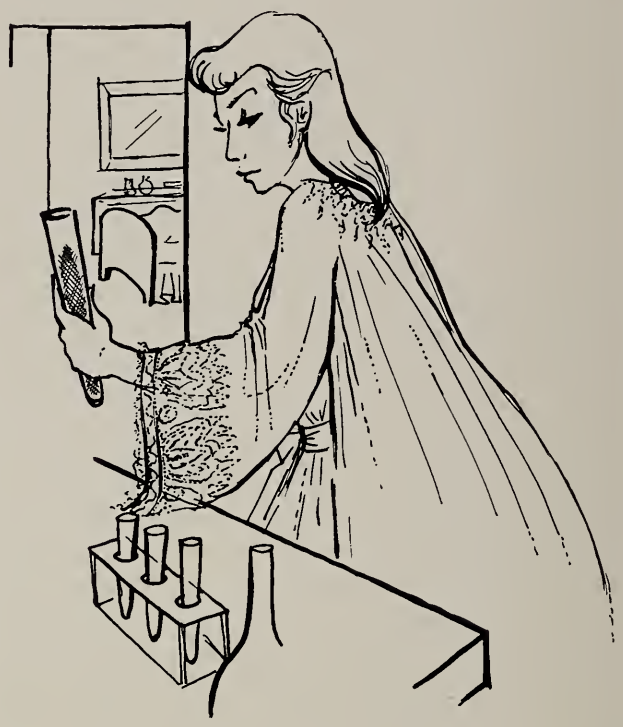
I returned to Sister Penitentia's bedside, gave her the maximum oral dose of hypnotic I dared prescribe, instructed the maid to make sure that no one disturbed her until the family physician passed by—and only then, finally, did my nurse and I leave. It was already broad daylight. Later that morning my friend and I went through many doors and were guided by several officials until we were in the prelate's office.

The preliminaries were courteous but brief; I plunged directly into my tale; a secretary was present to take it down in shorthand. As I concluded, several penetrating questions told me that the Prince of the Church had not missed much. Finally, we could see that his mind was arriving at definite conclusions. He pursed his lips and placed his elbows on the arms of the chair while touching all his finger tips to each other symmetrically. He spoke slowly, weighing each word.

A Fourth Person

"We can assume that the three members of this unfortunate triangle are all dead. Clearly, Sister Penitentia is a fourth person—the fourth side of the triangle, if you will. Clearly, also, she had no connection with the heinous crimes described. These deeds are actual, deadly sins and the souls of those perpetrating them must be in hell now. While I am not the Pope and so cannot speak with Infallibility, it is my considered opinion that Sister Penitentia has been blessed most singularly by a vision of Our Lord. If she is not molested as she performs the predestined tasks assigned to her by God, much good, indeed, may flow from her. Who knows but that—long after her earthly death—she may not some day be beatified and so join the Legion of the Blessed?"

This brings me full cycle back to the very opening paragraph of this case presentation; I had no further obligations in the matter. In the newspapers there was a brief obituary of Mr. John Gardener; a closing note stated that Mrs. Gardener was entering the convent; then—silence. I do wonder what she is doing. . . . ◄



1026 Sixth Ave.
New York, N. Y.

Path-finder
PUBLISHED UNDER THE AUSPICES OF THE INDIANA ASSOCIATION OF PATHOLOGISTS

DIAGNOSTIC USES OF RADIOISOTOPES

*WEI-PING LOH, M.D.**
Gary

IN RECENT YEARS radioisotopes have gained increasing importance as diagnostic tools in clinical medicine. Here are some of the common diagnostic procedures involving the use of radioisotopes.

Thyroid Studies

In studies of thyroid functions radioactive iodine (I-131) is most widely used. Following oral administration of a measured tracer dose of the I-131 a hyperactive thyroid will pick up more iodine and a hypoactive thyroid less iodine than normally. The I-131 uptake for a normal-functioning thyroid at 24 hours following an oral dose of the isotope is between 15 to 45%.

An uptake higher than 50% would indicate hyperthyroidism and a figure lower than 10% would indicate hypothyroidism. The uptake test can often be combined with a number of auxiliary tests, such as excretion of the radioisotope in saliva, urine or feces. In hyperthroidism less iodine is available for excretion and in hypothyroidism more is available. The I-131 uptake test is believed to be more accurate than the conventional PBI and BMR tests as a diagnostic tool for thyroid diseases. The I-131 in form of RISA (radioactive iodine serum albumin) can also be used for determination of radioactive PBI.

Recently the so-called "T-3 red cell uptake" test was developed in which the patient's red blood cells are incubated with I-131 labeled L-triiodothyronine and the percent red blood cells uptake will then be calculated. This in vitro test is suitable for use in children, and is useful in following the course of patients being treated with thyroid hormone without stopping the medication. In addition, suppression tests following a dose of triiodothionine may be used to clarify equivocal findings. Administration of thyroid stimulating hormone (TSH) is useful for distinguishing pituitary type of disease from those having intrinsic thyroid disease.

Radioisotopes in Hematology

Applications of radioisotopes in hematology include the use of radioactive cobalt (Co-60) labeled vitamin B-12 in Schilling test which can confirm pernicious anemia, even partly treated. The test can also differentiate between pernicious anemia and megaloblastic anemia due to malabsorption. RISA has been widely used for determination of plasma or blood volume. I-131 labeled oleic acid or radioactive iodotriolein has been used for evaluation of fat absorption in malabsorption syndrome. Radioactive chromium (Cr-51) is widely used for red blood cell survival and sequestration studies. Radioactive iron (Fe-59) is generally used for study on iron metabolism including absorption and utilization of iron and synthesis of hemoglobin.

Tumor Detection—Miscellaneous Uses

Other important applications include successful use of RISA, radioactive phosphorus (P-32) and radioactive arsenic (As-74) in detection and localization of malignant tumors, such as those

*Pathologist in charge of Clinical & Isotopes Laboratories, Methodist Hospital of Gary; Assistant Professor of Pathology, Chicago Medical School.

in the brain, breast and intestinal tract. I-131 labeled Rose Bengal dye has been used as a convenient liver function test. Diodrast containing I-131 has been used for analysis of renal functions. Radioactive oxygen (O-15) has been used for study of pulmonary functions. I-131, radioactive sodium (Na-24) and Cr-51 have all been used in the studies of circulation and cardiac output, as well as in the determinations of body water and electrolytes. Among these isotopes EDTA—(ethylenediamine tetraacetate) Cr-51 gamma-ray "carrier" appears to be most efficient in the determination of circulation time. It is quite possible that in the near future coronary circulation of the heart can be easily evaluated through the use of radioisotopes.

It is beyond the scope of this presentation to discuss the technical details and all the factors which might influence the test results. The readers are advised to present the clinical picture of the patient to the physician in charge of the radioisotopes procedures before any conclusion on the test results is reached. The physician taking charge of radioisotopes procedures may be a pathologist or a radiologist or an internist who is licensed by the Atomic Energy Commission for the use of radioisotopes. In case of postmortem examination to be performed on any patient who has received therapeutic doses of radioisotopes, the pathologist should be fully informed, so that suitable precautions may be taken to avoid radiation contamination and hazards. ◄

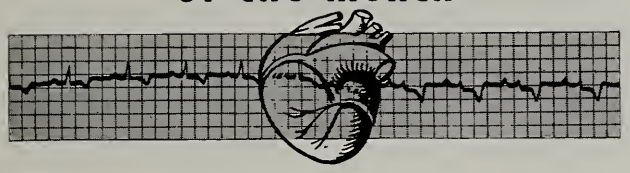
Burn Riddle Has New Answer

Newest answer to the burn riddle is milk. A British physician, Dr. Frederick Willington of Devon discovered the healing properties of the common liquid when a woman patient accidentally scalded herself severely and plunged her injured hand in the nearest cold fluid—a pitcher of milk. She kept it there for about half an hour and subsequently suffered no blisters and only a slight reddening.

According to *Insiders Newsletter,* Dr. Willington tested the remedy in over 200 burn victims. In all cases it proved effective for both first- and second-degree burns—provided it was used immediatley and compresses of cold milk kept over the burn for the first 24 hours.

Medical explanation: Cold moisture of any kind reduces heat caused by burn, and alleviates pain. Milk's colloidal quality makes it adhere to flesh without pressure, and it contains protein similar to that in human tissue.—*Journal of Miss. S.M.A.,* Oct., 1960.

Electrocardiogram of the month



Presented as a regular feature of The JOURNAL, Electrocardiogram of the Month is a series of short talks on cardio-vascular diagnosis and treatment, edited by the staff of the Robert M. Moore Heart Clinic of the Marion County General Hospital, Indianapolis.

Wolff-Parkinson-White Syndrome Simulating Ventricular Tachycardia

*CHARLES FISCH, M.D.**
Indianapolis

IN AN EARLIER communication to this *Journal* (Electrocardiogram of the Month, September 1960) it was pointed out that not infrequently is supraventricular tachycardia associated with aberrant intraventricular conduction or bundle branch block mistaken for ventricular tachycardia. The therapeutic implications of such an error are quite obvious. The purposes of this month's cardiograms are to point out that Wolff-Parkinson-White Syndrome (pre-excitation), when complicated by supraventricular arrhythmia, may also lead to an erroneous diagnosis of ventricular tachycardia.

The electrocardiographic pattern of this syndrome consists of a short P-R interval, prolonged QRS due to a slowly rising slurred component (△ wave) and a normal P-S interval. Of the many concepts proposed to explain this pattern, the one most widely accepted is the persistence of an accessory pathway (bundle of Kent). Normally the wave of excitation reaches the ventricle through the A-V node, where it is delayed, giving rise to the P-R interval. In W-P-W the ventricle may be excited early and without delay through the anomalous by-pass, giving rise to the short P-R and the △ wave. Shortly thereafter the impulse arriving via the normal pathway fuses with the △ and a fusion (combination) complex results.

The degree of aberrancy of the QRS will depend entirely on how much of the ventricles is excited through the anomalous by-pass. It seems obvious that any delay in the normal A-V conduction would "force" the excitation of ventricles to proceed through the bundle of Kent. Such an A-V delay may occur with rapid rates, pathological A-V blocks, vagal stimulation or digitalis effect. When the rate is rapid and large portions of ventricles are activated through the anomalous path the resulting aberrant intraventricular conduction resembles ventricular tachycardia.

Description of Electrocardiograms

The tracing presented here was obtained from a 58-year-old patient admitted to the Marion County General Hospital. Numerous cardiograms recorded in course of hospitalization illustrated most interesting aspects of W-P-W and were reported in detail elsewhere (Circulation, 16:1004,1957).

Figure 1: This tracing shows the classical features of W-P-W namely a short P-R interval (0.08 seconds), prolonged QRS (0.12 seconds)

* From the Robert M. Moore Heart Clinic, Marion County General Hospital, Indianapolis, Indiana.

Supported by the Herman C. Krannert Fund of the Indiana Heart Association, the Indiana State Board of Health and the National Heart Institute (H.T.S. 5363).

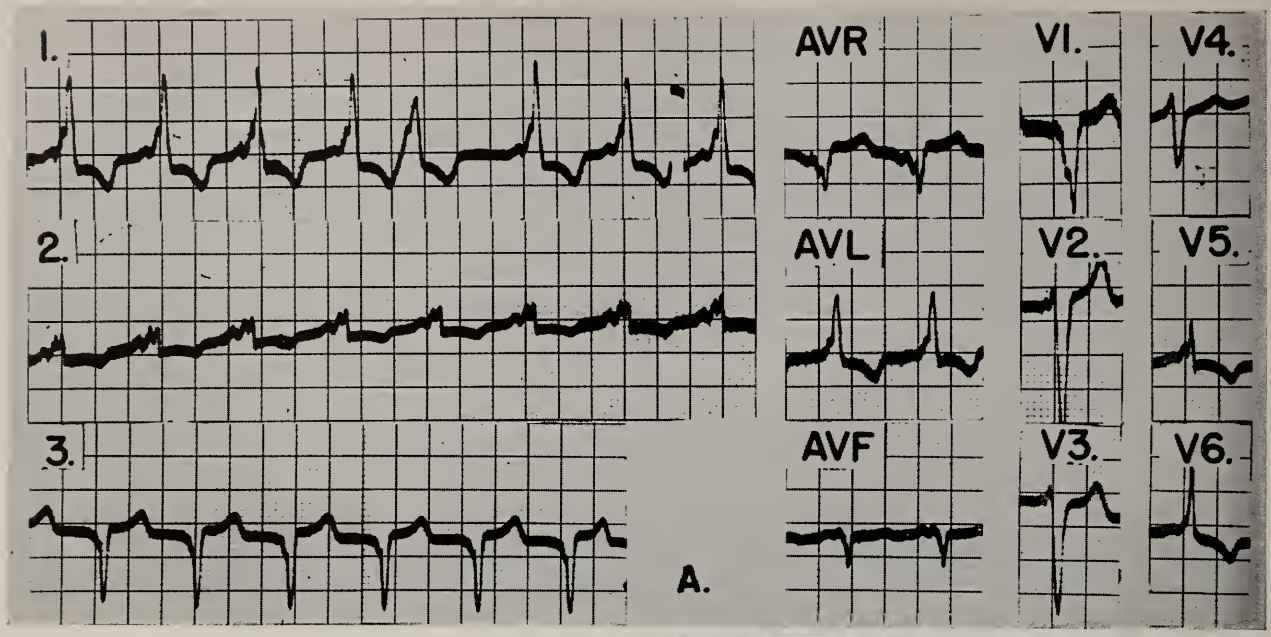


FIGURE 1 (above)
TRACING SHOWING the short P-R, slurring of QRS on the upstroke (△ wave) and a normal P-S interval.

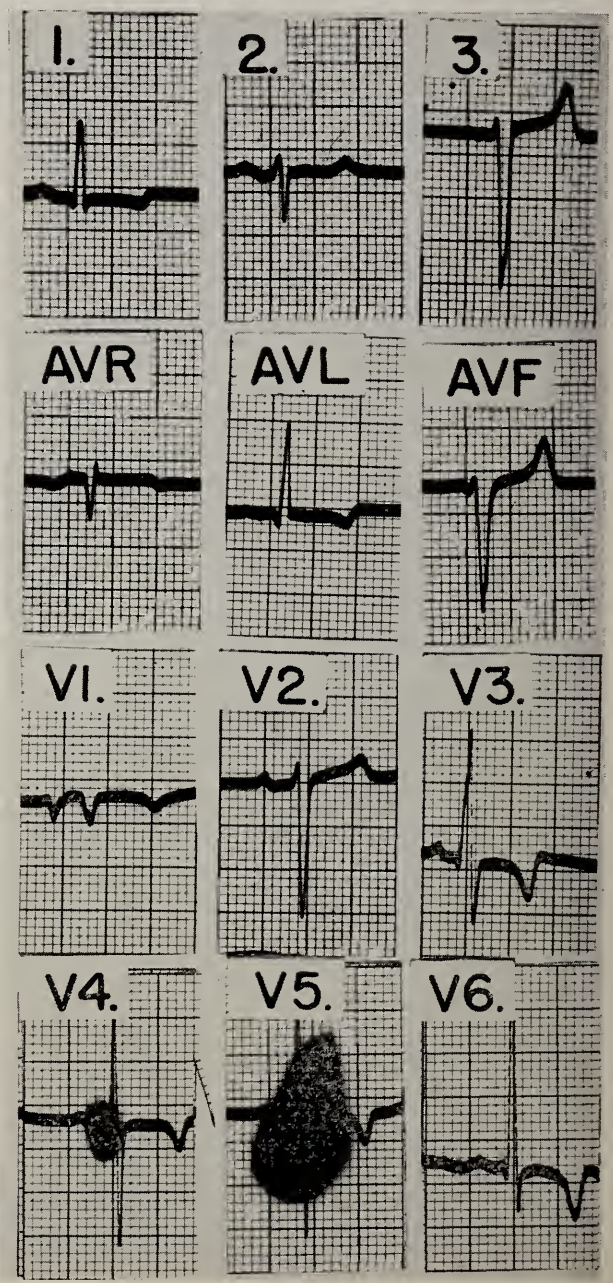


FIGURE 2 (right)
NORMAL ATRIO-VENTRICULAR conduction with inverted T waves in leads I, AVL, V-3, V-4, V-5, V-6.

and a slur on the upstroke (△ wave). A ventricular premature beat is recorded in lead I. The changes in S-T segment and T waves are assumed to be secondary to prolongation of the QRS. This may not always be the case, and the T wave changes may be primary, indicative of primary abnormality of the heart.

Figure 2: This cardiogram shows "normalization" with conduction via the normal A-V nodal and bundle of His pathway. The T waves are inverted in I, AVL, V3, V4, V5, V6 and upright in AVR indicating preexisting primary ST segment and T wave changes.

Figure 3: Lead V-5 represents atrial tachycardia with a rate of 160, a dominant 1:1 ventricular response with occasional blocked P waves and resulting 2:1 response. The first complex following the longer pause is composed of a △ wave due to early activation via the by-pass and final narrow segment which resulted from activation over the normal pathway (combination beat). Subsequent beats, however, were too rapid to permit recovery of the normal conduction and most if not all of ventricles was activated through the bundle of Kent, which being

ordinary muscle, has a shorter refractory period than the specialized tissue. Lead V-1 represents the same phenomenon but with a persistent 1:1 ventricular response. Failure to recognize the existence of W-P-W would in this instance lead to an erroneous impression of ventricular tachycardia.

Figure 4: This cardiogram demonstrates atrial fibrillation as the basic rhythm. The first and second QRS complexes in strip 2 (V-5) and eleventh, twelfth and fifteenth QRS complexes in strip 3 (V-5) are normal in appearance, indicating that the atrio-ventricular transmission of excitation was through the normal pathway.

The remainder of the complexes being aberrant indicate that the excitation wave reached the ventricles over the accessory pathway with most if not all of the chambers being activated in an aberrant manner. As was pointed out in connection with Figure 3, longer pauses allowing for sufficient recovery of the normal conduction pathway gave rise to normal-appearing QRS complexes. On the other hand rapid conduction was possible only through the bundle of Kent which does not delay trasmission as much as the A-V node. Again as in Figure 3, failure to recognize the existence of W-P-W would result in a diagnosis of ventricular tachycardia.

From the therapeutic standpoint, quinidine is the treatment of choice of arrhythmias complicating W-P-W. This drug, by blocking the muscular anomalous by-pass, enhances transmission through the normal pathway. On the other hand digitalis by depressing normal A-V conduction encourages rapid transmission through the anomalous pathway and propagates the arrhythmia. ◄

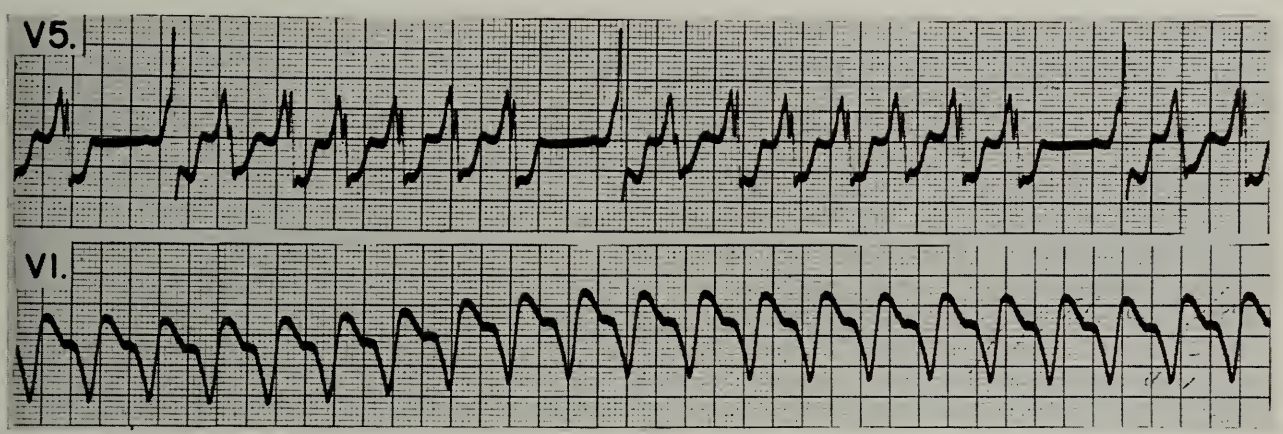


FIGURE 3

ATRIAL TACHYCARDIA with a predominant 1:1 conduction punctuated by occasional 2:1 atrio-ventricular response (lead V-5).

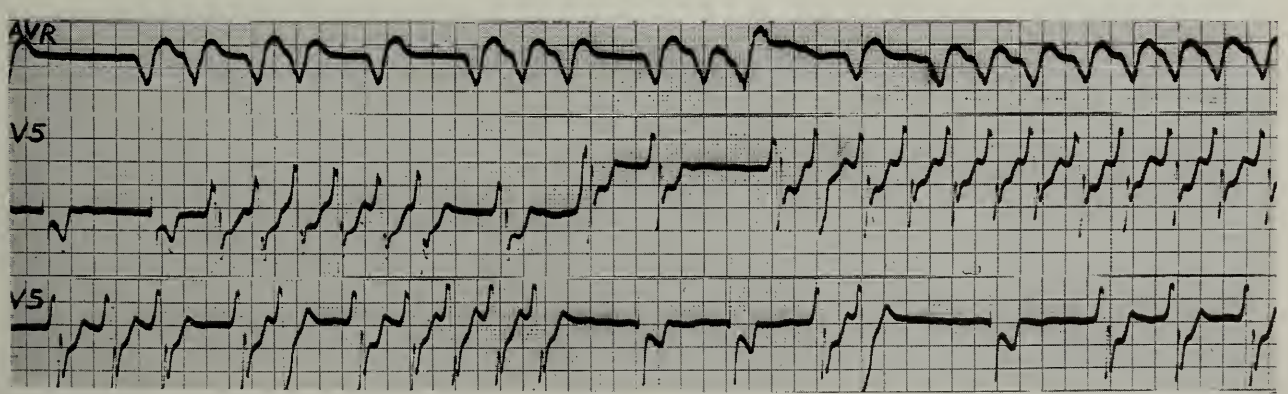


FIGURE 4

ATRIAL FIBRILLATION with runs of W-P-W complexes.



when sulfa is your plan of therapy..

pharmacologically and clinically the outstanding

Rapid peak attainment — for early control — KYNEX® Sulfamethoxypyridazine reaches peak plasma levels in 1 to 2 hours[1,2] . . . or approximately one-half the time of other once-a-day sulfas.[2] Uninterrupted control is then sustained over 24 hours with the single daily dose . . . through slow excretion without renal alteration.

High free levels — for dependable control — More efficient absorption delivers a higher percentage of sulfamethoxypyridazine — averaging 20 per cent greater at respective peaks than glucuronide-conversion sulfas.[2] Of the total circulating levels, 95 per cent remains in the fully active, unconjugated form even after 24 hours.[3]

Extremely low toxicity[4] . . . only 2.7 per cent incidence in recommended dosage — Typical of KYNEX relative safety, toxicity studies[5] in 223 patients showed TOTAL side effects (both subjective and objective) in only six cases, all temporary and rapidly reversed. Another evaluation[4] in 110 patients confirmed the near-absence of reactions when given at the recommended dosage. High solubility of both free and conjugated product[6] obviates renal complications. No crystalluria has been reported.

Successful against these organisms: streptococci, staphylococci, E. coli, A. aerogenes, paracolon bacillus, Gram-negative rods, pneumococci, diphtheroids, Gram-positive cocci and others.

1. Boger, W. P.; Strickland, C. S., and Gylfe, J. M.: Antibiotic Med. & Clin. Ther. 3:378, (Nov.) 1956. 2. Boger, W. P.: Antibiotics Annual 1958-1959, New York, Medical Encyclopedia, Inc., 1959, p. 48. 3. Sheth, U. K.; Kulkarni, B. S., and Kamath, P. G.: Antibiotic Med. & Clin. Ther. 5:604 (Oct.) 1958. 4. Vinnicombe, J.: Ibid. 5:474 (July) 1958. 5. Anderson, P. C., and Wissinger, H. A.: U. S. Armed Forces M. J. 10:1051 (Sept.) 1959. 6. Roepke, R. R.; Maren, T. H., and Mayer, E.: Ann. New York Acad. Sc. 60:457 (Oct.) 1957.



once-a-day sulfa...

NOTE: Investigators note a tendency of some patients to misinterpret dosage instructions and take KYNEX on the familiar q.i.d. schedule. Since one KYNEX tablet is equivalent to eight to twelve tablets of other sulfas, even moderate overdosage may produce side effects. Thus, the single dose schedule must be stressed to the patient.

KYNEX Tablets, 0.5 Gm., bottles of 24 and 100. Dosage: Adults, 0.5 Gm. (1 tablet) daily, following an initial first day dose of 1 Gm. (2 tablets).

KYNEX Acetyl Pediatric Suspension, cherry-flavored, 250 mg. sulfamethoxypyridazine activity per teaspoonful (5 cc.). Bottles of 4 and 16 fl. oz. Recommended Dosage: Children under 80 lbs.: 1 teaspoonful (250 mg.) for each 20 lb. body weight, the first day, and ½ teaspoonful per 20 lb. per day thereafter. For children 80 lbs. and over: 4 teaspoonfuls (1.0 Gm.) initially and 2 teaspoonfuls daily thereafter. Give immediately after a meal.

KYNEX®

Sulfamethoxypyridazine Lederle

NEW—for acute G.U. infection AZO-KYNEX® Phenylazodiaminopyridine HCl—Sulfamethoxypyridazine Tablets, contains 125 mg. KYNEX in the shell with 150 mg. phenylazodiaminopyridine HCl in the core. Dosage: 2 tablets q.i.d. the first day; 1 tablet q.i.d. thereafter.

LEDERLE LABORATORIES, a Division of AMERICAN CYANAMID COMPANY, Pearl River, New York

Lederle

The Journal
of the INDIANA STATE MEDICAL ASSOCIATION

Devoted to the interests of the medical profession of Indiana

Editor: Frank B. Ramsey, M.D., 1802 North Illinois Street, Indianapolis 2, Ind.

Associate Editors: A. W. Cavins, M.D., 221 South Sixth Street, Terre Haute; Lall G. Montgomery, M.D., Ball Memorial Hospital, Muncie; David A. Bickel, M.D., 515 Odd Fellows Building, South Bend; Stephen L. Johnson, M.D., 521 Sycamore Street, Evansville.

Editorial Board:	Term Expires
George M. Johnson, M.D., Richmond	Dec. 31, 1963
Irvin W. Wilkens, M.D., Indianapolis	Dec. 31, 1963
Harold D. Lynch, M.D., Evansville	Dec. 31, 1961
Jene R. Bennett, South Bend	Dec. 31, 1961
Samuel R. Mercer, M.D., Fort Wayne	Dec. 31, 1962
Franklin F. Premuda, M.D., Hammond	Dec. 31, 1962

Necrologist: James B. Maple, M.D., 117 West Washington Street, Sullivan.

Assistant Editor: Sara M. Snyder

Business Manager: James A. Waggener

1019 Hume Mansur Building, Indianapolis 4, Indiana

Few Oldsters Need Help

FACTUAL SURVEYS in 1960 showed that a majority of the older citizens either had health insurance or other means of providing their own care. Almost all of those who had unmet health problems had other reasons for not seeing a doctor. Only an occasional oldster reported that lack of funds prevented medical attention. A fairly large number of those over 65 stated that they not only were caring for themselves with their own resources but were also helping out their younger relatives in a financial way.

Health insurance is not only available to the over 65 group at a price they an afford—it is available in a variety of forms. The policies offered are flexible and can be obtained in a style which suits individual needs.

These policies are being written on a lifetime basis. One type is carried by the individual while he is under 65, and may be continued after 65, either on a paid-up basis at age 65, or with continuing reasonable premiums. Health coverage may be bought by individuals before or after 65. Policies acquired on a group plan may be continued at retirement on an individual basis. More and more of these plans give the aged policyholder the right to renew for lifetime.

Next year the socialists are going to have a hard time proving that voluntary health insurance is not taking care of the problem. By then they may have a new manufactured crisis by which to sell their socialized medicine schemes. Don't relax yet, there will be another campaign on this same front next year.

Enforcement Program Saves Lives

CONNECTICUT WAS DISSATISFIED in 1955 with having the fourth lowest highway fatality rate in the country. As a result state officials have been working hard on the problem ever since and now have the lowest traffic death rate.

If the United States had the same low rate the national toll would be 17,500 fatalities in-

stead of 37,800. Connecticut isn't satisfied yet, but if the rest of us did as well, there would be some 20,000 more people alive every year.

The program consisted of a well-planned and coordinated campaign involving the three E's—Enforcement, Education and Engineering.

Another 'E' was involved, and it apparently was a major factor in the improvement. Governor Ribicoff in an article in a recent issue of the *Journal of American Insurance* states: "We decided to try an experiment based on the ironic proposition that a driver who will not slow down to save his life will slow down to save his license."

Licenses were supended on all drivers convicted of speeding: 30 days for the first offense, 60 days for the second and indefinite for the third. In 1955, 372 licenses were suspended for speeding; in 1956 suspensions numbered 10,055. Early in 1956 traffic deaths began to drop. They are still dropping—the first few months of 1960 saw 22% fewer deaths than occurred in the same months in 1959.

License suspensions are also liberally handed out for convictions for reckless or drunken driving, but on a more sobering scale than for speeding. Reckless driving catches a 30-day suspension on the first offense, 90 days for the second. A drunken driver is suspended one year the first time, five years the second time and outright revocation is dealt out on the third offense.

Anyone who drives while under suspension of license has a year added to the original suspension on the first offense, five more years of suspension when caught the second time.

This is an enforcement program with teeth in it. It was opposed by many people at first. Now it is getting results and lots of them, and is popular.

Connecticut has done a lot to educate young drivers. It has spent a lot of money in building modern roads. It has a balanced program for safety. All this is necessary, but it is evident that the teeth in the enforcement program are what is saving lives.

Readiness Is a Desire for Perfection

A RECENT REPORT by World Wide Medical News Service, datelined Indianapolis, states that the newest crop of young physicians here wonders whether it's ready to handle a private practice. Based on a questionnaire which 24 members of the graduating class of Indiana University School of Medicine answered, misgivings are reported as "lack of training in surgical technics" and "lack of confidence in my knowledge and ability."

We never heard of such a survey being made before, but we can assure the surveyors that this state of affairs is not new. It has always existed, at least in the minds of physicians who are honest with themselves. It not only exists among new graduates but it also continues to some degree in every practicing physician throughout his life.

It is the result of a state of mind inherent in all good doctors—a burning desire for perfection in a discipline that has never seen perfection. This state of affairs accounts for the fact that a doctor's education is never completed. It is, we think, evidence that the newest crop of physicians have been well schooled; they are graduating with the kind of medical education which is setting them forth on a lifelong search for knowledge and more knowledge.

Aged Have Choice of 288 Health Insurers

THE NEXT TIME a socializer tells you that elderly people have difficulty in protecting themselves with health insurance, you can tell him that such guff is just so much hot air. And you can prove it. At a recent meeting of the Health Insurance Institute, Ardell Everett, an officer of the Prudential Insurance Company, reported that "at least 288 voluntary health insuring organizations currently issue new individual hospital or surgical policies to persons 65 years of age or over."

Further—"At least 51 insurance companies

offer individual health insurance policies guaranteed renewable for lifetime, and that of these, at least 31 companies issue this lifetime protection to persons 65 or over."

And more—"Several insurance companies offer policies through a mass enrollment approach to all senior citizens regardless of medical history."

And if that isn't enough—at least 82 insurance companies, which issue 90% of the group health insurance written by the insurance business, and a number of other insuring organizations offer policies continuing coverage under group plans for retired employees."

And finally—"At least 214 insuring organizations give retirees the option to convert from their group plan to an individual policy."

Editorial Notes

A new AMA commission has been formed to launch "a comprehensive study and action program to guide the consumer in spending his health-care dollars more wisely." The Commission on Medical Care Costs will aid the consumer to reduce the cost of his medical care without changing its quality. Dr. Louis M. Orr, past-president of the AMA is Commission chairman.

Self-prescribing with non-prescription and over-the-counter drug products will get an investigation and airing. Quackery, food-faddism, health gadgets, vitamins, cathartics and fake "cures" will also be exposed. It is estimated that the average American family now spends about $18 a month on non-prescription drugs; some of them are not harmful but most of them are a waste of money. "The goal of the AMA program is a higher quality of health care for a greater number of people at a lower cost."

The November issue of GP features an article on arthritis quackery and states that the public needs to know more about "arthritis cures" that only "cure" the promoters pocketbook and leave the arthritis victims worse off. The estimate of the dollar value of quack remedies is closed to a quarter of a billion dollars per year—$250,000,000. The American Academy of General Practice advocates a campaign on the part of the medical profession against such fraud and deceit.

The Veterans Administration has announced that since 1953 there has been over a 100% increase in the number of patients with severe mental illnesses recovering and leaving VA hospitals on trial visit in less than a 10-year period. VA said the increase in patients on trial visit can be attributed to changes in therapies, including use of newer drugs; to increased emphasis by hospitals on helping patients develop new habits of resocialization to prepare for return to community living, and to growth of VA programs in cooperation with community resources which help patients find suitable homes and jobs on release from the hospital.

Allergy information may be life-saving. Unconscious patients who are violently sensitive to drugs or who have some condition which requires daily treatment should carry this vital information on their person where it will be most easily noticed. Medic-Alert Foundation is a non-profit public service organization with headquarters in Turlock, Calif., which is promoting a Medic-Alert silver amulet to be worn as a wrist band or necklace and which is inscribed in red letters with important medical information about the wearer. "I am taking anticoagulant," "Diabetic," "Sensitive to tetanus antitoxin," "Hemophilia" or "Glaucoma" are examples of warning which aid in the treatment of unconscious persons. The Foundation also maintains a reference file with complete information for physicians at a distance who may be called upon to treat Medic-Alert labeled patients.

Apparently, doctors like it best in the big cities. *Medical World News* reports on the physician and population density changes as re-

vealed by the 1960 census. The 50 largest cities increased population since 1950 by five percent, and doctors by 23%. The rest of the nation reversed the percentages, population up 23%, doctors up 5%. Indianapolis has one doctor per 444 inhabitants, the national average is one per 835, the average for the 50 largest cities is one per 452.

The number of persons in U. S. mental hospitals, after rising steadily for many years, started to decline in 1956. While the number of admissions has increased since 1956, the number of dismissals has increased much faster and has resulted in a lower hospital population. With half of the hospital beds in the country devoted to mental illness it is encouraging to notice a drop in the demand. The decrease is attributed to increased effectiveness of treatment of such diseases as syphilis, to the newer drugs and to emphasis on treatment as contrasted to custodial care.

The Subcommittee on Blood Dyscrasias reports a steady increase in the number of cases reported to their Registry. During the first six months of 1960, 303 new cases were added, thus increasing the total in the Registry to 1173. The subcommittee was established to aid in the early detection of reactions caused by the newer chemicals and therapeutic agents and affecting the hematopoietic system. Physicians encountering such cases are requested to communicate with Dr. Norman De Nosaquo, 535 N. Dearborn St., Chicago.

Wall Street Journal reports a new "big business." Voluntary health agencies receive over $1 billion a year in contributions. Approximately 100 agencies conduct national fund drives. In Los Angeles last year there were 538 separate campaigns for local and national health groups. Naturally there is a lot of duplication. There are 19 national organizations to help the blind and three for muscular dystrophy. In Boston there are 63 organizations for rehabilitation of the handicapped.

It is evident that uncontrolled development will lead to such a conglomeration as to discourage public support for any of the health agencies. At present the Rockefeller Foundation is conducting a study of the entire problem.

Eugene Beesley, president of Eli Lilly and Company, in testifying before the Kefauver Committee, reported on a reduction in prices of Lilly antibiotics varying from 94% to 15%. The 94% decline is related to one of the penicillin preparations and has occurred over a period of 12 years. The 15% reduction was for Ilosone which was introduced in 1958. Mr. Beesley also stated that the Lilly sales price index of all human medicines had fallen by 14% in 10 years, during which time the consumer price index had risen by 20%.

The Atomic Energy Commission announced recently that three more of their major plants have exceeded 10,000,000 man-hours of operation without a lost-time accident. The record covers ordinary accidents as well as radiation injury. The AEC all-time safety record was established in September with a total of 14,936,159 man-hours work before a lost-time accident occurred.

Journal Offers $5 Each for Anecdotes

A new department of *The Journal* is being organized for the publication of accounts of personal experiences of Indiana physicians. The practice of medicine is interwoven and frequently involved with the drama of life. In a lifetime of practice doctors are in contact with many episodes of amusing, thrilling, ridiculous or dramatic import. Members of the association are invited to submit manuscripts for this purpose. Author's names need not be published, initials may be used. The narrations may be short, but should be limited to 1200 words. *The Journal* will pay $5.00 for each one published.

Statement by Leroy E. Burney
Surgeon-General, Public
Health Service.

Influenza Immunization

TWO OUTBREAKS of influenza swept the United States in the fall of 1957 and the winter of 1958, resulting in 60,000 more deaths than would be expected under normal conditions. There were, in addition, more than 26,000 excess deaths during the first three months of 1960 which also were considered to be the result of influenza.

These departures from the usually predictable norms prompted the Surgeon General's Advisory Committee on Influenza Research to analyze the cause and to seek measures to prevent such an occurrence in the future.

The committee found that a new antigenic variant, the Asian strain, because of its widespread introduction and the general lack of resistance to it, was the direct cause of the excess number of deaths, not only in the total population but most markedly among the chronically ill, the aged and pregnant women. As a result of these findings, the Public Health Service is urging a continuing program to protect these high-risk groups in order to prevent a recurrence of this excess mortality.

The high-risk groups who contribute most to the excess deaths and who the Public Health Service believes should be routinely immunized each year are:

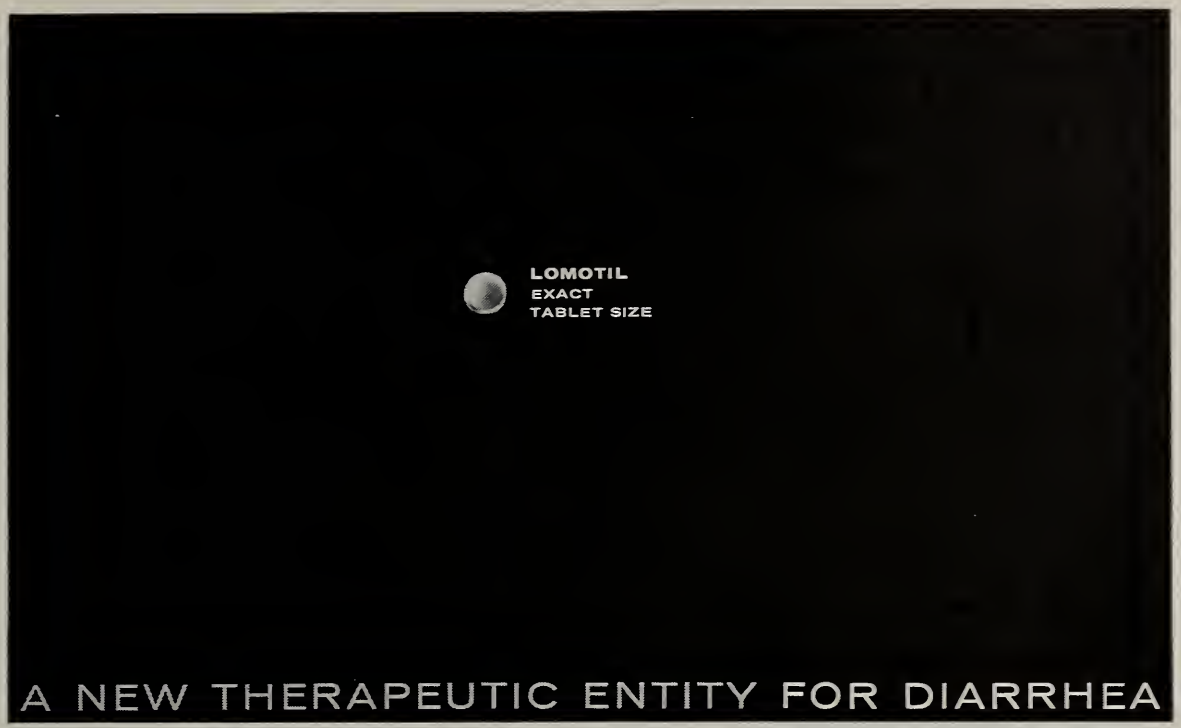
1. Persons of all ages who suffer from chronic debilitating disease, in particular: (*a*) rheumatic heart disease, especially mitral stenosis; (*b*) other cardiovascular diseases, such as arteriosclerotic heart disease or hypertension—especially patients with evidence of frank or incipient insufficiency; (*c*) chronic bronchopulmonary disease, for example, chronic asthma, chronic bronchitis, bronchiectasis, pulmonary fibrosis, pulmonary emphysema, or pulmonary tuberculosis; (*d*) diabetes mellitus; (*e*) Addison's disease.

2. Pregnant women.

3. All persons 65 years or older.

The adult dosage recommended by the advisory committee for initial immunization is 1.0 cc. (500 cca units) of polyvalent vaccine, administered subcutaneously on two occasions separated by two or more months. Preferably, the first dose would be given no later than Sept. 1 and the second no later than Nov. 1. Persons previously immunized with polyvalent vaccine should be reinoculated with a single booster dose of 1.0 cc. subcutaneously each fall, prior to Nov. 1. The only contraindication to vaccination would be a history of food allergy to eggs or chicken or a prior history of allergic reaction to an egg-produced vaccine, such as the commercial influenza product.

The time to start such a program is before the onset of the influenza season this fall. In the past, influenza vaccination has been sparse and sporadic, and primarily in response to an epidemic or the threat of an epidemic. The unpredictablility of recurrence of influenza and its continued endemic occurrence are well known. Therefore, the Public Health Service strongly recommends that immunization of these high-risk groups be started now and continued annually, regardless of the predicted incidence of influenza for specific years. ◄



A NEW THERAPEUTIC ENTITY FOR DIARRHEA

LOMOTIL®

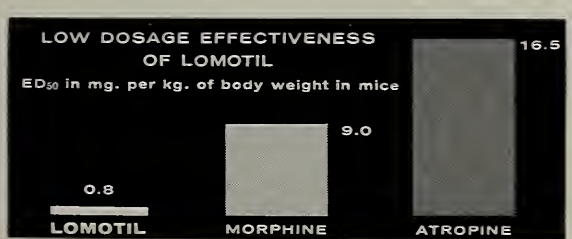
SELECTIVELY LOWERS PROPULSIVE MOTILITY

LOMOTIL represents a major advance over the opium derivatives in controlling the propulsive hypermotility occurring in diarrhea.

Precise quantitative pharmacologic studies demonstrate that Lomotil controls intestinal propulsion in approximately $\frac{1}{11}$ the dosage of morphine and $\frac{1}{20}$ the dosage of atropine and that therapeutic doses of Lomotil produce few or none of the diffuse untoward effects of these agents.

Clinical experience in 1,314 patients amply supports these findings. Even in such a severe test of antidiarrheal effectiveness as the colonic hyperactivity in patients with colectomy, Lomotil is effective in significantly slowing the fecal stream.

Whenever a paregoric-like action is indicated, Lomotil now offers positive antidiarrheal control . . . with safety and greater convenience. In addition, as a nonrefillable prescription product, Lomotil offers the physician full control of his patients' medication.



EFFICACY AND SAFETY of Lomotil are indicated by its low median effective dose. As measured by inhibition of charcoal propulsion in mice, Lomotil was effective in about $\frac{1}{11}$ the dosage of morphine hydrochloride and in about $\frac{1}{20}$ the dosage of atropine sulfate.

PRECAUTION: While it is necessary to classify Lomotil as a narcotic, no instance of addiction has been encountered in patients taking therapeutic doses. The abuse liability of Lomotil is comparable with that of codeine. Patients have taken therapeutic doses of Lomotil daily for as long as 300 days without showing withdrawal symptoms, even when challenged with nalorphine.

Recommended dosages should not be exceeded.

DOSAGE: The recommended initial dosage for adults is two tablets (5 mg.) three or four times daily, reduced to meet the requirements of each patient as soon as the diarrhea is controlled. Maintenance dosage may be as low as two tablets daily. Lomotil, brand of diphenoxylate hydrochloride with atropine sulfate, is supplied as unscored, uncoated white tablets of 2.5 mg., each containing 0.025 mg. ($\frac{1}{2400}$ gr.) of atropine sulfate to discourage deliberate overdosage.

Subject to Federal Narcotic Law.

Descriptive literature and directions for use available in Physicians' New Product Brochure No. 81 from

G. D. SEARLE & CO.
P.O. Box 5110, Chicago 80, Illinois
Research in the Service of Medicine

President's Page

Are You Tuned In?

On several occasions throughout the years subjects of significant importance are either formulated in our headquarters office or reach us through outside sources. When this happens the officers of our Association attempt in some way to reach the entire membership. One might draw the logical conclusion that this is one of the reasons for the President's page.

Recently a subject of vital importance was presented to each of us and a follow-up of this presentation showed that many among our membership either discarded the information in "file 13" or for one reason or another ignored it entirely.



This discussion then has to do with communication.

According to Dr. Ralph Nichols, author of "Are you Listening" 16% of our information comes via reading and 45% via listening. It is obvious from these conclusions that we would rather *hear* the subject we are interested in than *read* it. Since Dr. Nichols' essay is primarily dealing with the subject of "listening" he applies his findings to industry in an effort to show how much is lost through this medium. Because the "chain of command" in our organization bears marked resemblance to that of industry, let us apply "listening" to our own methods of communication in an effort to improve it.

In his treatise, Dr. Nichols states that when the chairman of the board transmits an oral message to the vice-president, plant manager, foreman, on down to the average worker, the percentage loss in the first instance is 33% with successive losses on the downward path until 20% of the original message reaches the worker.

If we accept the validity of this observation (and it has been tested repeatedly, with similar results, under comparable conditions) isn't it fair to conclude that since we prefer to listen rather than read, on a three to one basis, and because four-fifths of what we listen to is lost in the process of transmission—how much do we lose in the process of reading?

Whether this means of communication has been tested objectively is beside the point. The fact is, that in all of our sources of communication, speaking, writing, reading and listening, we lose much of the context.

Continued

Merry Christmas



To all our
members, friends
and advertisers

And Best Wishes
for a
Happy New Year

ISMA and
Journal Staffs

PRESIDENT'S PAGE

Continued

Analyzing this by direct application, we know that our Association consists of approximately 4,200 members. If, according to the above concept, 16% prefer reading to any other form of communication, it is probable that at most, 670 of the total read this page in the first place. We also recognize the fact that those who devote some part of their time to the cause of organized medicine in a state such as ours, numbers about 500. It is probably a reasonable conclusion, that of those who do communicate through reading, a majority have already interested themselves in the programs of organized medicine and therefore, have already received the message. If these figures are correct (and I sincerely hope they are not) we are actually reaching about five percent of the membership through this medium. If this stirs comment let's hope we hear from you.

How then, can we improve in the area of communication?

One way, of course, is to carry the message orally because it has been demonstrated that we would rather listen than read. This is true in spite of the fact that it has been shown by Dr. Nichols that we only retain 25% of what we hear after two months, but this is sufficient, if the idea developed through facts is the part retained.

The most recent example of poor communication, to use a current illustration, is the lack of knowledge concerning the "Indiana Health Organization for Political Education." In traveling about the state one is amazed that through the efforts already tried we have been unable to reach the "grass roots." It is true that some of this lack of information might be due to the price tag and in some instances the credulity or integrity of the organization has raised doubts. At any rate there are many who profess complete ignorance to the proposition.

In an attempt to correct this lack of communication it is my belief that we are failing to use our secret weapon, the Auxiliary. In cases where your officers feel the urgency of good rapport it might prove much more effective if the Auxiliary *called* each male member by phone and instead of notifying him of a "medical meeting," let's call it a "doctor's meeting." It is true that under such circumstances the officers would be required to appear in person to convey the message, but this is a small requirement if the benefits of improved communication are realized.

Guy A. Owsley



NEW CHEMOTHERAPY SIMPLIFIES VAGINITIS CONTROL

CENASERT® IMPROVED TABLETS

for vaginal administration

Specifically effective against *Trichomonas vaginalis, Candida albicans* (monilia)—and the mixed bacteria associated with nonspecific vaginitis.

- provides clinically proved results without antibiotics or corticosteroids
- avoids sensitization and adverse systemic effects
- lowers cost of medication
- avoids messiness and staining

Complete literature available

SUPPLIED: Bottles of 100 tablets, and combination packages of 30 with tablet inserter.

Each tablet contains: 1 mg. 9-aminoacridine undecylenate; 1 mg. N-myristyl-3-hydroxybutylamine hydrochloride; 1.8 mg. methylbenzethonium chloride; 12.5 mg. succinic acid; plus lactose and starch as excipients, in a rapidly disintegrating soluble vaginal tablet.

THE CENTRAL PHARMACAL COMPANY *Products Born of Continuous Research* ■ SEYMOUR, INDIANA

The Woman's Auxiliary

REPORTS TO ISMA



Dear Friends:

The chance to wax poetic
Comes seldom these busy days;
The flurry of life,
It's cheer and strife
Leaves us often with little to say.

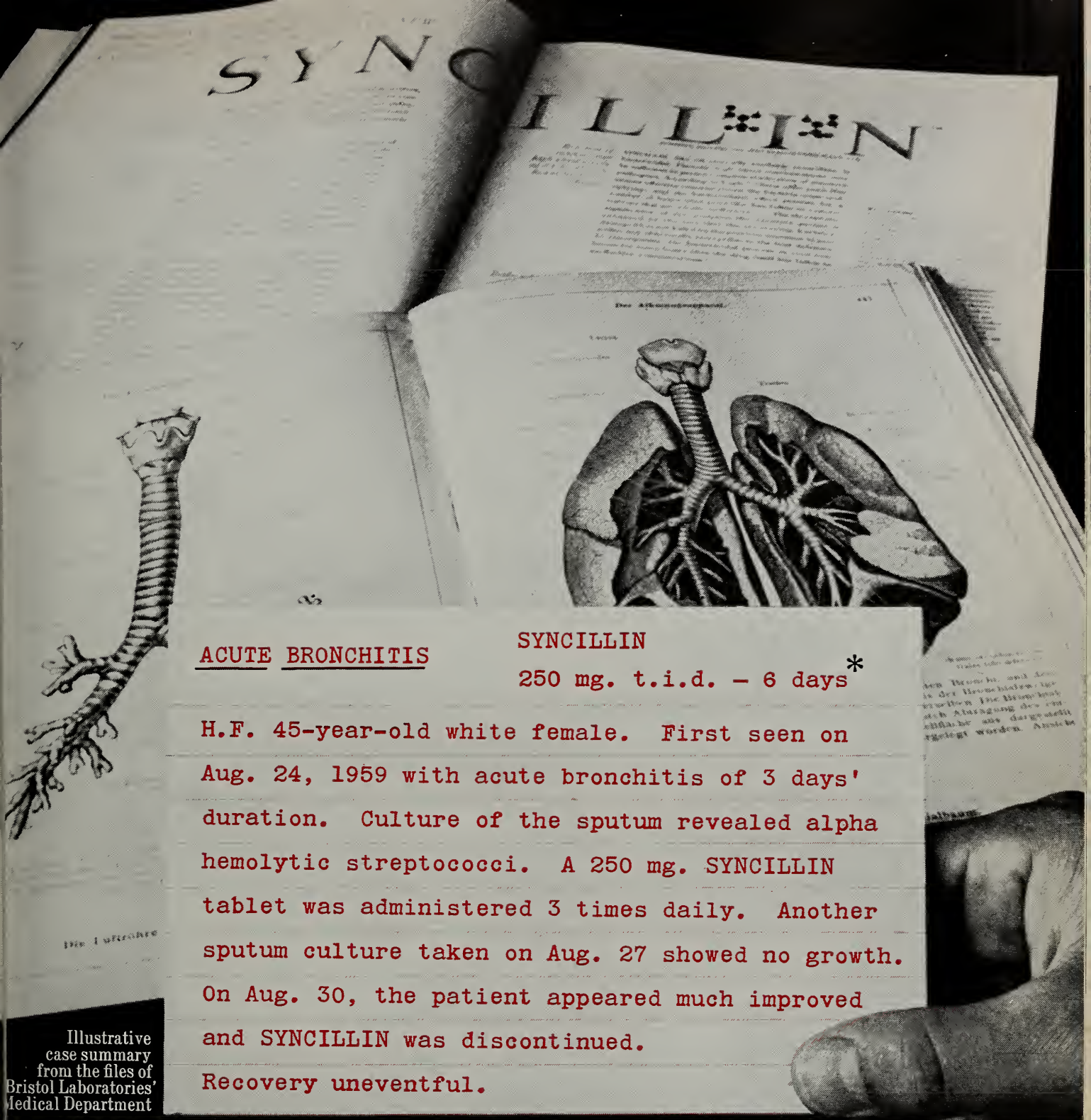
But Christmas somehow is different;
Time falters and slows to a crawl,
The trees are now bare
Wrapped in winter's care
And we've whispered farewell to the Fall.

It is now that we try to count them,
Our friends, those near and those far,
Like a clear-cut gem,
A flower's frail stem,
We cherish them just as they are.

If only we knew some white magic,
Secret words to bridge the air,
In a flash we'd appear
Full of joy and good cheer
To partake in your Holiday fare.

But of magic we know very little
Except to sincerely say,
"To all, Christmas cheer
And a Happy New Year,
God bless you this Sacred Day."

Ina. Rigley



ACUTE BRONCHITIS

SYNCILLIN
250 mg. t.i.d. – 6 days*

H.F. 45-year-old white female. First seen on Aug. 24, 1959 with acute bronchitis of 3 days' duration. Culture of the sputum revealed alpha hemolytic streptococci. A 250 mg. SYNCILLIN tablet was administered 3 times daily. Another sputum culture taken on Aug. 27 showed no growth. On Aug. 30, the patient appeared much improved and SYNCILLIN was discontinued. Recovery uneventful.

Illustrative case summary from the files of Bristol Laboratories' Medical Department

THE ORIGINAL phenethicillin

SYNCILLIN®

(phenoxyethyl penicillin potassium)

FIRST SYNTHESIZED AND MADE AVAILABLE BY BRISTOL LABORATORIES

A dosage form to meet the individual requirements of patients of all ages in home, office, clinic, and hospital:
Syncillin Tablets—250 mg. (400,000 units)...Syncillin Tablets—125 mg. (200,000 units)
Syncillin for Oral Solution—60 ml. bottles—when reconstituted, 125 mg. (200,000 units) per 5 ml.
Syncillin Pediatric Drops—1.5 Gm. bottles. Calibrated dropper delivers 125 mg. (200,000 units)

*Streptococcal infections should be treated for at least 10 days to prevent the development of rheumatic fever and as prophylaxis against bacterial endocarditis in susceptible patients.

Complete information on indications, dosage and precautions is included in the circular accompanying each package.

BRISTOL LABORATORIES, Div. of Bristol-Myers Co., SYRACUSE, N.Y.

Progress and Blue Shield

(One of a series of articles prepared by Blue Cross-Blue Shield)

Has Blue Shield been aggressive enough in pushing the better Blue Shield programs?

To get at the facts—we need to describe the actual progress Blue Shield has made in developing broader benefits, to relate what we have accomplished in selling these benefits and discuss some of the problems involved.

At our organization in 1946, the Blue Shield Board of Directors authorized the selling of the Standard $200 Schedule. Using this schedule as a base, we can readily trace the development of the Blue Shield benefits that followed. In 1948, the Blue Shield Board of Directors raised some allowances under the Standard Schedule so that payments to physicians increased 8.6%. In 1950, payments under the Standard Schedule were increased another 2.2%. In 1953, the payments were increased .9 of one per cent. Today, payments to physicians under the Standard Schedule are 11.9% higher than payments made to physicians in 1946.

The Preferred Schedule was developed in 1954. At that time the Standard Schedule was paying 87 to 90 cents of each membership fee dollar received. Due to the fact that Blue Shield is an indemnity program, and continually in competitive situations, the Blue Shield Board of Directors had no alternative but to offer a higher schedule, more realistic in terms of the charges being made, and for which a higher premium could be charged. Payments to physicians under the Preferred Schedule were 48% higher than those paid under the Standard Schedule. The Preferred Schedule was revised in 1956 and again in 1960. The Preferred Schedule now pays 54% higher benefits than the Standard Schedule. Today, Blue Shield is paying 71% more money to physicians for surgery than in 1946. Percent of increase does *not* include the effects upon payments of our increased membership.

The increase in benefits in the in-hospital medical portion of Blue Shield benefits is even more dramatic. In 1946, Blue Shield offered its members allowances of $3.00 per day starting with the third day for a total of 21 days per certificate year. In 1949, this benefit was increased to pay $3.00 per day starting with the second day for 30 days per certificate year, a 30% increase in payments for medical benefits. This program was revised upward again in 1954 so that Blue Shield paid $10.00 for the first day and $3.00 for each succeeding day for a total of 30 days per admission, an additional increase of 33%.

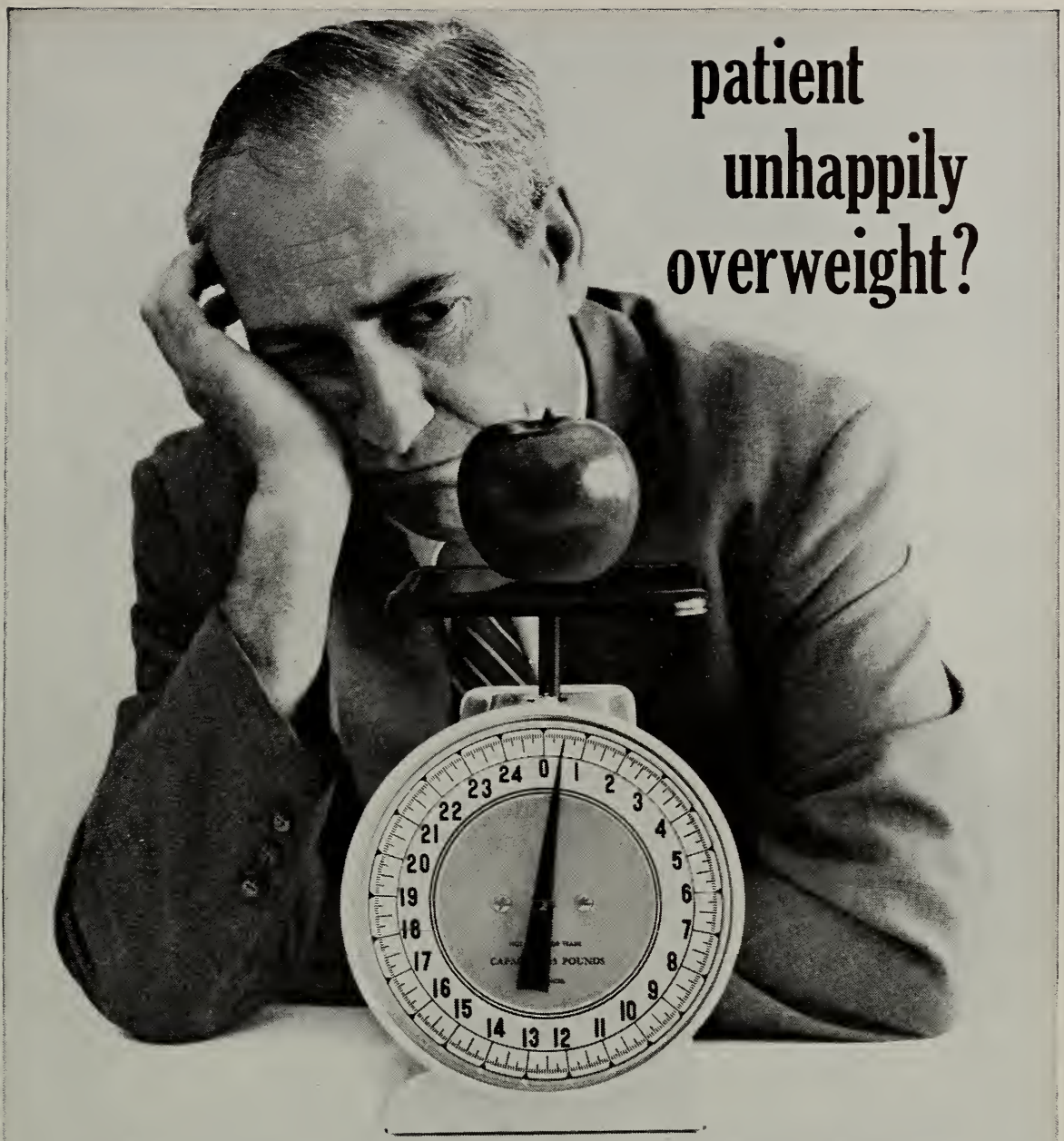
In 1956, Blue Shield developed the first Preferred in-hospital medical program, with allowances of $15.00 for the first day, $10.00 for the second day, $4.00 for each of the next eight days and $3.00 for each of the remaining days up to 120 days per admission. This change represented a 50% increase in payments over previous programs and brought the total increase in payments to physicians in the in-hospital medical area up 190% over the 1946 program.

Since June 1, 1960, the Preferred Surgical Schedule and Preferred In-hospital Medical coverage has been sold successfully to approximately 94% of all *new* accounts.

Blue Shield introduced the $50.00 Diagnostic X-ray and Pathology program and the home and office call program in 1952. The home and office call program has not been too widely sold, and is only offered when it is specifically requested, but the Diagnostic X-ray and Pathology program has enjoyed tremendous popularity among our accounts, and better than 25% of our members now have this protection.

Anesthesia benefits began to be transferred from Blue Cross to Blue Shield in 1955, and in 1957 the program was changed so that any person having any Blue Shield surgical schedule automatically had Blue Shield coverage for anesthesia.

The above is a condensed description of the development of Blue Shield benefits. We feel we've done a good job selling these programs, but there are some very real problems. Blue Shield is not a monopoly, and is in direct competition with many commercial insurance com-



minimize care and eliminate despair with 'METHEDRINE'®

brand Methamphetamine Hydrochloride

Controls food craving, keeps the reducer happy—In obesity, "our drug of choice has been methedrine . . . because it produces the same central effect with about one-half the dose required with plain amphetamine, because the effect is more prolonged, and because undesirable peripheral effects are significantly minimized or entirely absent."[1] Literature available on request.

Supplied: Tablets 5 mg., scored. Bottles of 100 and 1000.

[1] Douglas, H. S.: West. J. Surg. 59:238 (May) 1951.

BURROUGHS WELLCOME & CO. (U. S. A.) INC., Tuckahoe, New York

Wanted: Locations Physicians

Following is a list of physicians who have made inquiry at our office during the months of September and October 1960 concerning openings in our state for practice.

General Practice

Robert McKay, M.D., Edgewood, Tex.

Paul Bryan, M.D., 1742 W. Morris St., Indianapolis.

Jerzy Bazylczuk, Manteno State Hospital, Manteno, Ill.—also *Radiology.*

Robert C. Miller, M.D., 216 Lincoln St., Owatonna, Minn.—*Industrial Practice.*

Kenneth T. Woodsides, M.D., 1923 19th Loop, Sandia Base, Albuquerque, N. M.

Robert P. Soiseth, M.D., 2119 S. Olive, Sioux City, Ia.

James F. Grief, M.D., Broadlawns Polk County Hospital, Des Moines, Ia.

H. J. Strasser, M.D., Stanardsville, Va.

Specialists

Joseph T. Andrews, M.D., 1275 Delaware Ave., Buffalo, N. Y.—*surgery,* including trauma.

Rahim Farid, M.D., Homer Folks Hospital, Oneonta, N. Y.—*surgery.*

R. H. Zaki, M.D., 7741 Hasbrook Ave., Philadelphia 11, Pa.—*surgery.*

Richard A. Sinnott, Jr., M.D., 4532 Pine St., Bellaire, Tex.—*general thoracic and vascular surgery.*

Martin H. Perle, M.D., 765 Anderson Ave., Cliffside Park, N. J.—*orthopedic surgery.*

Nathan A. Ridgeway, M.D., 2438D S. MacGregor, Houston, Tex.—*internal medicine.*

R. E. Hammes, M.D., Children's Memorial Hospital, 707 Fullerton, Chicago, Ill.—*pediatrics.*

Wilfred B. Dodgson, M.D., 2751 Rhodesdale Ave., Akron 12, Ohio—*pediatrics.*

Arjan D. Amar, M.D., 550 11th Avenue, San Francisco, Calif.—*urology.*

James A. Chase, M.D., Lincolnway West, Ligonier, Ind.—*preceptorship-ENT;* also *general practice* in group practice. ◄

PROGRESS

Continued

panies. Blue Shield cannot, therefore, dictate to groups or individuals as to what kind of a program they must have. What we can do is develop the program, and do the best possible job selling it. As long as Blue Shield accepts the responsibility for protecting the over-65 and all segments of the population shunned by the commercial companies as "poor risks," Blue Shield must maintain its fair share of "good groups" on the basis of the highest program they can be sold in this competitive situation. If they can't get what they want from us, they'll buy what they want somewhere else.

Blue Shield membership falls into three basic categories. First of all, 76% of our members are employed by and enrolled through groups. Twelve percent are Direct Pay members who originally obtained their membership through a group. The remaining 12% obtained their membership through an open enrollment campaign or through the "Inquiry Card" type of membership that is available the year around.

All of our sales efforts stress the importance of adequate Blue Shield protection. Our enrollment division's sales brochures and sales presentations are based on the Preferred Surgical and Anesthesia schedules, Preferred In-hospital Medical protection and the $50.00 Diagnostic X-ray and Pathology program, and every effort is made to sell new accounts and convert old accounts to these benefits. We realize, however, that there are many people in Indiana who cannot afford this type of program. This is especially true in "low income" areas, and we have isolated cases in "high income" areas where the employees simply do not make enough money to pay for these benefits.

What is Blue Shield doing in the area of Direct Pay membership? On Oct. 20 we started a program of offering the Blue Shield Preferred surgical and in-hospital medical programs to the 12% of our Direct Pay membership who originally obtained their membership through a group.

What about the rest of our Direct Pay membership? Effective Nov. 15, 1960, everyone who submitted an "Inquiry Card" found in physicians' offices or hospitals was offered an option between Standard and Preferred.

With these developments, approximately 88% of our present membership has Preferred surgical and medical protection available to them. As of November 15, all of our new business has Preferred coverage available to them.

Blue Shield has made many improvements and will make more. From the beginning we have had to maintain a balance between all the services that might be included in a program and the services people want and are able and willing to pay for. Our future depends upon our ability to satisfy the needs of the people and upon the continued cooperation of the physicians of Indiana.

W. C. Huddlestone
Public Relations Division ◄

Diet or Drugs?

In the long term control of serum cholesterol, dietary therapy can achieve the objective in the manner most closely approximating physiological norm.

The long term control of elevated serum cholesterol through changes in the dietary pattern of the patient puts nature's own process to work most effectively to achieve the objectives of treatment. Here are the beneficial features of dietary therapy:

Offers a solution to the related problems of obesity.

Involves little or no added expense to the patient.

May be used with complete safety.

Produces no adverse side effects.

Preferable for the long-term management of a chronic condition.

Brings about reduction of serum cholesterol through physiological processes, as yet not fully understood.

Does not usually generate new compounds in the blood, thus helping the doctor make a more accurate analysis of blood serum cholesterol.

Elevated serum cholesterol has now been linked to an imbalance in the ratio of the type of fat in the diet. Reductions in cholesterol levels have been achieved repeatedly, both in medical research and practice, through the control of total calories and through the replacement of an appreciable percentage of saturated fat by poly-unsaturated vegetable oil.

An important measure in achieving replacement is the consistent use of poly-unsaturated pure vegetable oil in food preparation in place of saturated fat.

Free Wesson recipes for delicious main dishes, desserts and salad dressings are available for your patients. Request quantity needed from The Wesson People, Dept. N, 210 Baronne St.,

Poly-unsaturated Wesson is unsurpassed by any readily available brand, where a vegetable (salad) oil is medically recommended for a cholesterol depressant regimen.



About Our Cover

Many of the symbols and customs that we enjoy at Christmas have their origins in pagan times, long before the birth of Christ. These symbols and customs have evolved slowly to become the glitter and pageant we know and love today. Our Christmas tree with its glittering ornaments and flickering lights is thought to be of German origin. It was introduced into England in the middle of the nineteenth century by Queen Victoria's consort, Prince Albert of Saxe-Coburg, and into the United States by German settlers in Pennsylvania at about the same time. President Harrison was able to write in 1891, "We shall have an old-fashioned Christmas; the Christmas tree is in almost every home."

Our ancestors, the archaic peoples of Europe and Western Asia, kept the festival of Midwinter. When the sun was weakest and the hours of daylight shortest, they believed that by lighting bonfires the dying sun would be saved from death by the fire; buildings were decorated with evergreen branches so that the fallow fields would be reborn in the coming spring. The Barbarians—the Scandinavian races—celebrated Yule; and the Romans, the birthdays of Mithras and Saturn, during the ceremonies surrounding Saturnalia evergreen trees were decorated with small masks of Bacchus. Thus since time immemorial, the Winter Solstice has been celebrated as the Birthday of the Unconquered Sun—Dies Natalis Invicti Solis.

Today while we celebrate the Birthday of Christ, we perpetuate some of the heathen customs of our forebears.

Our Christmas cover, with its colorful candles so evocative of the approaching holiday season, was supplied to us through the courtesy of The Champion Paper and Fibre Company manufacturers of our cover stock, Kromekote® paper.—M.E.F.



What's she doing that's of medical interest?

She's drinking a glass of pure Florida orange juice. And that's important to her physician for several reasons.

How your patients obtain their vitamins or any of the other nutrients found in citrus fruits is of great medical interest—considering the fact there are so many wrong ways of doing it, so many substitutes and imitations for the real thing.

Actually, there's no better way for this young lady to obtain her vitamin C than by doing just what she is doing, for there's no better source than oranges and grapefruit ripened in the Florida sunshine. There's no substitute for the result of nature's own mysterious chemistry, flourishing in the warmth of this luxurious peninsula.

An obvious truth, you might say, but not so obvious to the parents of many teen-agers.

We know that a tall glass of orange juice is just about the best thing they can reach for when they raid the refrigerator. We also know that if you encourage this refreshing and healthful habit among your young patients — and for that matter, your patients of any age — you'll be helping them to the finest between-meals drink there is.

Nothing has ever matched the quality of Florida citrus—watched over as it is by a State Commission that enforces the world's highest standards for quality in fresh, frozen, canned or cartoned citrus fruits and juices.

That's why the young lady's activities are of medical interest.

©Florida Citrus Commission, Lakeland, Florida



Evansville Assistant, Doctor-Boss Named to National Offices

An Evansville medical assistant and her physician-boss were named to offices of the American Association of Medical Assistants at the group's fourth annual convention, Oct. 14-16 in Dallas, Tex.



Mrs. Bettye J. Fisher was elected vice president of the AAMA and Dr. Robert A. Royster, re-appointed to a three-year term on the AAMA advisory board.

Mrs. Fisher has been employed as assistant in Dr. Royster's office for 13 years. She was co-founder and vice president of the First District Medical Assistants Association and is currently serving as secretary and editor of the group. She was organizing chairman and the first president of the Indiana State Association of Medical Assistants.

Mrs. Fisher has served as legislation chairman of the AAMA during the past year; she was reappointed to this chairmanship for 1961.

Dr. Baker Honored For Role in Organizing Rehabilitation Center

Dr. Herman M. Baker, Evansville, former ISMA president and newly-initiated member of the 50-Year Club was honored recently by the Vanderburgh County Society for Crippled Children and Adults for his devoted service and key role in organizing the community rehabilitation center.

Dr. Baker received the Award of Merit from the National Society for Crippled Children and Adults, Inc. and witnessed the public unveiling of his portrait, a gift from patients and community associates, which will hang in the Evansville rehabilitation center.

Bluffton Physician New Prexy Of American Medical Clinics Group

Dr. Harold Caylor of Bluffton was inducted into the office of president of the American Association of Medical Clinics at a recent meeting in New Orleans. Dr. Joseph Davis of Marion is secretary-treasurer of the organization.

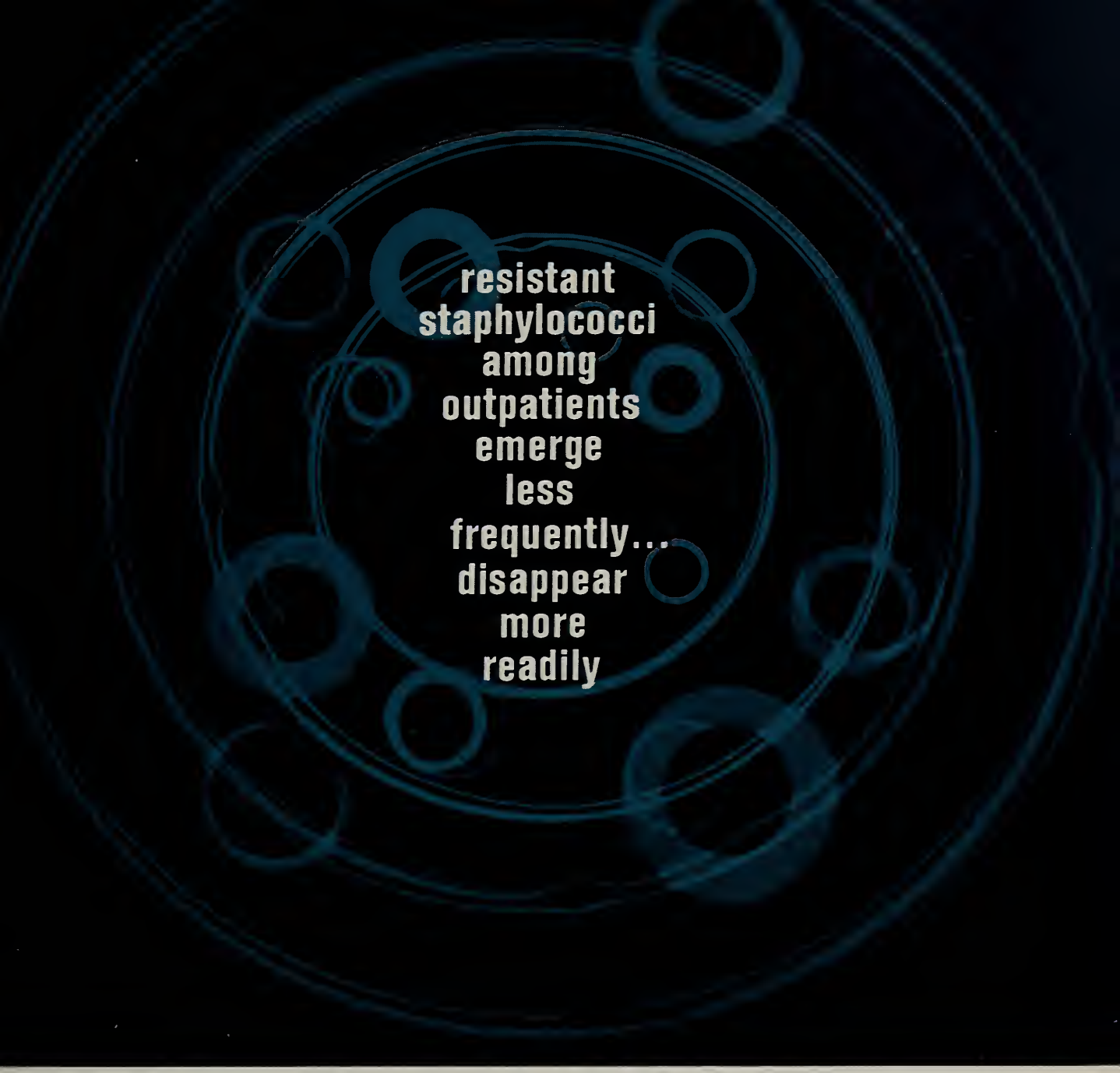
During the scientific program Dr. Charles Boonstra, Bluffton, participated in a workshop panel on Radioisotopes, Dr. C. E. Jackson, Bluffton, reported on an AAMC Survey on Blood Types in Parathyroid Adenoma Patients, Dr. Caylor moderated a panel on Problems of Graduate and Postgraduate Medical Education and Dr. George Plain, South Bend, moderated a panel on Insurance and Retirement Programs for Clinics.

Ob-Gyn Part I Written Exam Scheduled for January '61

The next scheduled examination—Part I, written—of the American Board of Obstetrics and Gynecology will be held in various cities of the U. S., Canada and military centers outside of the continental U. S. on Jan. 13, 1961.

Reopened candidates are required to submit case reports for review 30 days after notification of eligibility. Scheduled Part I and candidates resubmitting case reports must submit them prior to Aug. 1 each year.

Current bulletins may be obtained from Robert L. Faulkner, M.D. Executive Secretary and Treasurer, 2105 Adelbert Rd., Cleveland 6, Ohio.



CHLOROMYCETIN®

chloramphenicol, Parke-Davis

IN VITRO SENSITIVITY OF COAGULASE-POSITIVE STAPHYLOCOCCI TO CHLOROMYCETIN FROM 1955 TO 1959*



These sensitivity tests were done by the disc method on 310 strains of coagulase-positive staphylococci. Strains were isolated from patients seen in the emergency room. It should be noted that among inpatients, resistant strains were considerably more prevalent.

*Adapted from Bauer, A. W.; Perry, D. M., & Kirby, W. M. M.: *J.A.M.A.* 173:475, 1960.

10360

CHLOROMYCETIN (chloramphenicol, Parke-Davis) is available in various forms, including Kapseals® of 250 mg., in bottles of 16 and 100.

CHLOROMYCETIN is a potent therapeutic agent and, because certain blood dyscrasias have been associated with its administration, it should not be used indiscriminately or for minor infections. Furthermore, as with certain other drugs, adequate blood studies should be made when the patient requires prolonged or intermittent therapy.

PARKE-DAVIS

PARKE, DAVIS & COMPANY • DETROIT 32, MICHIGAN



NEWS NOTES

Continued

Medical History of War II Offered

Many of the medical lessons learned during World War I had to be relearned under fire during World War II because of paucity of distribution of the World War I medical history.

Lieutenant General Leonard D. Heaton, Army Surgeon General, in an endeavor to prevent this costly relearning process in the unhappy event of another war, has directed the preparation, publication and distribution of the "History of the Medical Department, United States Army, in World War II." General Heaton is particularly anxious that information of the existence and availability of this history be circulated widely among the profession, both military and civilian.

Of the 48 volumes programmed for the series, 15 have been published and can be purchased at modest cost from The Superintendent of Documents, Government Printing Office, Washington 25, D. C. The set of 15 volumes may be purchased for $66.50 or medical volumes can be obtained at remarkably low prices.

Volumes now available are:

General Surgery—Edited by Michael E. DeBakey, M.D.

Neurosurgery, Volume I (Head Injuries)—Edited by R. Glen Spurling, M.D., and Barnes Woodhall, M.D.

Neurosurgery, Volume II (Spinal Cord and Peripheral Nerve Injuries)—Edited by R. Glen Spurling, M.D., and Barnes Woodhall, M.D.

Hand Surgery—Edited by Sterling Bunnell, M.D.

Ophthalmology and Otolaryngology—Edited by Elliott Randolph, M.D., and Norton Canfield, M.D.

Orthopedic Surgery, European Theater of Operations—Edited by Mather Cleveland, M.D.

Orthopedic Surgery, Mediterranean Theater of Operations—By Oscar P. Hampton, M.D.

Physiologic Effects of Wounds—Edited by Fred W. Rankin, M.D., and Michael E. DeBakey, M.D.

Vascular Surgery—Edited by Daniel C. Elkin, M.D., and Michael E. DeBakey, M.D.

Cold Injury, Ground Type—By Tom F. Whayne and Michael E. DeBakey, M.D.

Dental Service—By George F. Jeffcott, D.M.D.

Environmental Hygiene—By James Stevens Simmons, M.D., and others.

Personal Health Measures and Immunization—By John E. Gordon, M.D., Tom F. Whayne, M.D., and others.

Communicable Diseases, Volume IV—By John E. Gordon, M.D., Joseph Stokes, M.D., and others.

Hospitalization and Evacuation, Zone of Interior—By Clarence McKittrick Smith.

Indiana G.P.'s Meet at Ft. Wayne

Speakers at the seventh annual road show of the Indiana Academy of General Practice, Dec. 6 at Fort Wayne, included Drs. Richard H. Ferguson, Consultant in Rheumatology, Mayo Clinic, and Donald B. Effler, Head of the Department of Thoracic Surgery, Cleveland Clinic.

Dr. Richard B. Juergens, Fort Wayne, was local arrangements chairman for the event.

College of Surgeons Inducts 13 Hoosiers as Fellows

The American College of Surgeons inducted 1175 surgeons as Fellows at its recent Clinical Congress in San Francisco. Those from Indiana included Drs. Gilbert J. Himebaugh, Evansville; William E. Brandt, Fort Wayne; Karl L. Manders, Michael W. Manzie, Robert F. Nagan, Frederic W. Taylor and Fred M. Wilson, Indianapolis; Edward J. Ploetner, Jasper; Edwin C. Mueller and John C. Richter, LaPorte; Howard E. Hill, Muncie; Clifford A. Wiethoff, Seymour, and Hossein Hashemi, Warsaw.

Dr. Lester D. Bibler, Indianapolis, presented two papers, "Care of the Aged" and "The General Practitioner of 1970," to the Mississippi Academy of General Practice in Jackson, Mississippi, September 29th, 1960.

INDIANA STATE BOARD OF HEALTH

Monthly Report — October, 1960

Disease	Oct. 1960	Sept. 1960	Aug. 1960	Oct. 1959	Oct. 1958
Animal Bites	484	561	795	435	784
Chickenpox	101	26	29	40	104
Conjunctivitis	37	62	65	38	41
Diphtheria	1	0	0	0	4
Dysentery, Unspecified	27	36	11	16	14
Impetigo	269	302	176	112	175
Infectious Hepatitis	68	43	54	18	17
Infectious Mononucleosis	10	9	10	12	19
Influenza	682	527	366	411	753
Measles (Rubeola-Rubella)	120	89	222	35	171
Meningitis, Meningococcal	1	1	5	1	4
Meningitis, Other	9	4	11	23	15
Mumps	56	39	67	41	87
Pertussis	11	6	11	40	147
Pneumonia	123	124	86	76	138
Poliomyelitis	23	49	32	20	39
Streptococcal Infections	254	296	385	135	372
Tinea Capitis	27	35	0	7	7

Tested . . . and proved . . .

ORAL therapy in diaper rash!



Convenient . . . simply open a capsule and add the contents to the baby's daily formula, or to fruit juice or water. No lotions . . . no rinses . . . no ointments . . . just oral therapy.

Send for samples and literature.

S. F. DURST & CO., INC.
Philadelphia 20, Pa.

Effective therapy! Thousands of pediatricians and general practitioners prescribe Pedameth for ammonia dermatitis—and they continue to prescribe it. Clinical tests have proved its effectiveness. Pedameth is safe because it contains only dl-methionine (0.2 Gm.) one of the essential amino acids. When Pedameth is administered, the pH of the urine is lowered and an as-yet-unknown antibacterial agent appears in the urine. Pedameth works . . . it's the safe, effective, convenient answer to ammoniacal diaper rash.

Prescribe

PEDAMETH®

(dl-methionine DURST)

NEWS NOTES

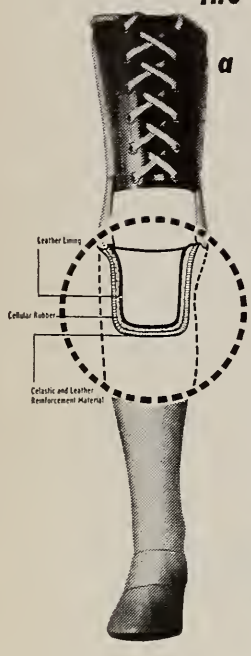
Continued

I.U. Alumnus Chosen Officer Of Ob-Gyn College

Dr. Nicholson J. Eastman, alumnus of Indiana University School of Medicine, and recently Professor of Obstetrics at Johns Hopkins University, has been chosen president-elect of the American College of Obstetricians and Gynecologists. Dr. Eastman has retired from active practice and plans to devote most of his time to the affairs of the College.

the SOFT SOCKET

a new solution for sensitive stumps



The Soft Socket for below-knee amputations provides a new solution for sensitive stumps where weight-bearing has been or may be uncomfortable. In constructing the Soft Socket Limb, a special socket is made which incorporates a layer of a new nitrogen-filled cellular rubber. This produces a slight but tangible degree of softness and resiliency in the socket, with the result that the sudden pressure on the stump caused by the first impact of weight-bearing is greatly reduced.

Hanger Research—by testing new ideas, methods and materials—is constantly seeking the better way to make even better prostheses that will bring greater happiness to amputees.

Hanger PROSTHESES

1529-33 N. Illinois St., Indianapolis 2, Ind.
3108 Burnet Avenue, Cincinnati 29, Ohio
Fairfield at Pontiac, Fort Wayne, Ind.
418 N. Main St., Evansville, Ind.

Dr. Mann Honored

Dr. Mortimer Mann, Indianapolis, was one of 17 physicians who received merit awards in Chicago from the American Academy of Ophthalmology and Otolaryngology, Oct. 10.

Dr. Mann was honored for his service in the academy's educational programs.

Attend Pathology Meeting

Drs. A. Wendell Musser and Clyde G. Culbertson, Indianapolis, reported on medical research at a joint annual meeting of the College of American Pathologists and the American Society of Clinical Pathologists, Sept. 23-Oct. 2 at Chicago.

Dr. Plain Named to U.F. Board

Dr. George E. Plain of South Bend has been elected to the board of directors of United Community Funds and Councils of America. Dr. Plain is chairman of the Indiana Better Health Foundation and is also a member of the USFC's Advisory Council and is chairman of their Committee on Local Health Programs.

Rhode Island Editor Dies

Dr. John E. Donley, Editor-in-Chief of *The Rhode Island Medical Journal* and a past president of the Rhode Island Medical Society died on September 17. He is succeeded as Editor-in-Chief by Dr. Seebert J. Goldowsky, who has served as Associate Editor for many years.

Modern living is also the fellow who thinks nothing of spending $50 to have a knock taken out of his old car, but cries if some doctor charges him $5 to take a kink out of his old carcass.—*Wall Street Journal*, June 23.



WABASH VALLEY SANITARIUM—HOSPITAL

Lafayette, Indiana
Telephone Riverside 3-1679

A hospital for the treatment of neuro-psychiatric disorders.

Custodial cases are accepted in limited numbers.

— OPEN STAFF —

DONALD R. KINZER
Manager

stops tension

For neuralgias, dysmenorrhea, upper respiratory distress, postsurgical conditions... new compound kills pain, stops tension, reduces fever—gives more complete relief than other analgesics.

Soma Compound is an entirely new, totally different analgesic combination that contains three drugs. First, Soma: a new type of analgesic that has proved to be highly effective in relieving both pain and tension.* Second, phenacetin: a "standard" analgesic and antipyretic. Third, caffeine: a safe, mild stimulant for elevation of mood. As a result, the patient gets more complete relief than he does with other analgesics.

Soma Compound is nonnarcotic and nonaddicting. It reduces pain perception without impairing the natural defense reflexes.*

NEW NONNARCOTIC ANALGESIC

soma® Compound

Composition: Soma (carisoprodol), 200 mg.; phenacetin, 160 mg.; caffeine, 32 mg.
Dosage: 1 or 2 tablets q.i.d.
Supplied: Bottles of 50 apricot-colored, scored tablets.

NEW FOR MORE SEVERE PAIN

soma® Compound + codeine

BOOSTS THE EFFECTIVENESS OF CODEINE: Soma Compound boosts the effectiveness of codeine. Therefore, only ¼ grain of codeine phosphate is supplied to relieve the more severe pain that usually requires ½ grain.

Composition: Same as Soma Compound plus ¼ grain codeine phosphate.
Dosage: 1 or 2 tablets q.i.d.
Supplied: Bottles of 50 white, lozenge-shaped tablets; subject to Federal Narcotics Regulations.

References available on request.

WALLACE LABORATORIES • Cranbury, N. J.

FUTURE MEETINGS, SEMINARS, COURSES

Cardiac Resuscitation Course Started in Fort Wayne

A Cardiac Resuscitation course, consisting of lectures, demonstrations and laboratory work, will be given at monthly intervals during the coming year at Fort Wayne, Ind.

It will occupy eight hours of time, on Thursday and Friday evenings and Saturday morning, at St. Joseph Hospital.

Approved for eight hours Category I credit by A.A.G.P., the course is sponsored by A.A.G.P., Bruggeman Foundation and the Northeast Indiana Chapter, American Heart Association. It has been organized by Drs. E. M. Hoetzer, A. F. Hoffman, R. P. Lloyd and J. W. McCallister, under the chairmanship of Dr. J. E. Arata.

Open to qualified physicians and dentists, the course is limited to an enrollment of 10, on a first-come, first-served basis. A $10 fee should accompany applications.

The course is scheduled for the following dates:

December	15, 16, and 17, 1960
January	26, 27, and 28, 1961
February	23, 24, and 25, 1961
March	23, 24, and 25, 1961
April	27, 28, and 29, 1961
May	25, 26, and 27, 1961

Reservations can be made with Dr. Arata, 347 W. Berry St., Fort Wayne.

Orthopaedic, Abdominal Surgeons Schedule Miami Beach Sessions

Miami Beach, Fla. will be the site of two medical meetings scheduled for January by national specialty groups.

The American Academy of Orthopaedic Surgeons will meet at the Hotel Americana, Bal Harbour, Jan. 8-13. Mr. John K. Hart, executive secretary, 116 S. Michigan Ave., Chicago 3, may be contacted for further information.

Also meeting in Miami, Jan. 30-Feb. 3, at the Deauville Hotel, will be the Clinical Congress of Abdominal Surgeons. Dr. Blaise F. Alfano, 663 Main St., Melrose 76, Mass., has additional information regarding this session.

Two Groups Choose Chicago For February Meetings

Meeting in Chicago during February will be the American College of Radiology and the American Academy of Forensic Sciences.

The radiology meeting, Feb. 8-11, will take place at the Drake Hotel, as will the forensic sciences session, Feb. 23-25.

Physicians interested in attending the radiology meeting should contact William C. Stronach, LL.B. 20 N. Wacker Drive, Chicago 6. Information concerning the forensic sciences meeting may be obtained from Dr. W. J. R. Camp, 1853 W. Polk St., Chicago 12.

ALLERGY GROUPS TO MEET IN FEBRUARY AND MARCH

Two allergy meetings are scheduled for early this year in Washington, D. C. and Dallas, Texas.

The American Academy of Allergy will meet Feb. 6-8 at the Statler-Hilton Hotel, Washington. Mr. James O. Kelley, 756 N. Milwaukee St., Milwaukee 2, Wisc., has information regarding this session.

Meeting in Dallas, Tex., Mar. 12-17 at the Statler-Hilton, will be the American College of Allergists. The secretary, Dr. Howard G. Rapaport, 16 E. 79th St., New York City, may be contacted about reservations.

A.A.G.P. SESSION IS APRIL 13-20

April 13-20 are the dates set by the American Academy of General Practice for a meeting in Miami Beach, Fla.

Continued

NEW *Antirheumatic Analgesic*

PLANOLAR*

for Rheumatoid Arthritis



Planolar combines the cumulative antirheumatic and anti-inflammatory action of Plaquenil® with the prompt analgesic action of aspirin.

Each tablet contains: **Plaquenil 60 mg.**
Aspirin 300 mg. (5 grains)

Plaquenil "...the preferred antimalarial drug for treatment of disorders of connective tissue..."[1]

Aspirin belongs to "...the most useful group of drugs for rheumatoid arthritis."[2]

WRITE:
for detailed information (clinical experience, side effects, precautions, etc.)

HOW SUPPLIED: ***Bottles of 100 tablets.***

Winthrop LABORATORIES
New York 18, N. Y.

DOSAGE: Adults, 2 tablets two or three times daily. After two or three months of therapy, the patient may no longer need the added benefit of aspirin. A maintenance regimen of Plaquenil sulfate alone (from 200 to 400 mg. daily) may then be substituted.

REFERENCES:

1. Scherbel, A. L.; Schuchter, S. L., and Harrison, J. W.: Cleveland Clin. Quart. 24:98, April, 1957.
2. Waine, Hans: Arthritis, rheumatoid, in Conn, H. F.: Current Therapy 1959, Philadelphia, W. B. Saunders Co., 1959, p. 565.

*Planolar, trademark

The executive director, Mr. Mac F. Cahal, Volker Blvd. at Brookside, Kansas City 12, Mo., may be contacted.

New Orleans Assembly to Include 57 Discussions, Many Conferences, Symposia

The New Orleans Graduate Medical Assembly will conduct its 24th annual meeting in New Orleans at the Roosevelt Hotel for four days from Mar. 6-9, 1961. Fifty-seven discussions on medical topics of current interest will be presented by a staff of guest speakers from the United States and Canada.

In addition there will be clinicopathologic conferences, symposia, roundtable luncheons, medical motion pictures and scientific exhibits. The registration fee is $20.00. Further information about the meeting and the clinical tour to the Orient after the meeting may be obtained by addressing the Assembly at 1430 Tulane Ave., New Orleans, 12.



"How am I going to explain this to my boss? I'm the only man in our advertising agency without an ulcer."

January 26-28 are dates for the eighth annual Cardiovascular Seminar, sponsored by the Northeast Florida Heart Association at Jacksonville, Fla. Further information may be obtained from Dr. Daniel R. Usdin, President, 1628 San Marco Boulevard, Jacksonville 7. ◄

Annual Clinical Conference

CHICAGO MEDICAL SOCIETY

FEBRUARY 28, MARCH 1, 2 and 3, 1961

Palmer House, Chicago

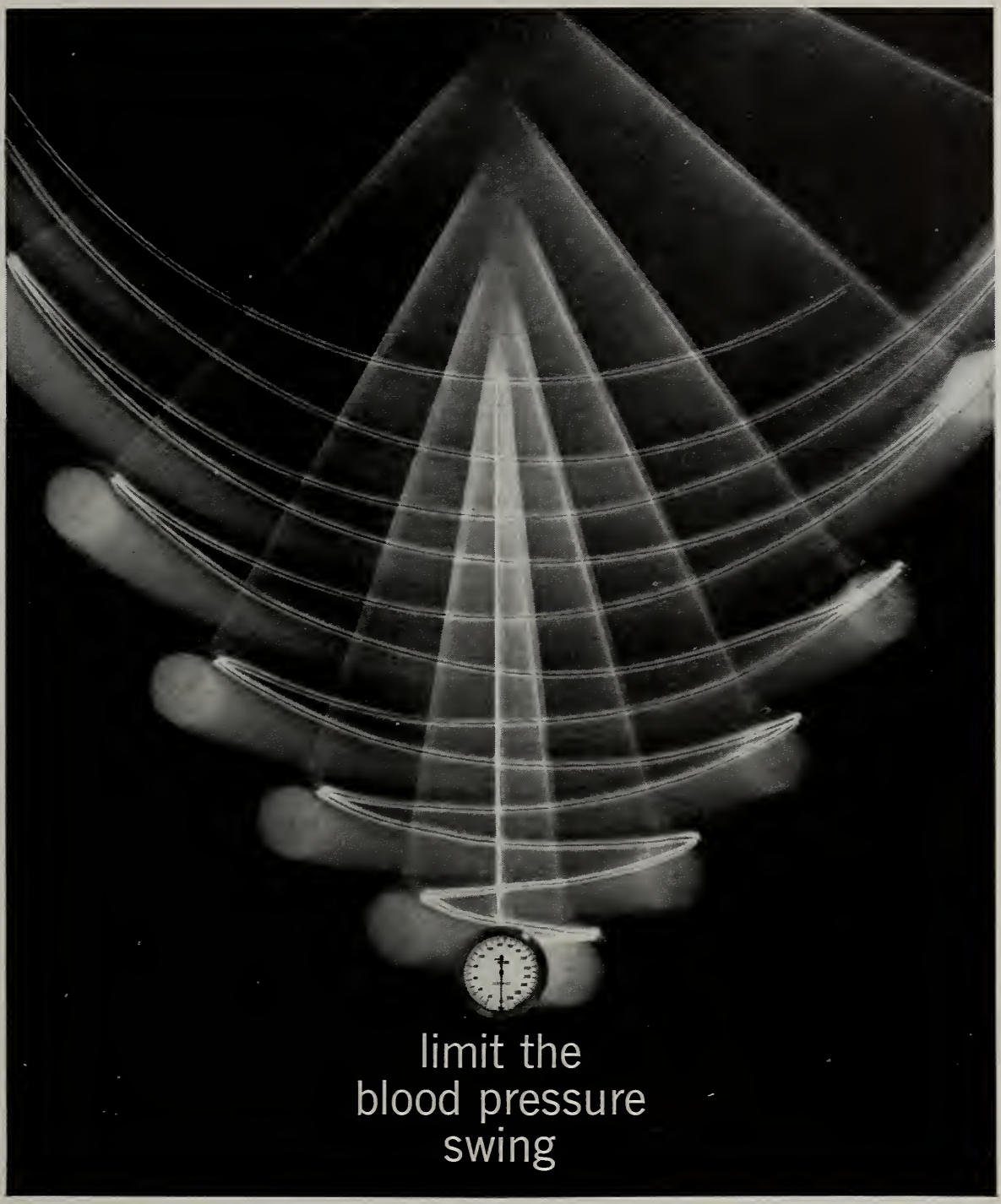
Daily Half-Hour Lectures by Outstanding Teachers and Speakers on subjects of interest to both general practitioner and specialist.

Panels on Timely Topics — **Teaching Demonstrations**

Medical Color Telecasts — **Instructional Courses**

Scientific Exhibits worthy of real study and helpful and time-saving Technical Exhibits.

The Chicago Medical Society Annual Clinical Conference should be a MUST on the calendar of every physician. Plan now to attend and make your reservations at the Palmer House.



Rautrax-N lowers high blood pressure gently, gradually . . . protects against sharp fluctuations in the normal pressure swing. Rautrax-N combines Raudixin, the cornerstone of antihypertensive therapy, with Naturetin, the new, safer diuretic-antihypertensive agent. The complementary action of the components permits a lower dose of each thus reducing the incidence of side effects. The result: Maximum effectiveness, minimal dosage, enhanced safety. Rautrax-N also contains potassium chloride – for added protection against possible potassium depletion during maintenance therapy.

Supply: Rautrax-N – capsule-shaped tablets – 50 mg. Raudixin, 4 mg. Naturetin, and 400 mg. potassium chloride. Rautrax-N Modified – capsule-shaped tablets – 50 mg. Raudixin, 2 mg. Naturetin, and 400 mg. potassium chloride. For complete information write Squibb, 745 Fifth Avenue, New York 22, N. Y.

new **Rautrax-N***

Squibb Standardized Whole Root Rauwolfia Serpentina (Raudixin) and Benzydroflumethiazide (*Naturetin) with Potassium Chloride

Squibb Quality—The Priceless Ingredient

SQUIBB

RAUDIXIN,® RAUTRAX,® AND NATURETIN® ARE SQUIBB TRADEMARKS.

Deaths

Carl H. McCaskey, M.D.

Dr. Carl McCaskey, Indianapolis, past president of ISMA and former chairman of the Department of Otolaryngology at the I. U. School of Medicine, passed away Oct. 8 at the age of 83.



Active in medical organizations for many years, Dr. McCaskey was president of the Marion County Medical Society, 1934-36, president of ISMA in 1943, and president of the American Academy of Ophthalmology in 1947. He was also a former vice president of the American College of Surgeons.

In ISMA, Dr. McCaskey served as chairman and vice chairman of the Section on Ophthalmology, and also as chairman of the Executive Committee, Committee on Arrangements, Budget Committee and Committee on Hard of Hearing.

Dr. McCaskey was a graduate of the I. U. School of Medicine, class of 1908.

Harold J. Pierce, M.D.

Dr. Harold J. Pierce, 78, Terre Haute radiologist since 1905, passed away Oct. 2.

One of the founders and the radiologist of the Associated Physicians and Surgeons Clinic, Dr. Pierce was a graduate of the Medical College of Indiana, class of 1905.

He was a Fellow of the American College of Radiology, and chief of radiology at Clay County Hospital, Brazil, and St. Anthony Hospital, Terre Haute.

Dr. Pierce was a former member of the ISMA Committee on Credentials and the Committee on Industrial and Civic Relations. ◄

The Harding Sanitarium

WORTHINGTON
OHIO

For the Diagnosis and Treatment of Psychiatric Disorders
and with
Limited Facilities for the Aging

GEORGE T. HARDING, M.D.
HARRISON S. EVANS, M.D.
Medical Directors

CHARLES W. HARDING, M.D.
Clinical Director

DONALD H. BURK, M.D.
CLARENCE E. CARNAHAN, M.D.
GEORGE T. HARDING, Jr., M.D.
HERNDON P. HARDING, M.D.
C. RICHARD JOHNSON, M.D.
ARNOLD L. NIELSEN, M.D.
R. EUGENE PROUT, M.D.

GRACE M. COLLET, Ph.D.
VERNON W. SHAFER, Ph.D.
Clinical Psychologists

MARY JANE McCONAUGHEY, M.S.W.
BENJAMIN E. WHEATLEY, M.S.W.
Psychiatric Social Workers

PAULINE L. TOOILL, R.R.L.
Medical Record Librarian

JAMES L. HAGLE, M.B.A.
Administrator

ESTHER L. SIMPSON, R.N.
Director of Nurses

Phone: Columbus TUXEDO 5-5381

500 Hear AMA Prexy Address Ft. Wayne Medical-Civic Meeting

Dr. E. Vincent Askey, Los Angeles, President of the AMA, addressed over 500 persons at a medical-civic dinner sponsored by the Allen County Medical Society in Fort Wayne, Nov. 1.

Guests included city officials, labor leaders, members of the clergy and local businessmen.

Dr. Askey spoke primarily of the AMA's opposing the social security approach to health care of the aged. He went on to discuss tremendous strides taking place in medicine, and termed "a deliberate falsehood" the criticism that the medical profession desires to limit the number of practicing physicians in the U. S. He praised Fort Wayne hospitals, which he toured while in the city.

The AMA President's talk was preceded by short addresses from Fort Wayne Mayor Paul M. Burns, ISMA President Guy A. Owsley, Dr. Walter E. Kruse, Society president and Dr. Francis L. Land, chairman of the Medical-Civic dinner meeting.

In other society news, the public relations committee met with representatives of Fort Wayne news media, Sept. 29. It was the third such conference between doctors and newsmen, aimed at improving mutual understanding.

DR. PAUL D. WHITE SPEAKER AT 13th DISTRICT MEETING

Dr. Paul Dudley White, Boston, internationally-known heart specialist, was principal speaker at the 13th District Medical Society annual meeting, Sept. 28 at Elkhart.

Dr. White discussed "The Health of the Physician Himself" at a dinner session which concluded the all-day meeting.

Dr. I. Phillips Frohman, Washington, D. C., editorial consultant and staff member of a number of medical publications, discussed "Research by the General Physician in His Practice" during the afternoon scientific session.

Also speaking during the afternoon, was Dr. Felix Wroblewski, New York City, Chairman of the Medical Enzymology Department, Sloan-Kettering Institute. His topic was "Enzymes in Clinical Diagnosis."

At a business meeting preceding the scientific session, Dr. C. E. Muhleman, LaPorte, was elected president for 1961. Assisting him will be Drs. D. Logan Dunlap, South Bend, vice president; James M. Wilson, South Bend, secretary-treasurer; R. E. Nelson, South Bend, Alternate Councilor and R. H. Denham, South Bend, Blue Shield Board representative. Councilor Dr. Burton Kintner, Elkhart, will not complete his term of office for another year.

The next district meeting of the society will be held Sept. 27 at LaPorte.

County, District News

Tenth District

ISMA President Guy A. Owsley was principal speaker at the Oct. 12 meeting of the 10th District Medical Society at Whiting. There were 118 physicians present.

Cass

Dr. Ernest Fogel discussed "Tranquilizers" at the Sept. 12 meeting of the Cass County Medical Society in Logansport. Twenty-two members attended.

Fountain-Warren

Eleven members of the Fountain-Warren Medical Society met at Attica Oct. 13 for a business meeting and to discuss reports on the ISMA annual convention.

Greene

Members of the Greene County Medical Society met Oct. 13 at Linton to hear the delegate's report of the ISMA annual meeting. Fifteen doctors attended.

Hendricks

Thirteen members of the Hendricks County Medical Society met Oct. 11 at Danville for a business meeting.

Knox

Sixteen members of the Knox County Medical Society gathered at Vincennes Oct. 18 for a dinner meeting.

LaPorte

Dr. H. C. Peltier spoke on progestational agents at the Oct. 18 meeting of the LaPorte County Medical Society at LaPorte.

The 26 members present heard a report on the ISMA annual meeting and then voted in favor of making polio shots available to children in grade schools which had least participation in immunization. The PTA in each school will reimburse physicians for administering injections to children from their respective schools.

Marion

Dr. Arthur B. Price, Chicago, Regional Medical Consultant for Civil Defense, spoke to members of the Marion County Medical Society at a Sept. 27 meeting in Indianapolis. Dr. Price discussed the plan that medical workers should follow in the event of major catastrophe.

The society was one of the sponsors of an institute emphasizing continuing patient care from hospital into the home, held Sept. 28 in Indianapolis. Representatives of hospital administrations, physicians, nurses and persons from health agencies attended the session.

Speakers included Drs. Harold F. Burdette, J. Hal Doran, John B. Hickam and Henry M. Parrish.

Montgomery

Dr. Robert Rhamey spoke on "Renal Hypertension Due to Lesions that Can Be Surgically Corrected" at the Oct. 20 meeting of the Montgomery County Medical Society at Crawfordsville. There were 24 members present.

Putnam

Dr. Robert Pickett, Indianapolis, spoke to 10 members of the Putnam County Medical Society on "Diseases of the Pancreas" at an Oct. 14 meeting held at DePauw University.

Shelby

Fifteen members attended a business meeting of the Shelby County Medical Society at Shelbyville Oct. 12.

St. Joseph

The St. Joseph County Medical Society and Indiana Academy of General Practice were sponsors of a symposium on Clinical Medicine and Surgery, Friday, Nov. 18, at South Bend. The event was made possible by a grant from Lederle Laboratories.

Dr. Carl S. Culbertson, Program Chairman for the society, moderated the sessions. Included on the program were Drs. Rachmiel Levine, Chicago; Frederic D. Zeman, New York City; Edward Litin, Rochester, Minn.; William M. Covode, Denver, Colo.; Donald A. Covalt, New York City and Harry F. Dowling, Chicago.

Wayne-Uunion

Dr. Stuart Bondurant spoke on "Space Medicine" at the Oct. 11 meeting of the Wayne-Union Medical Society at Richmond. Thirty-five members attended. ◄

OVER 80 YEARS' SPECIALIZED EXPERIENCE IN THE RESTORATIVE TREATMENT OF

"THE PROBLEM DRINKER"

At The Keeley Institute your patients are assured of receiving:

- the most modern, coordinated, comprehensive, rehabilitative regimen
- in addition to medical, nutritional and physiotherapeutic treatment, we also offer psychiatric diagnosis and psychotherapy
- full cooperation throughout with the referring physician
- in addition to the care of the alcoholic we also treat narcotic and drug addiction
- surprisingly low cost—to cover all medical care, medicines, laboratory work, room and excellent cuisine

You can obtain more detailed information by writing us direct.

WE WELCOME YOUR REFERRALS...

THE KEELEY INSTITUTE
DWIGHT, ILLINOIS

Member American Hospital Association, Member Illinois Hospital Association. Licensed by the Department of Public Health, State of Illinois.



1960 Convention Story

Last October marked the 111th time that Hoosier physicians have met to exchange medical information, renew old acquaintances, seriously consider business matters affecting medicine in Indiana and the nation.

Over 500 Indiana physicians and their wives gathered at the French Lick-Sheraton Hotel, Oct. 3-5. In addition to a full scientific program, they attended banquets, luncheons, receptions. Wives joined in the activities, after taking time to settle their own affairs of state.

The new president for 1960-61, Dr. Guy A. Owsley, Hartford City, took the gavel from Dr. Earl Mericle of Indianapolis. Elected as 1961-2 president was Dr. Harry R. Stimson, Gary. Other officers for this year are Drs. Irvin Wilkens, treasurer and Charles F. Gillespie, assistant treasurer.

On the following pages you'll find a picture story of some of the people and events which made up Indiana medicine's story for this year.

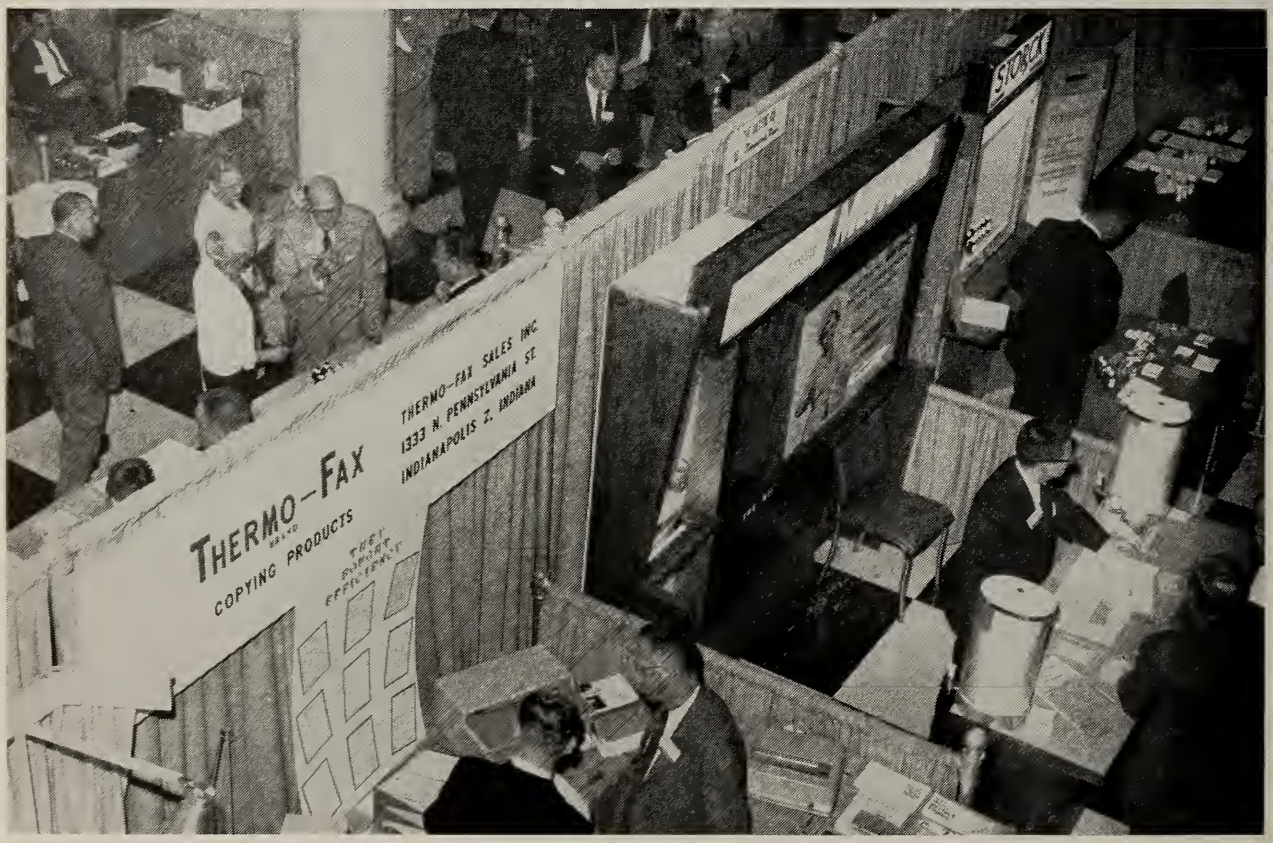




SCIENTIFIC SESSIONS featured guest speakers from throughout the United States. (above)

THE REFERENCE COMMITTEE on Insurance "gets down to business" after the first House meeting. (right)

TECHNICAL EXHIBITS in the Main and Mezzanine lounges were a convention highlight for over 525 physicians.





MONDAY EVENING found doctors and their wives gathered for dinner, followed by a dance in Convention Hall.



MANY PHYSICIANS found time to participate in the annual golf tournament, 18 holes, low gross, low net and blind bogie medal play at French Lick Hill Course.



MARKSMEN gathered at the French Lick Springs Trap and Skeet Club for the annual trap and skeet shoot.



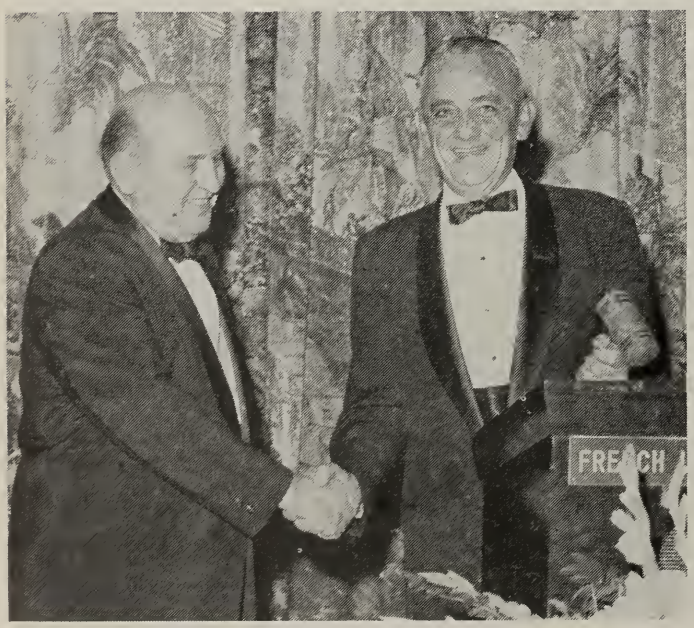
HOUSE OF DELEGATES MEMBERS relax before beginning their second meeting Wednesday morning.



THE WEATHER MAN catered to the ladies, who played bridge and canasta on the Hotel porch. (left)

DR. and MRS. RIGLEY, Dr. and Mrs. Owsley and Dr. and Mrs. Mericle greet guests at the president's reception.





NEW REGIME—Dr. Earl Mericle wishes his successor, Dr. Guy A. Owsley, a successful year as ISMA president.



THE COUNCIL met twice during the French Lick session to settle ISMA business matters at hand.



THE GREENE COUNTY BOYS, a group of Missouri physicians, evoked many a chuckle through a musical—and humerous version—of medical practice.



SPENDING LONG HOURS around the conference table was the Exective Committee of ISMA, headed by Dr. Don Wood.

50-Year Club Response

HERMAN BAKER, M.D.
Evansville

In speaking for this group I am going to use my own experience and I am sure it will fit pretty well with that of the group as a whole.

When I was born, Queen Victoria was on her throne and her grandson, Kaiser Wilhelm III, had just acceded to his throne, proclaiming the divine right of the House of Hohenzollern to rule. Grover Cleveland was still in the White House finishing out his first term. Labor unions were not a threat to anyone's peace of mind and the wound of our Civil War was healing. The Maine had not been sunk and Cuba and the Philippines were still Spanish possessions. The United States of America had not yet spread it's power beyond this continent. Just about 25 years before, Pasteur had announced the discovery of micro-organisms. It had only been 40 years since the discovery of nitrous oxide, chloroform and ether and 20 years since Lister had published his experiments in the prevention and cure of sepsis in wounds, thus laying the foundation for modern aseptic surgery. It had been just six years since Robert Koch discovered the tubercle bacillus.

I entered the medical school in 1906 about the time Schaudinn announced the discovery of the Spirochaeta pallida. During my years in medical school I worked as an office assistant to the surgeon who had written the first book, in any language, on diseases of the rectum and colon. At this time there were 155 medical schools in the United States, only 22 of which required more than a high school certificate, as shown by the famous Flexner report published in 1910. The hospital in which I interned had no x-ray and the only clinical laboratory work one could get was urinalysis for albumin and sugar, perhaps a microscopic study for casts and cells with an occasional blood count, all of which one did for oneself. Blood pressure readings were unknown. One could well carry in a small bag the instruments necessary to do the most complete examination anyone could do.

I could go on discussing infectious diseases, infant and maternal mortality, public health concepts, etc., but I think I have said enough to give you all some idea of the growth and evolution we have witnessed.

We have had a most interesting and perfectly wonderful time working in this period of evolution and transition and those of us who have been fortunate to have our health and maintain activity are most grateful.

To those of you who follow, the challenges of the future are indeed great. The changes will come more rapidly and I am sure more radically than we have seen. It is our hope that you will have the same satisfaction and gratification in serving society and this great profession of ours that we have had. ◄

Lake County G. P. Named President-Elect



HARRY RENNER STIMSON, M.D.

A Lake County General Practitioner, Dr. Harry Renner Stimson, will become president of the ISMA in 1961. He was elected to the office of president-elect by the ISMA House of Delegates at their annual meeting, Oct. 5.

Active in ISMA affairs since he first served as a delegate in 1948, Dr. Stimson has since served as member and chairman of several ISMA committees. In 1954 the House of Delegates accorded him the rare honor of a standing ovation for his report as Chairman of the Committee on Medical Education and Hospitals, dealing with the highly controversial subject of hospital accreditation and staff privileges.

Dr. Stimson was elected a member of the Indiana Blue Shield Board of Directors by the Tenth District in 1958, and still serves on the Board. He has also served as a delegate to the Indiana Academy of General Practice, of which he is a charter member.

When the Medicare program was initiated, Dr. Stimson was selected to administer the new law in Indiana and has since served as chairman of the committee. His interest in problems of prepaid medical care resulted in an invitation to address the American Medical Association's Conference on Prepaid Medical Care Plans.

Dr. Stimson was president of the Lake County Medical Society in 1955, and previous to that time served as county society secretary, 1953-54. He is a graduate of Indiana University, Class of 1934. ◄

Past-President's Message

At the time I was elected to this office I received a letter from Dr. W. U. Kennedy of New Castle, Indiana, with his plea to me that, if at all possible, I spend the year promoting unity in the ranks of our profession. As the year has gone by, efforts have been directed in that way. Our association has brought forth plans whereby professional groups such as the College of Surgeons, College of Physicians, General Practitioners and all members of our association could be brought more actively into the fold of our general meeting. In addition to this, efforts have been made to bring Indiana University School of Medicine more closely into the ranks of organized medicine. To some degree, I believe these efforts have been fruitful and the State Association is more unified than it has been in the past. It is our thought that, in the past, splintering of effort has weakened our united effort and if ever there is a time when unity is needed, certainly that time is now.



We are not only confronted with the continuing political situation wherein we are threatened by socializing influences from many sources, but also with increased demands of labor unions and other socializing groups. In addition to this there are times when the policies of our association are at odds with those of the Hospital Association. Sometimes, even the National Nursing Organization does not see eye to eye with us on issues.

Over the past year, I have had the opportunity to see other state associations in their deliberations; namely, Ohio, Kentucky, Michigan, and Illinois. I am

pleased to report that Indiana, in its efforts, does its job well and, in my opinion, better in some instances than do our sister states. It is heartening, in an experience such as has been mine, that one finds this to be true.

The future of organized medicine is still to be determined and will be determined by doctors of medicine; of that one can be certain. If, in the future, efforts stem from a united profession determined that our citizens be given the best in the way of health, then only good can come from this effort. The power of our association is great—greater, perhaps, than the total of our individual powers. By virtue of our being associated, we can keep freedom for medicine and, for our citizens, freedom to seek the doctor of their choice. People from other lands have come to talk to us telling of their experience and the dangers inherent in socializing. This should be a warning to guard carefully and watch carefully all inroads that are being made in our profession now. These inroads can come from within as well as from without, and it is necessary at all times, to be vigilant in protecting the rights and freedom that is now ours. If we continue to do so, one can be certain that the future will be good for us and for our patients because there is no power on earth that can take this from us if we stand united.

I wish to take this opportunity to thank the officers of this association, the Council, the Executive Committee, the Commissions, and the individual members who have rallied to aid in this cause and I wish, particularly, to thank our loyal employees, Jim Waggener and his staff, for their untiring efforts. I also wish to thank the Auxiliary for their willingness and cooperation. To my successor may I wish the best of health, a successful year and a pleasure equivalent to that which has been mine in the office during this past year.

Earle W Arnold M.D.

President, 1959-60

President's Address

Delivered October 4, 1960
French Lick, Indiana

EARL W. MERICLE, M.D.
Indianapolis

I believe it is fitting and proper that the president of this association should give some brief report of his activities and the activities of the association throughout the past year. This is a time when he learns from the calendar that he is to be replaced by someone who is fresh, strong, and eager. This is good.

In the past year, efforts have been made to unite our various members into a stronger group. We have asked the professional groups to meet with us in our state meeting so that we can have their support and we have been promised by some of their representatives that they will do so. This is good, because the more doctors are together, the more they understand each other's problems, and the more they will understand the general problems confronting all of us.

In addition to this, the year has been spent in the pursuit of obtaining a home for our association. At the present time I can report to you that we have selected a site but there is yet some legal technicality which keeps this purchase from becoming a finality. This site is at 3935 North Meridian Street.

In the past year, an organization has been developed, from members of this association, to pursue political efforts in a more practical way than heretofore has been possible by our association. This was effected after long deliberation and much consultation, and perhaps, in the future, this organization can do for medicine certain things that have not been possible in the past.

Our association has grown in numbers; we now have about 49 more members than we had at this time last year. This has brought us to a point where we are now represented in the AMA with five delegates, whereas, before, we had only four. Our delegates have expressed the wishes of our association ably in the national meetings and Indiana's voice has been heard and heeded on many occasions.

Following the advice of a management firm, our headquarters office has undergone a revamping and now we are in a better position to supply service to our individual members than was possible in the past. The financial system has been revamped until we are kept aware of our financial position at all times and our business methods are much better than they were.

Legislative Efforts Tremendous

Legislative activities, in the past year, have been tremendous. It is with considerable pleasure that tonight I can report to you that Forand-type legislation did not get by our national Congress. Organized medicine's effort in Indiana had a contributory part in defeating that legislation. Our legislative committee worked diligently, and Indiana had more resolutions sent to the members of Congress than any other state in the union. The Auxiliary's help in this matter was superb.

In addition to the foregoing, we have organized a joint council, in conjunction with dentists, hospitals and nursing homes, for the study of the problems of care of the aged and this joint council is currently supplying advice and counsel to the government of the State of Indiana. It is particularly pleasant to tell you that the Welfare Department of the State of Indiana is in closer liaison with our association than has ever been so in the past and our advice and counsel is being sought more and more by this body.

In the past year there has been marked effort on the part of our commissions, particularly those dealing with legislation, insurance and medical education. We have developed a closer liaison with the Blue plans than was ever before effected. We have a liaison committee with the

University which is functioning now in a better manner than ever before. We have people who are constantly studying insurance plans presented to us, to aid in our decision regarding these matters. In addition to meeting with the Blue plans, our association has met with commercial carriers of the State of Indiana. These efforts are directed toward covering all of the citizens of the State of Indiana with voluntary health insurance, and are directed, particularly, toward covering our senior citizens with insurance so that they may have proper medical care in a dignified manner without any governmental handout being necessary to them. In the field of voluntary health agencies, our commission has met with them and we are in much closer liaison with them than we have ever before known. Finally, in the past year, a basic health plan for the school system of Indiana has been established. These are, in the main, the accomplishments of the past year.

One cannot go through such a year as this without wondering what the future holds for medicine. As you all know, we are not as well regarded as we might be, and there are those who indicate that our image in the public's eye is not pleasant. We have been called Cadillac-driving, golf-playing, whiskey-drinking "no goods." This has been told to us by people within our own ranks and by experts in public opinion from outside our ranks. We need not look for any relief from the constant barrage of abuse that comes to us from sources that are opposed to our ideals.

Our ideals are still the right of free enterprise being available to anyone, particularly to anyone who is industrious enough to engage in free enterprise and help maintain it and pass it on to those who follow. Our own ranks must be scrutinized continually, too, because all of the profession's united effort toward good public relations cannot offset many deleterious effects of bad experiences in medical practice. The doctor must continue to be dedicated to a life of service. One must remember that the State of Indiana pays the major portion of the educational expenses coincident to becoming a physician. Receiving that payment, the physician accepts a community responsibility to give to the citizens of the community the best medical attention that can be obtained anywhere in the world.

This means a life of sacrifice to the physician but certainly one which compensates the giver very well. There are trends in our younger physicians' thinking which, perhaps, lean to the idea of free enterprise more than one realizes. There were times when it was thought that the younger men's indoctrination was not to free enterprise but to the socialistic influences. As one goes about the state, he notices younger men becoming more and more interested in protecting medicine's heritage than has been evidenced in the past. This is very heartening because soon to them will fall the load of carrying on their shoulders the future of medicine.

Vigilance in Politics

Another area in which medicine must be constantly vigilant is in the area of politics. We can no longer disdain political activity in our communities. It is necessary that all doctors contribute their part to the betterment of government in the communities in which they live. To not do so is to hide and indicate that one is disinterested in what happens.

The luxury of having interest only in clinical medicine is gone. Doctors find it necessary to protect the political climate too, and this is an absolute necessity not only to protect the future of medicine but also to protect the freedom of the citizens in the community. Doctors have been advised by various political figures of some stature, including governors of many states, and, no less a person than Sam Rayburn, that they must get into political activities at a general level if they are to stay free. The doctor must influence his family, his friends and his patients to help in the continuing fight for free enterprise.

Consideration should be given to the changing scene in medicine today. No longer are our members found almost entirely in the individual private practice of medicine. Many doctors are in federal positions, others in industrial practice and many are in the state service. Medical education is practically all done by full-time men. This situation is a result of social change and doctors' efforts in these areas have proven good by past performance. Society will not permit medicine to evacuate these positions. For this reason our association could study means to bring these people into the total picture and to make them welcome.

As a particular situation, the inclusion of the dean of the medical school in all Council meetings would certainly be an excellent means of

PRESIDENT'S ADDRESS
Continued

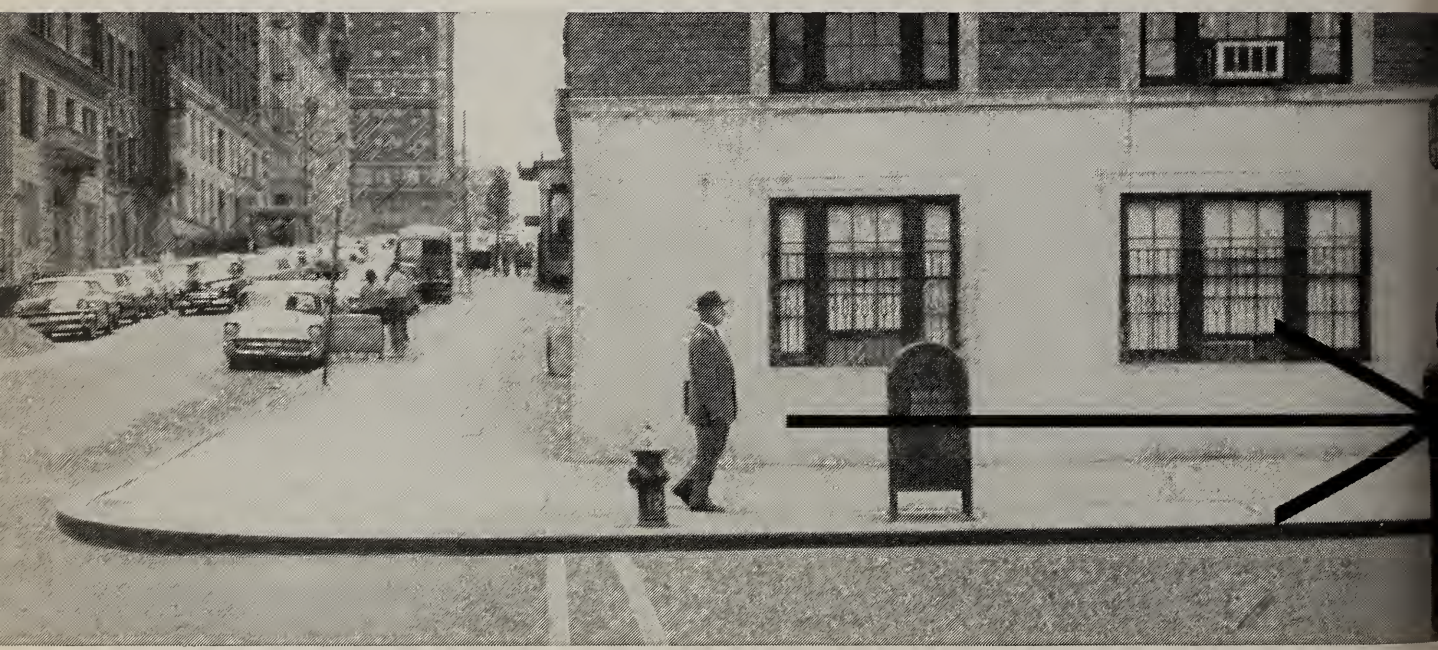
bringing needed liaison between the medical school and our association. In Michigan this has been done and both the association and the school are better for it.

Another person who could well attend our Council meetings is the secretary of the State Board of Health. His counsel could offer much to us and we have much to offer him. I also recommend that we study and take a long hard look at the proposal of the State Welfare Department. This proposal is that organized medicine take over the medical part of that department's program. Since 1957 our association has worked most harmoniously with the federal government in the Medicare program. Our state program is hailed in Washington as the best in all the 50 states. This success indicates that such a knotty problem can be dealt with and on a good basis.

Our association should take a long hard look at this challenge to us—to take over the medical part of the State Welfare program and operate it so that the recipients of welfare and the doctors who render the service are all treated fairly and well. Medicine throughout our nation is clamoring to have its voice heard—asking to lead in health matters. Maybe welfare activities rightly should be a part of our efforts as an organization. Done well, the state association would have the gratitude of the people and politicians forever; done poorly, our association would suffer disaster.

Rapid Growth of Knowledge

The future of medicine, if one can see it in the light of the past, presents another problem also. We are growing so fast in knowledge that it is practically impossible to keep abreast of things. It is almost impossible to keep a teacher currently abreast of things to the latest detail of information. This certainly exemplifies the fact that the average physician must work harder than ever before. If the past sheds light on what the future will be, and considering a few examples, such as the change in medicine brought about through penicillin and other antibiotics,



arlidin®

brand of nylidrin hydrochloride N.N.D.

safely increases local blood supply and oxygen where needed most... in distressed "walking" muscles for sustained, gratifying relief of pain and spasm in

intermittent claudication of
arteriosclerosis obliterans
thromboangiitis obliterans
diabetic atheromatosis

night leg cramps
ischemic ulcers
Raynaud's syndrome
cold feet, legs and hands

Arlidin is available in 6 mg. scored tablets, and 5 mg. per cc. parenteral solution. See PDR for dosage and packaging.

Protected by U. S. Patent Numbers: 2,661,372 and 2,661,373

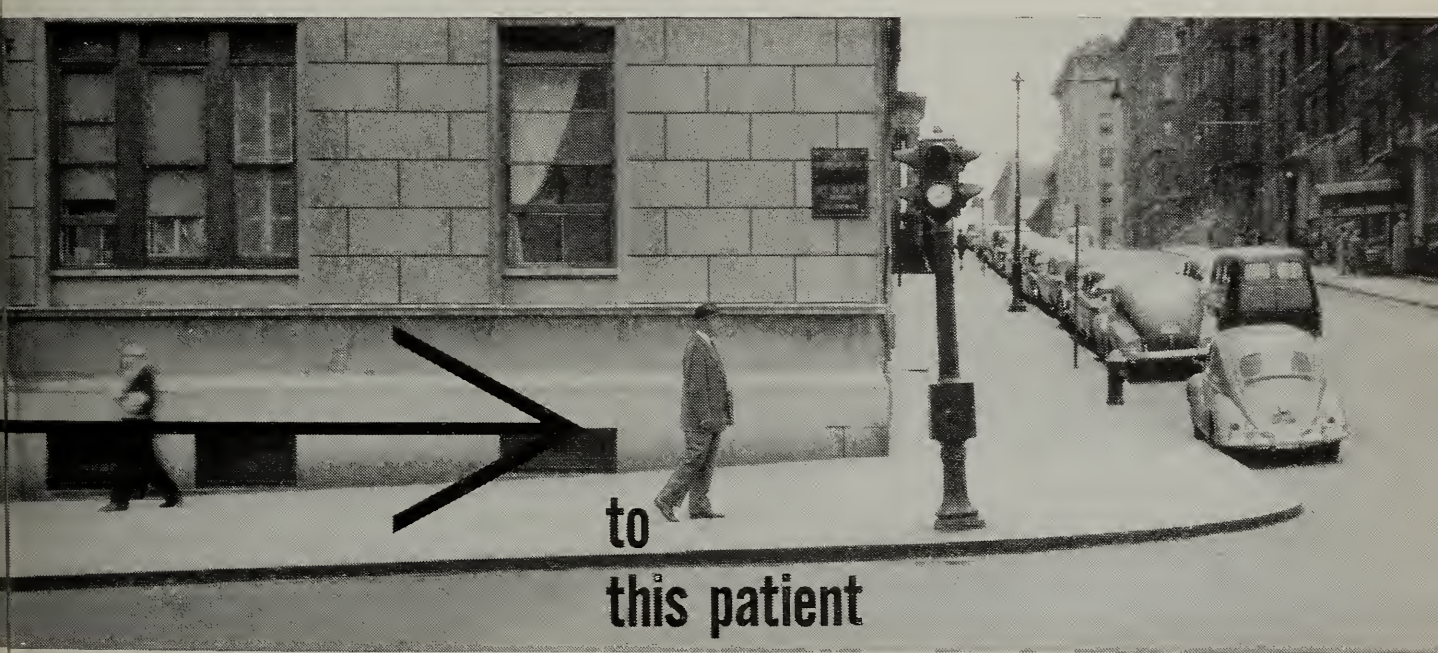
the steroids, the tranquilizers, cardiac surgery and Salk vaccine, one can anticipate changes of some magnitude.

Only a year ago in South Bend, Indiana, I had the privilege of hearing a doctor relate, as he worked in his germ-free laboratory, that virus, in his opinion, was an etiologic factor in cancer. He had slides to demonstrate reasons for that opinion and, in a recent newspaper, similar announcement was made that another carcinogenic virus had been found. The study of arteriosclerosis is going on all over the country. Similarly the study to produce Salk vaccine was done in many areas. If we have had success in the Salk vaccine study, that success may eventually come to the study of arteriosclerosis.

One Factor Remains Constant

These are intriguing thoughts because such tools as these, in the doctors hands, will go far in relieving human suffering. However, it is of concern to us that, in the developments of our scientific past, plus the developments anticipated in the future, we must remain steadfast with the concepts of the art of medicine. The art of medicine has shaped doctors throughout the centuries. One sees various types of practices and various types of medications come and go. There is one factor, however, which is constant in the medical relationship, and that is, when reduced to its ultimate simplicity, one doctor working with one patient. In times past patients have recovered from illnesses with remedies which we little understand today and perhaps in the future patients will recover with remedies which are so far more enlightened that, from our present vantage point of knowledge, we couldn't understand them. As long as the doctor keeps his concept of willingness to help, regardless of the expense to himself, and regardless of the patient's ability to pay, concerned only with contributing his efforts to improve the lot of one patient, or the lot of humanity in general, medicine will never be found wanting.

I am particularly indebted for help in the past year to the Executive Committee, the Council of the State Association, and the membership at large. Only on rare occasions were requests to



with intermittent claudication every block was a mile long

now... **arlidin**

makes the blocks so much shorter...
he can walk many more of them in comfort

u. s. vitamin & pharmaceutical corporation
Arlington-Funk Laboratories, division
250 East 43rd Street, New York 17, N. Y.

aid declined. The Auxiliary was always ready and willing to aid us in any way that they could. Mrs. Joe Black, and later, Mrs. Edward Rigley, have done a remarkable job and deserve our thanks. The president-elect has been a stalwart. His counsel and support have been most helpful. It would be utterly impossible for a physician to occupy this office, and do any private practice of medicine, without the aid of our most loyal employees, and particularly, the help and support that Jim Waggener has given.

One leaves this office with mixed feelings—first there is a feeling of pride in having a living experience in such a position. As one grows older in practice, his appreciation of his colleagues increases. To take the rigors and disappointments that come to physicians, I believe, requires someone considerably above the norm and one realizes that he is associating with doctors, the finest group our society has brought forth. In this, one can have pride.

The same experience brings humility also. Learning of the scope of the medical needs of our citizens in a state such as ours is a sobering influence. Likewise, to learn at first hand the magnitude of medicine's effort to supply these needs is sobering. The president of this association soon learns that his own contribution is infinitesimal in comparison to the total effort. This brings humility. Whatever my contribution to our association has been, I am indebted to it, for I have profited far more by my association with the finest group in the world, the doctors of Indiana. ◄

Double Talk

Articles about drug testing provide a rich source of euphemisms. Drucker has collected some routine samples and provided a pithy translation of each. For example:

"'We determined to conduct a controlled comparative evaluation of the most commonly used agents in order to assay their respective advantages and disadvantages.'

"Translation: *What else could we do with those samples?*

"'Exhaustive perusal of the available literature revealed the paucity of experimentation in this area.'

"Translation: *Nothing in this week's JAMA.*

"'Subjects were randomly selected without prior attention to inherent clinical variables.'

"Translation: *We used anybody we could get.*

"'Side effects generally occur as a result of personal idiosyncrasy rather than as a predictable response to the dosage level.'

"Translation: *Be careful with this stuff.*

"'Periodic determinations of variation in laboratory values revealed no significant alterations attributable to this modality.'

"Translation: *He died in balance.*

"'The precise mechanism through which the response is mediated has not yet been defined.'

"Translation: *We don't know what happened.*

"'We gratefully acknowledge the cooperation, in many areas of this study, of the Blank Laboratories.'

"Translation: *They paid us.*

—*U. S. Armed Forces Medical Journal,* June, 1960.

President-Elect's Message

Given before the House of Delegates, French Lick, Indiana, October 2, 1960

GUY A. OWSLEY, M.D.
Hartford City
President, 1960-61

One year ago this House conferred upon me the signal honor to serve as your President-elect, and for the coming year, as your President. For this vote of confidence, words are lacking to express my personal gratitude.

To have served during the term of our President, Dr. Mericle, has been most rewarding. His calm deliberate temperament has contributed much to one whose inclinations may have been at times, more explosive, and I hope that much has been learned from our association. To say that serving with him has been a pleasure is to put it mildly and I want to be among the first to salute him for a job well done.

When one dedicates himself to the cause of organized medicine and finds himself in a position of stewardship it is his duty, I believe, to spell out for the membership a "state of the union version" of our organization, the AMA and our own State Association.

In recent years, one of the most lucrative sources of income for the Madison Avenue public relations expert has come about through creation of an image of whatever subject his client might request. The result of his labor may, in fact produce three separate species: the true image, the false image and the blurred image. The price one pays for this service is not only beyond his personal budget but is not provided in the generous allowance of this office. Your president-elect is therefore compelled to draw upon some 30 years of constant association with those who provide this source of information in attempting to create an image of our organization both internally and externally.

Before bringing each of these internal images into focus it is appropriate that we digress briefly to review some of the operations of our parent organization. First of all, we have always accepted the fact that the House of Delegates has served as a grass roots type of policy-making body for all of organized medicine.

Why then have some individuals, and in rare instances, some rather large segments of our state and county associations, obtained a false or blurred image of this great organization rather than the true picture?

At the risk of oversimplification, the answer can probably be found in the manner in which basic policy, has, in the past, been implemented.

Most of us remember when a secretariat featuring Dr. Pepy's Diary guided our national affairs. This management attained the dubious distinction of becoming involved in Federal litigation, the result of which carried our prestige to a new low. Succeeded by the "manager system," there was little, if any, change in the climate at National Headquarters, and no real enthusiasm was generated to improve the situation. It was not until the present staff system was installed that our professional esteem began a perpendicular rise, and if one reviews the events through the years he finds that the blurred image was created by circumstances resulting from management by personalities and the true image has been regained through the present system.

Born of the network of county and state associations, the American Medical Association has thrived beyond the fondest expectation. While it is true that many physicians do not, at this late date, belong to this great organization, the ranks are closing fast and our own records reveal during the past 10 years an increase of

PRESIDENT-ELECT

Continued

13.3% in membership in the State Association and an increase of 41.6% in the American Medical Association. These figures show a ratio increase of 3/1 for the American Medical Association. When one recognizes the self-determination and self-sufficiency of members of our profession this result is little short of amazing.

Furthermore we can be proud of the many contributions our Association has made to frequent requests of the American Medical Association, and for this we are eternally grateful. Indiana was sixth among the 50 states in bequests to the American Medical Education Fund last year and recently we have received notice that more resolutions opposing Forand-type legislation were received from our state than from any other. These examples serve to illustrate our cooperation in problems of national importance. At this point, however, we should raise a question—Has our labor born the fruits of reward to members of our Association that one should expect? We, the officers of your State Association, have reviewed the table of organization of the American Medical Association and it is our conviction that we are not receiving our fair share of national recognition. We believe that it is reasonable to be self-seeking in matters that pertain to our welfare, and we are convinced that the morale of any constituent association will suffer when the dedicated membership of that segment of the whole is denied the opportunity to continue service after a training period which in itself prepares one for higher responsibilities. It is trite to say that this is the rule of any prudent organization and of necessity the elimination of the unwilling worker is generally automatic.

Looking back at our image from the viewpoint of internal interest we would suggest that our State Association never relax in its effort to strengthen our national structure but at the same time let us not forget to give consideration to those who represent us. If we plan properly for the future we will not be denied that recognition, which many believe is long overdue.

Now as we examine our image from the external viewpoint we find ourselves confronted



For the Family Man of Adventurous Spirit...the Jaguar 3.8 Litre Family Sports Sedan

The brilliant new 5-passenger "Three-Point-Eight" sedan is the ideal Jaguar for the sports car enthusiast with a family! COMPACT, without sacrificing roominess, comfort and luxury, it incorporates such features as optional power steering, automatic transmission, 4-wheel disc brakes, polished walnut dashboard and glove leather upholstery. Powered by the new 3.8 litre XK engine, this proud new Jaguar has a top cruising speed of 120 m.p.h. . . . the "fastest sedan of its class in the world!" See the other 1961 Jaguars, too . . . the luxurious Mark IX sedan and the XK 150 sports models. Convenient terms!

JAGUAR **MIDWEST DISTRIBUTORS, Inc.**

2330 NORTH MERIDIAN STREET • INDIANAPOLIS

with allegations that "the American Medical Association is against everything; the American Medical Association never offers a constructive solution" and a multiplicity of ethereal criticisms which in general can be attributed either to a total lack of understanding or an unwillingness to align oneself with an organization of such dedication or in too many instances by those with divided allegiance.

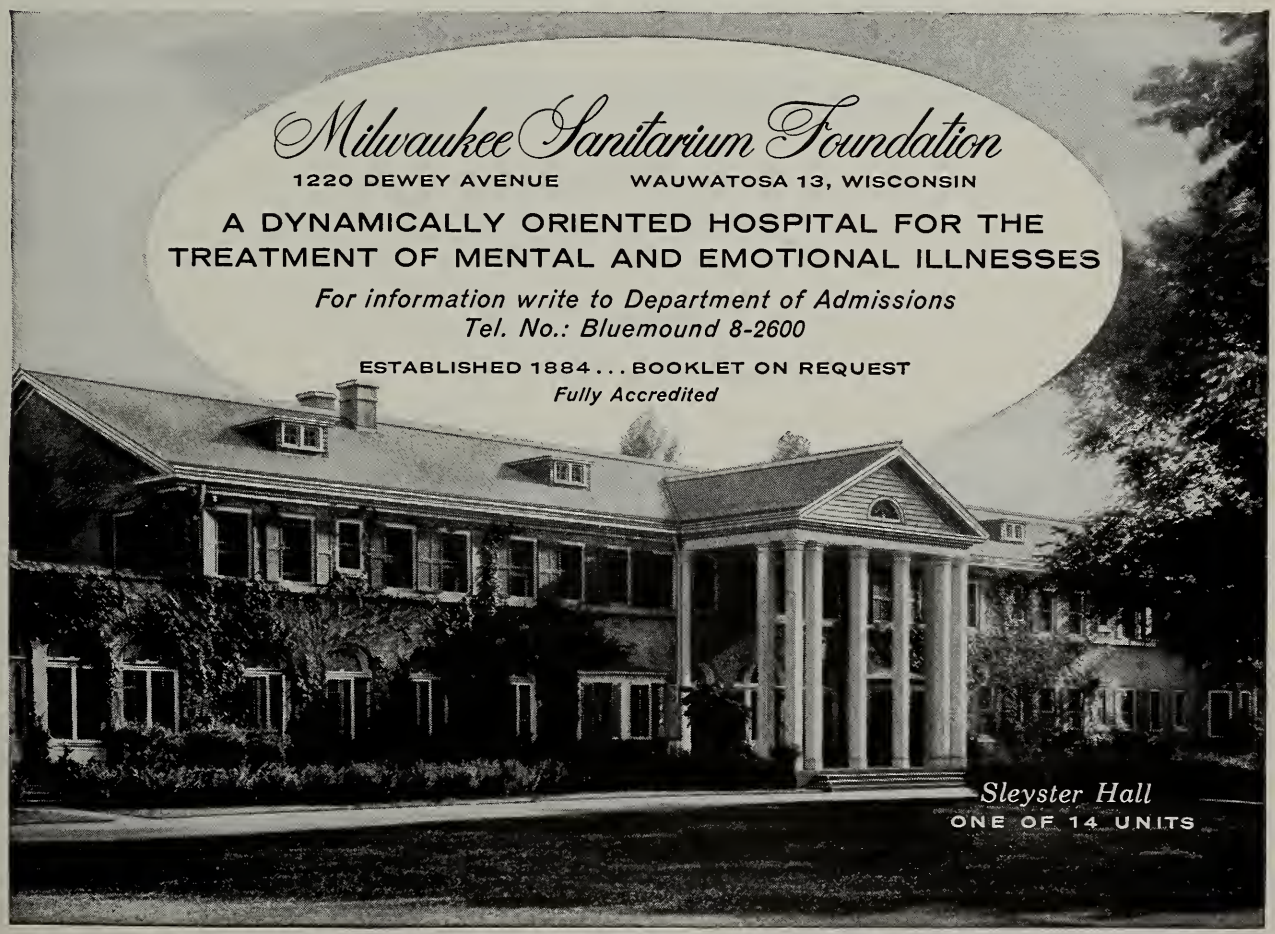
With this atmosphere becoming more evident, our policy-makers on a national level have come to the inevitable conclusion that we as physicians have not assumed our civic responsibilities with the same degree of enthusiasm as our counterpart on the left.

In this connection I quote from an action taken by the AMA House of Delegates at the June meeting in Miami Beach: "The delegates have not only urged their fellow doctors to fight socialized medicine but have recommended that physicians get into politics to see that their objectives are carried out."

A resolution submitted by the Oklahoma delegation declared, "It has become apparent that the medical doctors in America and their organizations are not exerting the effective influence on local, state and national political affairs which it is their right and obligation to exert." The resolution continues, "The American Medical Association should encourage its members to take a greater interest in public affairs, looking toward the utlimate goal of developing a practical political program consistent with the medical profession's role of leadership in the United States."

While the foregoing resolution was adopted we should hasten to add that the American Medical Association had already implemented this mandate in a conference held in St. Louis last December, and has continued to work toward this goal through a series of regional conferences, the most recent of which was held in this Hotel in August of this year and attended by many members of our Association. As a result of these conferences the groundwork for the development of such an organization has been completed and the effectiveness of it is beyond question, providing there is unity of purpose and an unselfish desire on the part of every member of our state and national organizations to become a part of this great crusade.

Writing in his treatise on Public Relations in



PRESIDENT-ELECT

Continued

Medical Practice, James Bryan stated, "I earnestly believe that the salvation of American Medicine's prestige in the political area—national, state and local—depends upon the individual physician taking a new look at himself as a political animal. I think he should cast out his fears, suspicions and antagonisms toward politicians and political institutions. He should resolve to play an active part in forwarding every proposition that may conceivably improve our social life, thus manifesting the fact that the physician is vitally interested in the public good."

This is a time for plain talk. Some may believe that the brainwashing process which has penetrated both major political parties has also infiltrated our own profession to the point where effective resistance is no longer possible, but with this viewpoint, I cannot agree. The fact is that there are few physicians of either political party who subscribe to the Welfare State philosophy, although many are too apathetic to recognize the danger we face and expect a few to provide for all.

Although we have seen the extension of welfare statism beyond the imagination of anyone, a decade ago, it is my firm conviction that the inclusion of medical service in this extension, either now, or in the future, can be prevented, if we, the ones who purvey this service, will unite in a positive manner.

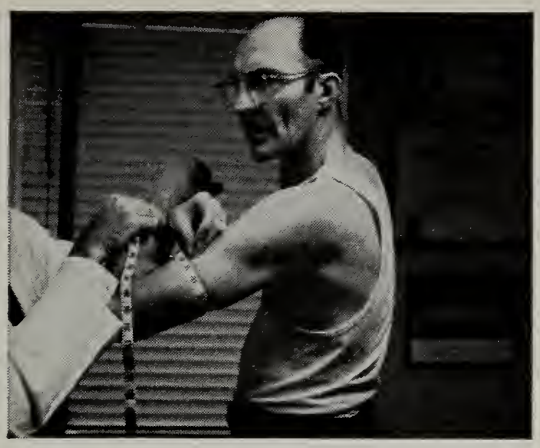
It is just as much the duty of physicians as citizens to diagnose, treat and attempt to cure the socialistic ailments of our government as to dedicate ourselves to the care of our private patients.

For the past 30 years politics has been interested in medicine, and now it's high time that medicine becomes interested in politics.

Continued

RADIUM
(including Radium Applicators)
For All Medical Purposes
Est. 1919
Quincy X-Ray & Radium Laboratories
(Owned and Directed by a Physician-Radiologist)
Harold Swanberg, B.S., M.D., Director
W.C.U. Bldg., Quincy, Illinois

Reliable
PROFESSIONAL LIABILITY
INDIVIDUAL INSURANCE
with proficient defense
that cuts the cost
Unparalleled Experience ● Specialized Service ● Saving in Cost
THE
MEDICAL PROTECTIVE COMPANY
FORT WAYNE, INDIANA
Professional Protection Exclusively since 1899
INDIANAPOLIS OFFICE: Kenneth W. Moeller, Rep.
P.O. Box 20132, Indianapolis 20 Tel. CLifford 5-6525
FORT WAYNE OFFICE: A. Russell Quilhot, Rep.
5814 Reed Road, Fort Wayne Tel. Trinity 1161



Dianabol: new, low-cost anabolic agent

By promoting protein anabolism, Dianabol builds lean tissue and restores vigor in underweight, debilitated, and dispirited patients. In patients with osteoporosis Dianabol often relieves pain and increases mobility.

As an anabolic agent, Dianabol has been proved 10 times as effective as methyltestosterone. Yet it has far less androgenicity than testosterone propionate, methyltestosterone, or norethandrolone.

Because Dianabol is an oral preparation, it spares patients the inconvenience and discomfort of parenteral drugs.

And because Dianabol is low in cost, it is particularly suitable for the aged or chronically ill patient who may require long-term anabolic therapy.

Supplied: *Tablets,* 5 mg. (pink, scored); bottles of 100.

Complete information sent on request.

Dianabol®
(methandrostenolone CIBA)

converts protein to working weight in wasting or debilitated patients

2/2829MB

CIBA
SUMMIT, NEW JERSEY

PRESIDENT-ELECT

Continued

We have witnessed in this election year the spectacle of complete capitulation of one of our major political parties to those self-styled liberals who would supply any and all service at the federal level. We have witnessed, too, the near surrender of the political opposition to this paternalistic philosophy. With the element of choice becoming narrowed to the point of extreme danger, it is most imperative that we, as one of the last guardians of political and economic freedom, rise to the occasion and through our personal and financial contributions widen the gap between these two diametrically opposed forms of political philosophy.

In the foregoing, as we examined our image internally, we have recognized that it is reasonable and fair to be self-seeking in all matters pertaining to our own organizational structure. On the contrary when we discuss those problems of extrinsic origin we can find no such justification under the terms of requirement when defending our social and economic freedom.

For many years it was this writer's opinion that the multiple organizations, which through bonds of common interest have become a part of our professional lives, were duplicating our efforts, taking our eye from the objective of the whole good for the whole number and creating a dilution of our effectiveness. More recently, however, the thought has occurred that these organizations are in no way related to the program of organized medicine as we know it today. Let's face facts. The so-called splinter groups have assumed their proper place in the didactic necessities of our profession and organized medicine as such, has become engulfed in the political problems of our time to such an extent, that we have entrusted the security of our philosophy to our parent organizations.

At the same time we have failed to recognize that due to the legal prohibitions placed upon non-profit, tax-free organizations they do not have the tools to accomplish our needs except through guidance and encouragement. This is singularly true of the American Medical Association and constituent state associations.

What then is the solution? If there ever was a time when the solution appears obvious that time is the present.

Acting in your role as citizens you have ratified the principle and the details of an organiza-

Continued

tion legally equipped to combat the enemy. It is gratifying to know that this was done by an almost unanimous decision but ALMOST isn't enough. When any segment of our organization defers its approval of the last best hope for all of us it is asking that those who do approve, carry the ball for them. How any group, however large or small, regardless of professional interests, regardless of its views on localized issues and regardless of other affiliations could fail to give its approval to this organization is beyond comprehension. The battle cry now is for joint survival and we must approach it in a spirit of all for one and one for all.

Two excuses have been heard from those who up to this time have withheld their support—one is that HOPE won't work because the membership won't donate and the other is that they prefer to make their contributions locally. In answer to the first excuse it can be said that this type of defeatism is juvenile and holds to the proposition that our cause is hopeless. As for the second evasion we can say without fear of contradiction that if this method had been successful we would not now have one Senator and at least five Representatives from the conservative state of Indiana, expressing attitudes and actions inconsistent and in oppostion to ours.

What then should our target be? It appears certain that there can be but one target and that is the welfare monster created by our elected representatives to the federal Congress.

Many years ago Dr. J. William Wright who almost single-handedly defended our position in legislative matters recognized that the medical practices act in Indiana was so written that, in the main, it was about as invulnerable as any piece of legislation could be, and that with constant effort it would stand the test of time and could be defended. Experience has born this out, and through the able continued leadership of Dr. Don Wood, working with his devoted legislative commission in perfect harmony with our headquarters staff, has proved that so far as Indiana is concerned we can hold our own.

Localized issues then become of minor importance when compared with the destruction of our fundamental concepts on a federal level. It is perfectly simple to conclude that we should direct our efforts toward the choice, the support and the election of those men who will in the final analysis control our destiny, namely the representatives and senators in the Congress.

In closing, I would like to quote that great scientist, Charles Kettering, who once said that "Action without intelligence is a form of insanity, but intelligence without action is the greatest stupidity in the world." ◄

WINNERS OF AWARD PLAQUES SCIENTIFIC EXHIBITS, French Lick, 1960

AWARD No. 1—RESISTANT URINARY TRACT INFECTIONS

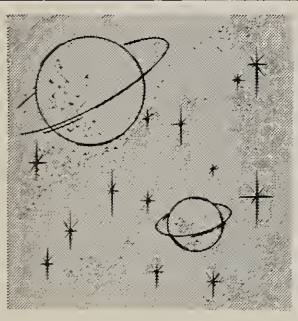
Robert Lich, Jr., M.D., Louisville, Ky., exhibitor.

AWARD No. 2—DIAGNOSIS OF XANTHOMATOSIS

Richard M. Caplan, M.D., University of Michigan Hospital, Ann Arbor, Mich., exhibitor.

AWARD No. 3—NEUROPHARMACOLOGY OF THE GAMMA LOOP

Robert W. Begley, Indiana University School of Medicine, Indianapolis, exhibitor.



VISION STIMULATES KNOWLEDGE

Truly, the age we live in is the age of vision — of far-sighted plans for a future totally different from the past. Such vision must, however, be based on past performance . . . the foundation from which to build. Just as the more than a half-century of White-Haines experience in fine ophthalmic craftsmanship is your guarantee of professional performance in the years to come.

THE White-Haines OPTICAL COMPANY
34 Modern Laboratories
OHIO • PENNSYLVANIA • MARYLAND
KENTUCKY • W. VIRGINIA • INDIANA
MICHIGAN • ILLINOIS

Minutes of the House of Delegates

1960 Meeting

CREDENTIALS COMMITTEE REPORT **2281**

In Memoriam **2281**

1959 Minutes **2282**

Introduction of Guests **2282**

Amendments to Constitution and Bylaws **2282**

1960 Reference Committees **2282**

REPORTS OF OFFICERS REFERENCE COMMITTEE **2284**

President's Address **2284**

President-Elect's Address **2284**

Reference Committee Action **2284**

Report of the Executive Secretary **2284**

Report of the Treasurer **2284**

Report of Chairman of the Council **2284**

Reports of District Councilors **2284**

Report of Executive Committee **2285**

Woman's Auxiliary Presidential Address **2285**

Reference Committee Action **2286**

Report of Editor of the Journal **2286**

Reports of Delegates to the AMA **2286**

Report of Student AMA **2286**

SECTIONS AND SECTION WORK COMMITTEE **2286**

MEDICAL EDUCATION AND HOSPITALS COMMITTEE **2286**

Reference Committee Action **2288**

Medical Education **2288**

Special Activities **2288**

Student Loan **2288**

Resolution No. 18 ..... **2289**

Reference Committee Action **2289**

Resolution No. 14 ..... **2289**

Reference Committee Action **2289**

Resolution No. 9 ..... **2290**

Resolution No. 11 ..... **2290**

Reference Committee Action **2290**

Resolution No. 1 ..... **2290**

Reference Committee Action **2290**

LEGISLATION COMMITTEE **2292**

Reference Committee Action **2292**

Resolution No. 10 ..... **2292**

Reference Committee Action **2292**

Resolution No. 12 ..... **2292**

Reference Committee Action **2292**

Resolution No. 16 ..... **2292**

Reference Committee Action **2293**

Resolution No. 17 ..... **2293**

Reference Committee Action **2293**

PUBLIC RELATIONS COMMITTEE **2293**

Reference Committee Action **2294**

HYGIENE AND PUBLIC HEALTH COMMITTEE **2276**

Public Health **2296**

Reference Committee Action **2296**

Vountary Health Agencies **2296**

AMA Guide for Industrial Immunization Programs **2296**

Resolution No. 19 ..... **2296**

Reference Committee Action **2296**

Maternal Mortality Report for 1958 ..... **2297**

AMENDMENTS TO THE CONSTITUTION AND BYLAWS COMMITTEE **2297**

Reference Committee Action **2297**

Report of the Commission on Constitution and Bylaws **2297**

Paragraph 6 from The Report of the Commission on Medical Education and Licensure **2298**

Resolution No. 15 ..... **2298**

Reference Committee Action **2298**

INSURANCE COMMITTEE **2300**

Reference Committee Action **2300**

Resolution No. 8 ..... **2301**

Reference Committee Action **2301**

Resolution No. 2 2301
Resolution No. 4 2301
Reference Committee Action 2302
Report of The Commission on Medical Economics and Insurance 2302
Resolution No. 5 2302
Reference Committee Action 2304
Resolution No. 13 2304
Resolution No. 6 2304
Resolution No. 7 2305
Reference Committee Action 2305
MISCELLANEOUS BUSINESS COMMITTEE 2306
Building Committee Report 2306
Reference Committee Action 2306
Convention Arrangements 2306
Building Committee 2307
ELECTION OF OFFICERS 2307
ADDRESS OF PRESIDENT-ELECT STIMSON 2307
PLACE OF 1962 ANNUAL CONVENTION 2307
ADJOURNMENT 2307

House of Delegates Proceedings

FRENCH LICK SESSION
October 2-5, 1960

The House of Delegates convened at 6:00 p.m., Sunday, Oct. 2, 1960, and again at 9:00 a.m., Wednesday, Oct. 5, 1960, in the West Dining Room of the French Lick-Sheraton Hotel, French Lick, with the president, Dr. Earl W. Mericle, Indianapolis, presiding.

Dr. John M. Paris, New Albany, gave the invocation at the opening of the first meeting.

Credentials Committee Report

On motion of several, seconded by Dr. Wilder, credentials cards presented by the delegates were accepted in lieu of a roll call at the first meeting. Dr. William E. Amy, chairman of the Reference Committee on Credentials, reported 107 delegates, six past presidents, 11 councilors, the president, the treasurer, two delegates to the AMA, the editor of *The Journal,* 12 alternate delegates, and 10 guests, present.

At the second meeting attendance slips signed by the delegates were accepted as constituting the roll call, on motion of Drs. Wilder and Steele. These slips registered 111 delegates, five past presidents, 12 councilors, the president, the president-elect, the treasurer, three delegates to the AMA and one alternate AMA delegate as present at this meeting.

According to Chapter IV, Section 3, of the Bylaws, 50 delegates constitute a quorum. The House of Delegates, therefore, was declared open and ready for the transaction of business.

The president read Chapter XXXI, Section 1, of the Bylaws, and Article XIV of the Constitution regarding amendments to the Bylaws and Constitution.

In Memoriam

The House stood in memory of the following physicians who had served as members of the House of Delegates, or in an official capacity in the Association, and who had died since the 1959 annual convention:

LOWERY H. BEAR, Vevay. Secretary, Switzerland County Medical Society, 1945-46; delegate, Switzerland County, 1944-1952.

ANDREW BRENNER, Winchester. Secretary, Randolph County Medical Society, 1938-39.

CLARENCE E. BRISCOE, New Albany. Delegate, Floyd County, 1936, 1942, 1945.

CHARLES N. COMBS, Terre Haute. Secretary, Vigo County Medical Society, 1908-1924 inclusive; member, Committee on Convention Arrangements, 1908-09, 1924; member, Committee on Scientific Work, 1910-13-16-19; ex-officio member, Committee on Public Policy and Legislation, 1910-11; secretary 1911-1924, and treasurer 1915-1924, Indiana State Medical Association; member, Military Committee, 1924; president, Indiana State Medical Association, 1926; member, Committee on Administration and Medical Defense, 1926; member, Budget Committee, 1927; member, Committee on Postgraduate Work, 1930-31; AMA delegate, 1931-32; member, Editorial Board, 1933-45-47; vice-chairman, 1935, chairman, 1936, Section on Anesthesia; member, Committee on Necrology and History, 1941-44; chairman, 1945-48, member, 1949, Centennial Celebration Committee; chairman, Committee on Centennial History and Publication, 1949; member, Grievance Committee, 1950; member, Committee on Physician-Patient Relations, 1950.

JOHN E. DALTON, Indianapolis. Delegate, Marion County, 1944.

JOSEPH E. DUDDING, Hope. Delegate, Bartholomew-Brown County Society, 1943-44, 46, 48, 50, 53 and 54. Member, 1950-1954, chairman, 1953-57, Committee on Rural Health; member, Permanent Study Committee on Medical Care Insurance, 1952; member, Committee on Preceptorships, 1953-54; member, County Medical Society Officers' Conference, 1954; member, Council, 1954-59; member, Subcommittee on Preceptorships, 1955-56; member, Commission on Public Health, 1958.

WILLIAM M. DUGAN, Indianapolis. Member, Committee on State Fair, 1937; secretary, Marion County Medical Society, 1939-1945; member, Committee on Secretaries' Conference, 1940-45; member, OPA Medical Advisory Committee, 1944-45; secretary, 1945, vice-chairman, 1946, chairman, 1947, Section on Medicine; delegate, Marion County, 1946; member, Committee on Public Relations, 1948; member, Committee on Heart Disease, 1950; member, 1956, chairman, 1957, Committee on Diabetes.

JACK R. GLOSSON, Clay City. Secretary, Clay County Medical Society, 1960.

E. VERNON HAHN, Indianapolis. Vice-chairman, 1931, chairman, 1933, Surgical Section; member, Committee on Publicity, 1936-37; delegate, Marion county, 1944, 45, 47, 49; member, Committee on Rehabilitation Services, 1945; member, Medical Advisory Committee for Vocational Rehabilitation, 1946; member, 1947, 48, 49, chairman, 1950, 51, 52 and 54, Committee on Mental Health.

CLAYTON B. HATHAWAY, Butler. Secretary, DeKalb County Medical Society, 1939-1945; delegate, DeKalb County, 1946.

CLARENCE P. HINCHMAN, Geneva. Secretary, 1922, president, 1955, Adams County Medical Society.

ROBERT O. KENNEDY, Rushville. Secretary, Rush County Medical Society, 1929.

LA MAR KNEPPLE, Kokomo. Secretary, Howard County Medical Society, 1910.

L. A. LAIRD, Richmond. Secretary, Kosciusko County Medical Society, 1944-46.

MINOR MILLER, Evansville. Delegate, Vanderburgh County, 1937-1953; member, 1937, 38, 39, 40, chairman, 1941, 42 and 43, Committee on Syphilis Control; member, 1944-48, chairman, 1949-1952, Committee on Venereal Disease; member, Centennial Celebration Committee, 1945-46 member, Editorial Board, 1945-46; member, Building Committee, 1946; member, Committee on Civic Relationship and Community Health Agencies, 1949; member, Board of Appeals on Patient-Physician Relations, 1953; vice-chairman, 1953, chairman, 1954, Section on Public Health and Preventive

Medicine; member, Council, 1954, 55, 56; chairman, Committee on Venereal Disease, 1955; chairman, Committee on Polio, 1956, 57.

HAROLD O. MURPHY, Claypool. Secretary, Kosciusko County Medical Society, 1954.

JAMES H. STYGALL, Indianapolis. Member, Bureau of Publicity, 1924, 1930-35; chairman, Diphtheria Committee, 1927-29; chairman, 1939-1944, 1946, 47, and member, 1945, Anti-Tuberculosis Committee; chairman, 1948, 1955, and member, 1949-54, 1956, Committee on Tuberculosis.

MORRELL SIMPSON, Bedford. Secretary, Lawrence County Medical Society, 1910, 1943, 44; delegate, Lawrence county, 1935.

GEORGE VAIL, Lawrenceburg. Delegate, Dearborn-Ohio County Society, 1951.

JOHN A. VAN KIRK, Frankfort. Secretary, 1929, president, 1956, Clinton County Medical Society; delegate, Clinton County, 1943.

FRANK C. WALKER, Indianapolis. Member, Advisory Committee to Bureau of Maternal and Child Health of Indiana State Board of Health, 1945.

ARTHUR J. WHALLON, Richmond. Secretary, Wayne-Union County Medical Society, 1914-17.

GUTHRIE H. WISENER, Richmond. Secretary, Wayne-Union County Medical Society, 1922; member, 1944-45, chairman, 1946, Committee on Civic and Industrial Relations; member, Council on Medical Service and Public Relations, 1946.

CHARLES E. WOODCOCK, Greenwood. Secretary, Johnson County Medical Society, 1923, 24, 25; member, Liaison Committee of the Division of Service for Crippled Children, 1945.

1959 Minutes

Minutes of the meetings held at Indianapolis Oct. 6 and 9, 1959, were approved as printed in the December, 1959 *Journal* on motion of Drs. Wilder and Paris.

Introduction of Guests

MR. JAMES E. WENGER, Indianapolis, president, Indiana Chapter of Student AMA.

MR. TOM ALT, Indianapolis, vice-president, National Student AMA.

MISS MARGARET DAVIS, Indianapolis, secretary, Indiana Chapter of Student AMA.

MR. RUEBEN DALBEC, Chicago, field representative of the American Medical Association.

MR. THOMAS A. HENDRICKS, Chicago, assistant to the executive vice-president, American Medical Association.

MR. JOSEPH P. SANFORD, Louisville, executive secretary, Kentucky State Medical Association.

RAYMOND M. McKEOWN, M.D., Coos Bay, Oregon, secretary-treasurer; and member of the Board of Trustees, American Medical Association.

Dr. McKeown addressed the House on current AMA matters.

Amendments to Constitution and Bylaws

(1) *Speaker and Vice-Speaker of House of Delegates.* On motion of Drs. Paris and Oliphant the House of Delegates voted that all of the proposed amendments to the Constitution and Bylaws regarding the creation of the offices of Speaker and Vice-Speaker of the House of Delegates not be adopted.

(2) *Election in absentia.* On motion of Dr. Paris, duly seconded, the House adopted the amendment to Section 3, Article IX, of the Constitution which would allow a member not in attendance at an annual convention to be elected an officer of the Indiana State Medical Association.

As amended, Section 3, Article IX, of the Constitution reads as follows:

ARTICLE IX—OFFICERS

Sec. 3—The officers of this Association with the exception of the executive secretary shall be elected by the House of Delegates as the first order of business of the last day of the Annual Convention, and no person shall be elected to any such office who has not been an active member of the Association for the preceding two years.

1960 Reference Committees

The chairman announced the appointment of reference committees for the 1960 session as follows:

Sections and Section Work

Norman Silverman, Terre Haute (Vigo), chairman
Truman E. Caylor, Bluffton (Wells)
A. E. Stouder, Kempton (Tipton)
Charles P. Schneider, Evansville (Vanderburgh)
Robert A. Hedgcock, Frankfort (Clinton)

Rules and Order of Business

Frank H. Green, Rushville (Rush), chairman
Charles F. Gillespie, Indianapolis (Marion)
R. N. Bills, Gary (Lake)
Robert S. McElroy, Princeton (Gibson)
V. Earle Wiseman, Greencastle (Putnam)

Medical Education and Hospitals

Eugene F. Senseny, Fort Wayne (Allen), chairman
John W. Beeler, Indianapolis (Marion)
F. R. N. Carter, South Bend (St. Joseph)
Philip T. Holland, Bloomington (Owen-Monroe)
Donald R. LaFollette, New Albany (Floyd)

Legislation

Jack Shields, Brownstown (Jackson), chairman
Floyd A. Boyer, Indianapolis (Marion)
P. J. Rosenbloom, Gary (Lake)
Paul T. Lamey, Anderson (Madison)
George Willison, Evansville (Vanderburgh)

Public Relations

Harry R. Stimson, Gary (Lake), chairman
J. C. Richter, LaPorte (LaPorte)
Irvin W. Wilkens, Indianapolis (Marion)
Frank W. Oliphant, Mt. Vernon (Posey)
Glen Ward Lee, Richmond (Wayne-Union)

Hygiene and Public Health

O. T. Scamahorn, Pittsboro (Hendricks), chairman
William R. Thompson, Winamac (Pulaski)
Lowell J. Hillis, Logansport (Cass)
Ralph C. Eades, Valparaiso (Porter)
Peter R. Petrich, Attica (Fountain-Warren)

Amendments to Constitution and Bylaws

M. C. Topping, Terre Haute (Vigo), chairman
Kenneth L. Olson, South Bend (St. Joseph)
Walter L. Portteus, Franklin (Johnson)
Clarence G. Kern, Lebanon (Boone)
Joseph M. Black, Seymour (Jackson)

Reports of Officers

Harry E. Klepinger, Lafayette (Tippecanoe), chairman
Marvin L. McClain, Scottsburg (Scott)
John M. Young, Indianapolis (Marion)
Howard T. Hammel, Bedford (Lawrence)
Ray Elledge, Hammond (Lake)

Credentials

William E. Amy, Corydon (Harrison-Crawford), chairman
John E. Alexander, Evansville (Vanderburgh)
Howard S. Williams, Indianapolis (Marion)
E. B. Lett, Loogootee (Daviess-Martin)
James W. Crain, Williamsport (Fountain-Warren)

Insurance

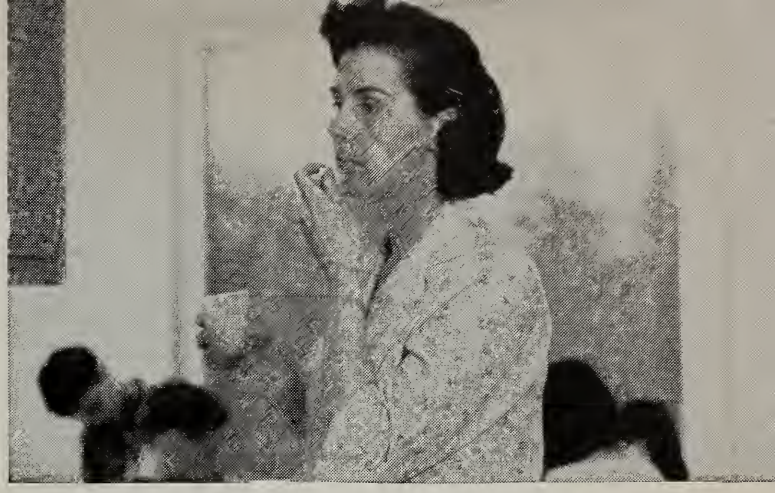
James M. Leffel, Indianapolis (Marion), chairman
Gordon B. Wilder, Anderson (Madison)
David L. Adler, Columbus (Bartholomew-Brown)
R. B. Dubois, Lafayette (Tippecanoe)
Stuart R. Combs, Terre Haute (Vigo)

Miscellaneous Business

William B. Challman, Mt. Vernon (Posey), chairman
Francis L. Land, Fort Wayne (Allen)
Russell J. Spivey, Indianapolis (Marion)
Basil M. Merrell, Rockville (Parke-Vermillion)
Wendell C. Stover, Boonville (Warrick)



After a history and a physical ruled out organic disease, the physician diagnosed the case as recurring states of anxiety. To relieve these symptoms for this busy, on-the-go housewife, he prescribes Meprospan-400, the *only* meprobamate in *sustained-release* form.



As directed, the patient takes one Meprospan-400 capsule at breakfast. Her symptoms of tension and nervousness are soon relieved, and she will not have to remember to take another capsule until dinnertime.



Calm and relaxed, the patient is no longer upset by the pressures and irritations met in everyday life, nor is she likely to be incapacitated by autonomic disturbances, drowsiness, ataxia or other untoward reactions.



Alert and attentive, the patient participates in a P.T.A. meeting, following her second capsule of Meprospan-400 taken with the evening meal. Meprospan-400 does not decrease her mental efficiency or interfere with her normal activities or behavior.



Peacefully asleep, the patient enjoys beneficial rest . . . Meprospan-400 has relieved the tensions that previously prevented sleep or kept her tossing and turning throughout the night.

most widely prescribed tranquilizer . . .
most convenient dosage form . . .

ONE CAPSULE LASTS 12 HOURS

Meprospan®-400

400 mg. MILTOWN® SUSTAINED-RELEASE CAPSULES

Usual dosage: One capsule at breakfast lasts all day, one capsule with evening meal lasts all night. **Supplied:** Meprospan-400, each blue-topped *sustained-release* capsule contains 400 mg. Miltown. **Also available:** Meprospan-200, each yellow-topped *sustained-release* capsule contains 200 mg. Miltown. **For children:** Capsules can be opened and the coated granules mixed with soft foods or liquids.

Both potencies in bottles of 30.

Samples and literature available on request.

WALLACE LABORATORIES / *Cranbury, N. J.*

Reports of Reference Committees

REPORTS OF OFFICERS

The following matters were referred to the Reference Committee on Reports of Officers. All reports will be found on the pages indicated in the September, 1960, Vol. 53, No. 9, *Journal* of the Indiana State Medical Association, with the exception of the president's and president-elect's addresses which will be found on pages 2266 and 2271 of the December, 1960 issue.

President's address
President-elect's address
Executive Secretary (page 1751)
Treasurer (pages 1751-1754)
Chairman of Council (pages 1754-1756), except (1) AMA Guide for Industrial Immunization Programs (page 1755), which was referred to Reference Committee on Hygiene and Public Health, and (2) resolution on establishment of a panel on Impartial Medical Witnesses (page 1756), which was referred to Reference Committee on Public Relations.
Councilors' reports (pages 1756-1760)
Executive Committee (pages 1761-1765)
Address of President of Woman's Auxiliary
Journal Editor (page 1760)
Delegates to AMA (pages 1533-1538, August 1960, *Journal*)
Remarks of Messrs. Wenger and Alt, Indiana and National Student AMA officers.

President's Address

The address of the president, Dr. Earl W. Mericle, is printed on page 2266 of the December, 1960, *Journal* of the Indiana State Medical Association.

REFERENCE COMMITTEE ACTION

Dr. Harry E. Klepinger, chairman, presented the following report, which was adopted on motion of Drs. Klepinger and Steele:

The Reference Committee on Reports of Officers reviewed the reports referred to them found on pages 95 to 132 in the Handbook, plus supplemental reports, the address of the President, the President-elect and the President of the Woman's Auxiliary.

The committee found these reports comprehensive, indicating that the work of the Indiana State Medical Association was in competent and capable hands.

Item 1. Your reference committee wishes to commend President Mericle for an excellent thought-provoking address and wishes to reiterate three points which Doctor Mericle discussed in his paper.

(1) The importance of physicians becoming active participants in practical politics.

(2) The organization of a joint council of health ancillary services for the purpose of studying problems of the aged.

(3) That liaison with the State Welfare Department of the State of Indiana be continued.

President-elect's Address

DR. GUY A. OWSLEY, president-elect, presented an address printed on page 2271 of the December 1960 *Journal* of the Indiana State Medical Association.

REFERENCE COMMITTEE ACTION

Dr. Harry E. Klepinger, chairman, presented the following report:

Item 2. President-elect Owsley's "State of the Union" message described organized medicine's past and present image and outlined recommendations for the coming year.

We wish to commend Dr. Owsley's aggressiveness and his desire for all doctors to become active as citizens in the diagnosis and treatment of the socialistic trends in our nation. We also approve his recommendation that the various specialty groups must put more support behind the parent organizations.

Mr. President, I move the adoption of this portion of our report.

(Motion seconded by many, put to vote, and carried.)

Dr. Harry E. Klepinger, chairman, continued with the report of the Reference Committee on Reports of Officers, as follows, which was adopted in each separate part and as a whole:

Report of Executive Secretary

Item 3. The increase of responsibility and the work accomplished in the headquarters office indicates the ability and efficiency of our executive secretary. We wish to compliment the field men for the excellent work they have done, particularly from the standpoint of public relations with our doctors. It is gratifying to note that our Association has shown a continued steady growth for the past 10 years.

Mr. President, I move the adoption of this portion of our report.

(Motion seconded by many, put to vote, and carried.)

Report of Treasurer

Item 4. It is gratifying to see the Association continue on a strong and sound financial basis. The Association is fortunate in having so able a treasurer as Dr. Sicks.

Mr. President, I move the adoption of this portion of our report.

(Motion seconded by Dr. Stover, put to vote, and carried.)

Report of Chairman of Council

Item 5. The committee wishes to commend the chairman of the Council. His report reflects the great volume of business of the Council accomplished during the year.

Mr. President, I move the adoption of this portion of our report.

(Motion seconded by Dr. Wilder, put to vote, and carried.)

Reports of District Councilors

Item 6. The reports of councilors show general progress at the district level. We compliment the councilors for their devotion and unselfish service.

Mr. President, I move the adoption of this portion of our report.

(Motion seconded by Dr. Wilder, put to vote, and carried.)

Report of Executive Committee

Item 7. The comprehensive reports of the numerous meetings of the Executive Committee reflect the thoroughness with which this committee conducts its meetings. Our committee cannot find words that express appreciation to the men who serve on this committee.

Mr. President, I move the adoption of this portion of our report.

(Motion seconded by many, put to vote, and carried.)

Woman's Auxiliary Presidential Address

MRS. EDWARD L. RIGLEY, South Bend, president of the Woman's Auxiliary to the Indiana State Medical Association, addressed the House as follows:

Dr. Mericle, members of the House of Delegates, and guests: Primarily, I am here to report on the activities of the Woman's Auxiliary to the Indiana State Medical Association. Secondly, I am here to enjoy myself, like you. To help insure your enjoyment—I shall endeavor to make this report as brief and to the point as possible.

Before commencing, however, I want to pay tribute to Dr. Mericle, your president—to Dr. Don Wood, our Auxiliary advisor—to Mr. James A. Waggener, the executive secretary to the ISMA—and to the Executive Committee of the Indiana State Medical Association. Under the leadership of your fine president, Dr. Mericle, these gentlemen have guided the Auxiliary through one of the most successful years in the 34-year history of the Woman's Auxiliary.

Today, your Auxiliary stands at its greatest strength in its history—providing new and broader services to the public, in conjunction with the medical profession. Before we look at the accomplishments of the past year, I want to emphasize the definite need for the continued strengthening of the relationship between our organizations. As Auxiliary members we are participating because we desire to be a part of your activities. Our purpose is to implement your policies and to help promote health improvement. We desire to assist you with any and all problems. But we need your help too. As you know, membership is of the prime importance, and in the last year we have achieved gratifying results. Two new auxiliaries have been organized and Auxiliary membership is now 2,743, an increase of approximately 10%. But this is still only 70% of our membership potential. It is true that all doctors' wives cannot become active Auxiliary members, but there is nothing to prevent them from becoming registered Auxiliary members. This is where we desire your help. Encourage enrollment in the Auxiliary. Our efforts are being intensified in this direction. Our program for new membership is continuous.

Legislation . . . American Medical Education Foundation . . . community service . . . These have been our priority projects for the past year.

On the legislative front, our Auxiliary members have outdone themselves. Hundreds of letters, wires, petitions and resolutions have been directed to members of Congress opposing undesirable legislation and supporting AMA-approved legislation. Legislative forums have been held in many counties, concerning the health problems of the senior citizens. The Auxiliary legislative committee is stronger and eager to continue in action, as long as is necessary. I wish to assure you that we shall take an active part in the forthcoming election, backing those candidates who will preserve our free enterprise medical system.

Concerning the American Medical Education Foundation, the gifts from our own state of Indiana to AMEF totaled $13,956.88, an increase of $5,395.21 over the previous year. Based on Auxiliary membership this comes to a per capita of $5.23 per member. The following states received awards at the AMA convention for the highest per capita contributions—in order—Hawaii, Alaska, Nevada, New Hampshire, Indiana, Tennessee, Wyoming, Ohio and Alabama.

A new and exciting addition to the yearly awards was the Ethel Gastineau Trophy. A beautiful silver bowl, a traveling award, to go each year to the state having the most outstanding record. This year, the winner was determined on the basis of a composite standing of the ten states ranking highest in the following four categories: per capita contributions, total amount given, amount of increase over the previous year and percentage of increase over the previous year. Two states—Indiana and Tennessee—were on all four lists. A difference of just one point made Tennessee the fortunate first winner. It was truly a magnificent effort on the part of Indiana which should make us all very proud. The total National contribution given by the Woman's Auxiliary to the American Medical Association was $175,000.00, an average of $2.24 from every Auxiliary member.

Our AMEF program for this year is already under way. We want that trophy for Indiana next year. Our prime fund-raiser is a statewide Christmas card project. Stop by our AMEF booth and order your Christmas cards now. Credit will be sent to your county. We are counting on your support.

Our remaining priority project—community service, is an area in which all Auxiliary members actively participate. Community service is so broad in scope that it is impossible to compile data with any degree of accuracy. In every county Auxiliary members are serving at the community level in programs, such as church, voluntary health agencies, P.T.A., politics, Red Cross, Mental Health and other projects too numerous to mention. We shall continue to support and serve those organizations that make communities a better place in which to live.

There are several other programs which I would like to mention. The recruitment program, now known as "Health Careers" continues to merit our attention. Health careers have been placed on the priority projects list for the forthcoming year. Emphasis on recruiting the high caliber medical student is being stressed. It is interesting to note that Indiana Auxiliaries this past year provided over $11,000.00 for 73 scholarships for nurses and medical technicians. Another year of chal-

lenge to help provide the health worker of the future lies ahead.

Civilian defense has become a permanent part of our way of life. Civilian Defense programs were presented throughout the state this past year. The assistant state director of Civilian Defense was the principal speaker at many of these meetings. We shall continue to educate ourselves by keeping informed regarding all new developments in the field of civilian defense so that we may be better prepared to help ourselves and others in the event of disaster.

Our safety program was three dimensional—with emphasis on highway safety, home and farm safety, and poison control. Our safety theme for 1960-61 will stress water safety and be known as "SWAT"—safe water activity training.

Mental health activities for the year include many projects. Almost all auxiliaries helped in the Christmas gift program for patients. One group contributed 96 shaving or cosmetic kits. Four auxiliaries held mental health meetings with film and speaker. A large number of individual members are doing volunteer work in state hospitals and schools. Auxiliaries have sponsored mental health films in public high schools—at health fairs—and before Sunday school groups. Auxiliary members will continue to assist organized medicine with this number one health problem.

In passing, let me mention our publication, the *Hoosier Doctor's Wife*. It keeps us informed on all aspects of the Auxiliary program—and right proud of it we are. It is the official publication of the Auxiliary for the entire membership in the State of Indiana, and is published four times a year.

And this is my report. The past months have been very busy, but also very enjoyable. Working with you has been a pleasure. I know that my own interest in the Auxiliary will be unfailing, and I am equally certain that you can count on the continued enthusiasm and support of every Auxiliary member. Thank you.

REFERENCE COMMITTEE ACTION

Dr. Harry E. Klepinger, chairman, presented the following report:

Item 8. The address of Mrs. Rigley, president of the Woman's Auxiliary, was received by the House of Delegates with interest and attention. The reference committee notes with gratification the volume of work done by the Auxiliary in its many activities. Commendation is especially due for the AMEF contribution which showed a 60% gain over last year.

Your committee recommends that the Association express its appreciation by giving its wholehearted support to the Auxiliary program.

Mr. President, I move the adoption of this section of our report.

(Motion seconded by many, put to vote, and carried.)

Dr. Harry E. Klepinger, chairman, continued with the report of the Reference Committee on Reports of Officers, which was adopted in each separate part and as a whole:

Report of Editor of *The Journal*

Item 9. Your committee notes with pride the high national rating of our State *Journal* and commends the Editor and his staff.

Mr. President, I move the adoption of this portion of our report.

(Motion seconded by Dr. Schneider, put to vote, and carried.)

Report of Delegates to AMA

Item 10. Your committee recommends that each member of the Association read the comprehensive report of the delegates to the AMA. Major subjects in the reports are:

1. Health care for the aged.
2. Pharmaceutical issues.
3. Occupational health programs.
4. Relations with allied health groups.
5. Relations with the National Foundation for polio.

It is of particular note that Indiana was well represented on the program of the last AMA convention, both with speakers and scientific exhibitors.

Mr. President, I move the adoption of this section of our report.

(Motion seconded by Dr. Silverman, put to vote, and carried.)

Report of Student AMA

Item 11. Your committee wishes to commend Mr. Wenger and Mr. Alt, representing the Student AMA at Indiana University School of Medicine, for their report to the delegates. This student organization has made great strides in fostering medical ideals and stimulating early interest in organized medicine.

Mr. President, I move the adoption of this section of this report.

(Motion seconded by Dr. Steele, put to vote, and carried.)

The chairman wishes to thank the members of this committee for their efficient services.

Mr. President, I move the adoption of this report as a whole.

(Motion seconded by many, put to vote, and carried.)

SECTIONS AND SECTION WORK

Dr. Norman M. Silverman, chairman, presented the following report, which was adopted:

The Reference Committee on Sections and Section Work met at 9:00 a.m. on Oct. 3, 1960. The committee desires to highly commend the program committee on the excellent scientific program which was presented to the members of the Indiana State Medical Association.

There were no resolutions or other business on the agenda of this committee.

MEDICAL EDUCATION AND HOSPITALS

The following matters were referred to the Reference Committee on Medical Education and Hospitals. All reports will be found on the pages indicated in the September, 1960, Vol. 53, No. 9, *Journal* of the Indiana

when she's not like herself anymore

Metalex® basic in the care of the aging



when body tone, mental and sensory faculties begin to fade—*she's irritable, confused, forgetful, apathetic*

when voices begin to fade—*in loss of auditory acuity, in tinnitus*

when vision begins to dim—*in loss of visual acuity, in loss of peripheral vision*

℞ Metalex® *cerebral stimulant / vasodilator*

The stimulant—pentylenetetrazol—facilitates cerebral and reflex nerve activity.

The vasodilator—nicotinic acid—augments blood and oxygen supply to vital areas—

Thus, METALEX increases body tone and aids mental and sensory faculties.

Composition: Each teaspoonful (5 ml.) of the Elixir and each Tablet contains: Pentylenetetrazol 100 mg., Nicotinic Acid 50 mg.

Dosage: One or two teaspoonfuls of the Elixir or one or two Tablets four times a day—one-half hour before meals and before bedtime.

Available: Elixir: Pint and Gallon bottles. Tablets: Bottles of 100 and 1000.

References: 1. Goodman, L. S. and Gilman, A.: The Pharmacological Basis of Therapeutics, 2nd Ed., New York, Macmillan Company, 1955. 2. O'Reilly, P. O., Demay, M. and Kotlowski, K.: Cholesteremia and Nicotinic Acid. A.M.A. Arch. Int. Med. 100:797-801 (Nov.) 1957.

STORCK Pharmaceuticals, Inc.,
2326 Hampton Blvd., St. Louis 10, Mo.

State Medical Association. Resolutions introduced before the House and referred to this committee are printed herewith.

Commission on Medical Education and Licensure (pages 1777-1778), with exception of paragraph No. 6, which was referred to Reference Committee on Amendments to Constitution and Bylaws.

Commission on Special Activities (pages 1778-1779)

Student Loan Committee (pages 1765-1766)

Resolution No. 1—Recommendation in Regard to Specialization

Resolution No. 9—Nursing Education

Resolution No. 11—Nurses

Resolution No. 14—Doctor-Teacher Relationship in the Teaching of Health Subjects

Resolution No. 18—Efforts of the Woman's Auxiliary Concerning AMEF Funds

REFERENCE COMMITTEE ACTION

Dr. Eugene F. Senseny, chairman, presented the following report:

Medical Education

The Reference Committee reviewed the report of the Commission on Medical Education and Licensure and wishes at this time to commend the commission for the completeness of their report. This Reference Committee would like to emphasize several points in the report of the Commission and urge that they be adopted as follows:

1. That a copy of the inspection report of individual nursing homes be directed to the secretary of each component county medical society in which the home is located.

2. That this Reference Committee emphasizes the recommendation that each county medical society stimulate the increased immunization in their own local counties by whatever means they see fit.

3. Your Reference Committee concurs with the commission that the State Board of Medical Registration and Examination re-investigate and re-evaluate the osteopathic schools, their faculties and facilities. If they be found to meet the standards of the Indiana State Board of Medical Registration and Examination then the matter of privileges granted to these men be reconsidered by the Indiana State Medical Association. We further recommend that the Delegates to the American Medical Association carry to the House of Delegates of the American Medical Association this information.

4. It is also recommended that the Indiana State Medical Association be asked to request the Joint Commission on Accreditation to reconsider its qualifications for accreditation of hospitals in the State of Indiana, primarily in regard to osteopathy.

5. It is also recommended that the Council of the Indiana State Medical Association reconsider the ethical relationship of osteopaths and the Doctors of Medicine in the State of Indiana with particular reference to clinical pathologists and radiologists.

6. We further recommend that the Commission on Medical Education and Licensure, the Indiana State Board of Medical Registration and Examination and the Grievance Committee of the Indiana State Medical Association jointly study the Washington State Medical Society Project on Discipline.

7. The Reference Committee approves the balance of the report with, of course, the exception of paragraph six on page 176 of the Handbook which has been referred to the Reference Committee on Constitution and Bylaws.

Mr. President, I move the adoption of this portion of this report.

(Item No. 3 was discussed at length by Drs. Kubley, Dalton, Owsley, Land, Bowers and Kintner.)

(Motion seconded by Dr. Stover, put to vote, and carried.)

Special Activities

The next item considered by our committee was the report of the Commission on Special Activities. Your committee concurred in the opinion of the Executive Committee of not authorizing approval of "Counseling Service" as in the case of Floyd County.

The committee feels that any approval of such projects are a matter for local determination.

The Reference Committee is in full agreement with the commission that more lay groups are being formed in para-medical fields and they are seeking medical organization approval and recognition. Whether these groups be rehabilitation, counseling service or other fields, this problem must be faced by organized medicine. Your Reference Committee approves the report of the Commission on Special Activities and compliments the committee on its fine work the past year.

Mr. President, I move the adoption of this portion of this report. Motion seconded by Dr. Amy. Dr. Paris announced there was no counseling service going on in Floyd County but it was being conducted in Jeffersonville (Clark county), by an organization known as the Southern Indiana Rehabilitation Center.

(Dr. Paris' motion that the reference committee report be amended to specify the organization in question, the Southern Indiana Rehabilitation Center, was seconded by many, put to vote, and carried.)

(Dr. Senseny moved that this portion of the report be accepted as amended. Motion seconded by Dr. Schneider, put to vote, and carried.)

Student Loan

The next item considered was the report of the Student Loan Committee. Your committee, after a full study of the report of this committee, makes the following recommendations:

1. That the previous action of the House of Delegates to establish an interest rate of 6% on loans to students be rescinded and that a new nominal interest rate of 2%, to cover expenses only, be authorized by this body to become effective immediately with the granting of future loans.

2. Your Reference Committee feels that it is the responsibility of the Medical Association to encourage good students to enter the field of medical practice and this can be aided by increasing the loan fund by an additional $20,000.00 to make the total principal for loan $40,000.00.

Mr. President, I move the adoption of this portion of this report.

(Motion seconded by Dr. Holland; discussed by Drs. Green, Glock, Holland and Rang; put to vote, and carried.)

Resolution No. 18

Introduced by: COMMISSION ON MEDICAL EDUCATION INDIANA STATE MEDICAL ASSOCIATION

Subject: EFFORTS OF THE WOMAN'S AUXILIARY CONCERNING A.M.E.F. FUNDS

WHEREAS, the House of Delegates of the Indiana State Medical Association adopted in 1958 an assessment in the amount of $10.00 per year per physician for A.M.E.F., and

WHEREAS, the simple signing of this check has diminished the interest in the purpose of A.M.E.F., and

WHEREAS, the Woman's Auxiliary has continued their interest and their efforts with various projects to raise funds for this cause, and

WHEREAS, they now are entering a statewide project for the sale of Christmas cards for the benefit of their A.M.E.F. Fund, therefore

BE IT RESOLVED, that the House of Delegates go on record as supporting this effort and encourage each physician attending this 111th annual convention of the Indiana State Medical Association to visit the booth in the North Convention Hall and order Christmas cards.

REFERENCE COMMITTEE ACTION

Dr. Eugene F. Senseny, chairman, presented the following report:

The next item considered was Resolution No. 18. Your committee approves this resolution regarding the efforts of the Auxiliary to raise funds for the American Medical Education Foundation and recommends such procedure.

The committee wishes further to commend the Auxiliary for their increasing efforts and loyal devotion to the Indiana State Medical Association.

Mr. President, I move the adoption of this portion of this report.

(Motion seconded by many, put to vote, and carried.)

Resolution No. 14

Introduced by: COMMISSION ON MEDICAL EDUCATION AND LICENSURE AND THE SUB-COMMITTEE ON MEDICAL EDUCATION

Subject: DOCTOR-TEACHER RELATIONSHIP IN THE TEACHING OF HEALTH SUBJECTS

WHEREAS, Health Education has long been considered the basic cardinal principle of education, we respectfully submit a Resolution to strengthen that point of view by creating more effective and closer liaison between the medical and education professions, and

WHEREAS, the matter of health is being exploited by many pressure groups, the Medical men must develop and support their own programs or suffer the consequences. Teachers are our best and most efficient allies, and

WHEREAS, the Medical profession of Indiana has now approved a School Health Policy Book, in collaboration with the Indiana State Board of Health for use in all our schools to further that purpose, and

WHEREAS, the Sub-committee on Health Education of the Commission on Medical Education and Licensure has set up plans and specifications for encouraging the Medical profession to take the initiative in carrying on a more active health education program to the children of the state by closer association with the schools, through their teachers, especially those teaching health and allied subjects, and

WHEREAS, we desire to continue such worthwhile activities in Health Education as examining school texts, immunization, physical examinations, health needs, health as a basic subject, First Aid kits, etc., the local societies should furnish consultants to the teachers who feel the need of such assistance as only the Doctors of Medicine can provide and thus avoid an admitted "feel alone" by the teachers, and

WHEREAS, this being a project for both county and state levels, we urge that each county society cooperate in seeing that appropriate mechanisms be established to make Health Teaching workable at the local level, and now

THEREFORE BE IT RESOLVED, that the House of Delegates assembled at French Lick, Indiana, this 2nd of October, 1960 in the 111th annual convention of the Indiana State Medical Association do endorse this Resolution and approve its application through all county, district, and state committees; and

BE IT FURTHER RESOLVED, that a committee for this purpose be added to the usual committees wherever necessary to create a working unit to help the teachers of Health in schools served by each Society. the specific duties to be worked out by the Doctors and Health Teachers concerned; and

BE IT FURTHER RESOLVED, that this House of Delegates approve addresses by Physicians over the state who would be asked to appear before teachers' conventions, groups or special meetings for the purpose of consultation, instruction, or other scientific purposes when so requested by the Educators.

REFERENCE COMMITTEE ACTION

Dr. Eugene F. Senseny, chairman, presented the following report:

The next item considered was Resolution No. 14. Your committee wishes to highly commend the people involved in preparation of the pamphlet "Suggestion for School Health Policies for Indiana Schools" as prepared jointly by the State Department of Public Instruction and the Indiana State Board of Health in cooperation with the sub-committee on School Health of the Indiana State Medical Association and the Indiana State Dental Association. We approve wholeheartedly Resolution No. 14 as submitted.

Mr. President, I move the adoption of this portion of this report.

(Motion seconded by many, put to vote, and carried.)

Resolution No. 9

Introduced by: TIPPECANOE COUNTY MEDICAL SOCIETY

Subject: NURSING EDUCATION

WHEREAS, a shortage of active nursing personnel exists in our country.

AND WHEREAS, present methods of educating and training nurses appears to be inadequate from a volume standpoint.

AND WHEREAS, certain portions of nursing education could be administered much more effectively at a college level.

AND WHEREAS, the cost and training regulation of School of Nursing in community hospitals has become almost prohibitive.

THEREFORE BE IT RESOLVED, that the Indiana State Medical Association encourage colleges and universities in our state to seriously consider the development of Schools of Nursing at the various levels, such as Registered Nurse, Collegiate Nurse, and Lay Practical Nurse, and

BE IT FURTHER RESOLVED, that the Indiana University School of Nursing be encouraged to supply advisory and administrative support to any state educational institution desiring such assistance.

Resolution No. 11

Introduced by: LAKE COUNTY MEDICAL SOCIETY

Subject: NURSES

WHEREAS, it is evident that the shortage of nursing personnel threatens to continue for many years, and;

WHEREAS, the shortage has led to shifting of nursing assignments, removing many qualified Registered Nurses from areas of direct patient care where they are needed, to teaching, supervisory and administrative duties, and;

WHEREAS, the hope for alleviation of the problem through the Licensed Practical Nurse has not materialized to the desired extent, and;

WHEREAS, standards of nurses training are not uniform in hospitals and other institutions, and little has been done by them to provide a greater supply of trained nurses for patient care, and;

WHEREAS, this problem should be the joint concern of the medical, nursing, and hospital professions; NOW, THEREFORE,

BE IT RESOLVED, that a joint study commission of representatives of the Indiana State Medical Association, Indiana State Nursing Association, and Indiana Hospital Association be created to examine the situation and its causes, and to recommend possible solutions.

REFERENCE COMMITTEE ACTION

Dr. Eugene F. Senseny, chairman, presented the following report:

Your committee next considered Resolutions Nos. 9 and 11 together, as both concern nursing and nursing education. Your committee calls your attention to the fact that these Resolutions clearly point out the problems involved in nursing training and the inadequate supply of nurses in existence today. It is therefore recommended by your Reference Committee that an ad hoc joint study committee as recommended in Resolution 11 be appointed, composed of representatives of the Indiana State Medical Association, the Indiana State Nurses Association and the Indiana Hospital Association. It is hoped that this committee in its function will clearly examine the situation creating the nursing shortages and to try and find solutions to the problem.

Mr. President, I move the approval of Resolutions 9 and 11 as combined and amended.

(Motion seconded by Dr. Steele, put to vote, and carried.)

Resolution No. 1

Introduced by: LAWRENCE COUNTY MEDICAL SOCIETY

Subject: RECOMMENDATION IN REGARD TO SPECIALIZATION

WHEREAS, the number of family doctors is being depleted by specialization, and

WHEREAS, the family doctor is being replaced by chiropractors, osteopaths and cultists, and

WHEREAS, the deficiency cannot be met by more graduates from approved medical schools, inasmuch as students proceed directly into specialization, and

WHEREAS, only by having good medical doctors to refer them patients can a specialist obtain an ethical practice, and

WHEREAS, a specialist should understand the relationship of the patient in the family doctor situation; therefore be it

RESOLVED, that the Indiana State Medical Association recommend to all Specialty Boards and to the American Medical Association that all applicants have at least two years' general practice as a requirement for specialization.

REFERENCE COMMITTEE ACTION

Dr. Eugene F. Senseny, chairman, presented the following report:

The next item considered was Resolution No. 1. Considerable testimony was heard by your committee on this resolution. In executive session the committee reviewed the discussion, carefully re-examined Resolution No. 1, and came to the conclusion that it has a great deal of merit in basic principle; however, the committee feels that it is a great moral responsibility to recommend to any young man that he pursue two more years of training over and above that already established. Therefore, we feel that this subject should be given further consideration and study before any hasty decision is made.

Mr. President, I move that this resolution be referred to the Commission on Medical Education and Licensure for further study.

(Motion seconded by many, put to vote, and carried.)

Mr. President, I move the adoption of this report as a whole as amended.

(Motion seconded by Dr. Wilder, put to vote, and carried.)



"It's in the bag—if you have Blue Cross-Blue Shield!"



Blue Shield

Mutual Medical Insurance, Inc.
110 N. Illinois St., Indianapolis 9, Ind.
Phone MElrose 5-9411

Sponsored by the Indiana State Medical Association

LEGISLATION

The following matters were referred to the Reference Committee on Legislation. All reports will be found on the pages indicated in the September, 1960, Vol. 53, No. 9, *Journal* of the Indiana State Medical Association. Resolutions introduced before the House and referred to this committee are printed herewith.

Commission on Legislation (page 1768)
Resolution No. 10—Medical Care for Needy Aged
Resolution No. 12—Health Officers' Remuneration
Resolution No. 16—Non-Partisan Selection of Judges
Resolution No. 17—A Study to Develop Legislation to Regulate Those Who Practice Psychotherapy

REFERENCE COMMITTEE ACTION

Dr. Jack Shields, chairman, presented the following report, which was adopted on motion of Drs. Shields and Lamey:

The Reference Committee on Legislation met in Parlor D at 9:00 a.m., Monday, Oct. 3, 1960. All members were present. The meeting was called to order by the chairman who appointed Dr. Boyer as temporary secretary.

The first order of business was a review of the report of the Commission on Legislation. After discussion the report was unanimously adopted as printed on page 152 of the Handbook. The reference committee recommends that the report be filed as written. The committee wishes to commend the Commission on Legislation for its arduous work during the past year. The committee also wishes to commend the Woman's Auxiliary and the component county societies for their fine work and excellent cooperation.

Resolution No. 10

Introduced by: LAKE COUNTY MEDICAL SOCIETY
Subject: MEDICAL CARE FOR NEEDY AGED

WHEREAS, the Federal Government has enacted into law a program for the medical care of the needy aged, and;

WHEREAS, this program was supported by the American Medical Association and represents the medical profession's thinking on this subject, and;

WHEREAS, the law provides Federal financial assistance to the several states which appropriate funds for this purpose; NOW, THEREFORE,

BE IT RESOLVED, that the Indiana State Medical Association support and, if necessary, introduce in the 1961 General Assembly, legislation providing the machinery, including appropriation of funds, for the implementation of this assistance to the needy aged citizens of the State of Indiana.

REFERENCE COMMITTEE ACTION

Dr. Jack Shields, chairman, presented the following report:

After careful deliberation and discussion, Resolution No. 10 was recommended for acceptance with the following changes:

The paragraph reading "BE IT RESOLVED, that the Indiana State Medical Association support and, if necessary, introduce in the 1961 General Assembly, legislation providing the machinery, including appropriation of funds, for the implementation of this assistance to the needy aged citizens of the State of Indiana," be changed to read as follows:

"BE IT RESOLVED, that the Indiana State Medical Association support legislation providing the machinery for the implementation of this voluntary method of assistance to the needy aged citizens of the State of Indiana."

Mr. President, we move that this section as changed and supplemented be adopted.

(Motion seconded by Dr. Silverman, put to vote, and carried.)

Resolution No. 12

Introduced by: SECTION ON PUBLIC HEALTH AND PREVENTIVE MEDICINE
Subject: HEALTH OFFICERS' REMUNERATION

WHEREAS, the Indiana State Board of Health has experienced serious difficulty in obtaining Doctors of Medicine to serve as part-time health officers in part-time health departments, and;

WHEREAS, the Indiana State Board of Health has requested the Indiana State Medical Association and the Indiana Health Officers Association to assist in obtaining Doctors of Medicine to serve as part-time health officers, and;

WHEREAS, the duties of the health officer have greatly increased in the past 15 years, and;

WHEREAS, the Health Officers have received no increases in remuneration in more than 15 years although other state, county and municipal officials have had one or more pay increases in the corresponding time, and;

WHEREAS, many physicians have been reluctant to accept the increasing duties and responsibilities of a health officer because the trivial remuneration is not commensurate with the time and effort involved;

THEREFORE, BE IT RESOLVED, that the Indiana State Medical Association and the Indiana Health Officers Association encourage and request that the Indiana State Board of Health make strenuous efforts during the coming session of the Indiana General Assembly to assure that statutory provision be made that the remuneration of the Health Officers be increased to a scale commensurate with the duties and responsibilities involved.

REFERENCE COMMITTEE ACTION

Dr. Jack Shields, chairman, presented the following report:

The committee, after careful deliberation and consideration, recommends the acceptance of Resolution No. 12 as written but suggests that implementation of the existing law for county health boards be instituted as soon as is feasible.

Mr. President, the committee recommends the adoption of this resolution, and I so move.

(Motion seconded by several, put to vote, and carried.)

Resolution No. 16

Introduced by: THE COUNCIL
Subject: NON-PARTISAN SELECTION OF JUDGES

BE IT RESOLVED, that the Indiana State Medical Association in annual convention assembled do hereby commend the efforts of both the bar associations and lay groups in endeavoring to improve our judicial systems by removing the judiciary from partisan politics, and

BE IT FURTHER RESOLVED, that the Indiana State Medical Association and its members lend their support to this effort.

REFERENCE COMMITTEE ACTION

Dr. Jack Shields, chairman, presented the following report:

The committee recommends that Resolution No. 16 as submitted by the Council, be adopted in its entirety. I so move.

(Motion seconded by Dr. Kintner, put to vote, and carried.)

Resolution No. 17

Introduced by: B. E. KINTNER, M.D., ON BEHALF OF THE THIRTEENTH DISTRICT

Subject: A STUDY TO DEVELOP LEGISLATION TO REGULATE THOSE WHO PRACTICE PSYCHOTHERAPY

WHEREAS, (1) the practice of psychotherapy has long been an essential part of the specialty of psychiatry, and whereas

(2) the diagnosis and treatment of mental illness implies the greatest skill, not only in psychotherapy, but also in the general field of medical practice, and whereas

(3) there is a growing tendency in the collateral helping professions, such as psychology and social work in the direction of practicing intensive psychotherapy, and whereas

(4) there as yet is a lack of internal and external supervision in control of these professional groups and

(5) that therefore, there is danger to patients because of the potential for inadequate medical evaluation of such patients both during their diagnosis and subsequent treatment.

BE IT THEREFORE RESOLVED, (1) that the Indiana State Medical Association through an appropriate committee work with its counterpart in the Indiana Neuropsychiatric Association and the Northern Indiana Psychiatric Society in the study of this problem, and

(2) that as a result of these studies appropriate recommendations be made to the Indiana State Medical Association and to the State Legislature for suitable legislation to protect both the patients and the professional status of our own and the other professional groups involved.

REFERENCE COMMITTEE ACTION

Dr. Jack Shields, chairman, presented the following report:

Resolution No. 17, introduced by Dr. B. E. Kintner on behalf of the Thirteenth District, concerning a study to develop legislation to regulate those who practice psychotherapy, is recommended for adoption by this committee, as written.

Mr. President, we move the adoption of this section of the report.

(Motion seconded by many; discussed by Drs. Bowers and Kintner; put to vote, and carried.)

Dr. Shields concluded his report as follows:

The committee wishes to thank those members who appeared and discussed the above resolutions for their participation, and the chairman wishes to thank the members of this committee for their diligent service.

Mr. President, we move the adoption of this report in its entirety.

(Motion seconded by Dr. Everly, put to vote, and carried.)

PUBLIC RELATIONS

The following matters were referred to the Reference Committee on Public Relations. All reports will be found on the pages indicated in the September, 1960, Vol. 53, No. 9, *Journal* of the Indiana State Medical Association. Resolutions introduced before the House and referred to this committee are printed herewith.

Grievance Committee report (page 1765), and the following supplementary report, presented by Dr. Philip B. Reed, chairman:

Mr. President, members of the House of Delegates, and guests: The Council referred to the Grievance Committee the question of Medical Disciplinary Committees and Medical Disciplinary legislation, as it has been approached in other states with the very broad question, "Is there anything to be gained for Indiana in following successful examples set elsewhere?"

As you all know the Trustees of the American Medical Association appointed a Medical Disciplinary Committee in 1958. My job has been the easy one of simply listening to some 40 physicians over the state, several occupying official positions, as on the State Board of Medical Registration. It appears, as would be expected with this relatively new or different approach, at least different sounding approach, that some confusion would arise. The confusion rests between the two poles, (1) that any such approach is to supplant all existing disciplinary measures on the part of organized medicine as well as on the part of those legislatively-approved bodies as the State Boards. The other pole is to the effect that this may have some kind of whitewash, will change nothing and therefore help no one.

I think that I need not tell the members of the House of Delegates and many of the guests that there is a gray area in medical discipline that is not always effectively touched, if I may draw upon the testimony of the 40 physicians solicited. Some of the offenders are not members of the Indiana State Medical Association. They therefore certainly feel themselves completely free of the moral suasion or direct disciplinary measures utilized by organized medicine. There are some offenders who embarrass us in the public press and elsewhere, who are members of the State Medical Association, and the constituent county medical societies, but they somehow feel that they are not answerable to their colleagues.

Now, this is our large problem—Is there a gray area that can be better considered by some approach such as that taken in the State of Washington.

The Grievance Committee feels that this matter is an extremely important and delicate matter and that we certainly should wait until the fact-finding function of the American Medical Association Disciplinary Committee has at least gathered a number of reports of legislation as it has actually functioned elsewhere, as well as a broad sample of legislation that is now proposed.

The Grievance Committee therefore wishes to add to its report merely the thought that this extremely important responsibility assigned to it should be a subject of continuing study. I may no longer be the chairman of that committee; therefore, if any of you have suggestions, thoughts, or ideas, simply direct them to Chairman of the Grievance Committee, because this, we feel, should continue to be a real subject of study. Thank you.

Commission on Public Information (pages 1768-69).
Resolution No. 3—Impartial Medical Witness Plan, and similar resolution from the Council.

REFERENCE COMMITTEE ACTION

Dr. Harry R. Stimson, chairman, presented the following report:

Your Reference Committee on Public Relations was given four problems to study and report to this House—namely, (1) A Resolution from the Council regarding Panel and Impartial Medical Witnesses printed in your Handbook on page 109; (2) Resolution No. 3 which is identical to the above resolution and printed in your Handbook on page 89; (3) The report of the Commission on Public Information printed in your Handbook on pages 153, 154 and 155 and (4) the report of the Grievance Committee printed on page 145 of the Handbook.

The committee met at 9:00 a.m., on Monday, Oct. 3 and listened to officers and members of the Association give their personal and represented areas' views on these subjects and followed with a discussion lasting almost four hours. Not having all the information available on one of the subjects, the committee reconvened for a short session on Tuesday morning.

Resolution No. 3

Introduced by: LAKE COUNTY MEDICAL SOCIETY
Subject: IMPARTIAL MEDICAL WITNESS PLAN

WHEREAS, the Impartial Medical Witness Plans in the Federal Courts of several cities, outside the State of Indiana, have been tried for periods of up to seven years and have proven to be of value to physicians in those areas, and

WHEREAS, Indiana Federal Court Justices have indicated a desire to institute similar plans in their courts, and

WHEREAS, a study made by the Lake County Medical Society has determined a need for such a program in Indiana, and

WHEREAS, the formation of the necessary panel of qualified and impartial physicians is difficult, if not impossible, on a county-wide basis; now therefore,

BE IT RESOLVED, that the Indiana State Medical Association undertake to assist in bringing about the Impartial Medical Witness Plan on a regional basis corresponding with each Federal Court, or on a statewide basis to serve all Federal Courts in Indiana.

REFERENCE COMMITTEE ACTION

Dr. Harry R. Stimson, chairman, continued with his report, as follows:

First we shall report on items (1) and (2) together which are identical and regard Impartial Medical Witnesses. Again let me remind you that this is printed on pages 109 and 89 of your Handbook. Your committee feels that these resolutions should not be approved by the House at this time because of the impracticability of the plan and the widespread opposition voiced by various areas. We feel that for such a plan to be workable. It should be studied much further and we recommend that the appropriate commission be given this problem for further study and in the meantime we suggest that the local county medical societies give every possible cooperation requested of them by any federal judges in their area.

Mr. President, I move this section of the report be accepted as read.

(Motion seconded by many, put to vote, and carried.)

REFERENCE COMMITTEE ACTION

Dr. Harry R. Stimson, chairman, presented the remainder of the report of the Reference Committee on Public Relations, as follows:

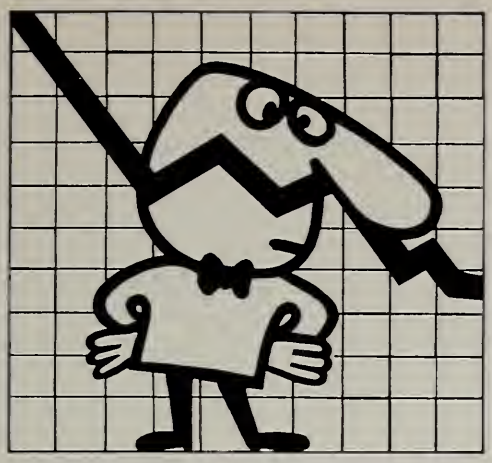
The report of the Commission on Public Information (Handbook pages 153, 154 and 155) was studied thoroughly and approved as printed. During our discussion on Public Relations, the annual Medico-Civic Dinner sponsored by the Vanderburgh County Medical Society was brought to our attention and the committee thought well enough of this idea to at this time suggest to the state association that this event be studied by the Public Information Committee with the view of possible duplicating this affair in other areas.

Mr. President, I move that this portion of the report be approved.

(Motion seconded by Dr. Stover, put to vote and carried.)

Your Reference Committee approves the report of the Grievance Committee as printed (Handbook pages 145-146) together with the supplemental report requested by the Council and given by Dr. Reed, chairman of the committee, at the first meeting of the House of Delegates. This supplemental report caused your Reference Committee to carefully study the Washington State Law regarding this matter and to hold public hearings with the Chairman of the Grievance Committee and other interested parties to bring out the ramifications of the operation of a disciplinary group, be it legislative or otherwise.

We are informed from extracts of committee hearings on the AMA level that in many states this device is being used to discipline many physicians on fees charged and claimed to be excessive, particularly in those states having a fee for service plan and/or relative value fee schedule. Therefore we wish to



A U. S. Senator recently said, "In investigating the pharmaceutical industry, we are investigating and inquiring into an industry that has won and which deserves public approval and confidence... It has been my judgment that the hearings to which I have referred, so far have been prejudiced and distorted." To paraphrase a political saying...

Let's Look At The Record On Drug Prices

In relation to "real income," drug prices have actually declined in recent years. At prevailing wages in 1929, it took 91 minutes of working time to pay for the average prescription. Only 86 minutes of labor paid for the average prescription in 1958. As one economist put it, "If the retail prices of drugs had risen as much as the consumer price index since 1939, it would cost the consumer at least an additional one billion dollars to buy the drug preparations now consumed." He goes on to compare the $19.02 per capita drug expenditure in 1958 with the $37.19 spent on tobacco products and $53.72 for alcoholic beverages.•When your patients inquire about the cost of medication, perhaps these facts will be helpful in explaining that today's prescription, averaging about $3.00, is a relatively modest investment in better health and a longer, more productive life.

This message is brought to you in behalf of the producers of prescription drugs. For additional information, please write Pharmaceutical Manufacturers Association, 1411 K Street, N.W., Washington 5, D.C.

recommend extreme caution in this further study and we would hope that your eventual conclusions would guard against the use of a disciplinary group being used to regulate fees.

We wish to commend the work done by the whole Grievance Committee and especially its chairman, Dr. Philip Reed.

Mr. President, I move the adoption of this portion of the report.

(Motion seconded, put to vote and carried.)

Mr. President, I move the adoption of the report as a whole.

(Motion seconded, put to vote and carried.)

HYGIENE AND PUBLIC HEALTH

The following matters were referred to the Reference Committee on Hygiene and Public Health. All reports will be found on the pages indicated in the September, 1960, Vol. 53, No. 9, *Journal* of the Indiana State Medical Association. Resolutions introduced before the House and referred to this committee are printed herewith.

Commission on Public Health (pages 1772-1773)

Commission on Voluntary Health Agencies (pages 1773-1775)

AMA Guide for Industrial Immunization Programs (page 1775)

Maternal Mortality Report for 1958. (Copy handed to each delegate).

Resolution No. 19—Administration of Sabin Oral Vaccine

REFERENCE COMMITTEE ACTION

Dr. O. T. Scamahorn, chairman, presented the following report:

Public Health

The first item considered was the report of the Commission on Public Health. The committee commends this commission for its outstanding report and wishes to call attention to the report of the sub-committee on Rural Health and the sub-committee on Physicians Placement. This section constitutes an excellent review of the activities of this commission and its sub-committee and we recommend that a continued report should be made.

Mr. President, I move the adoption of this portion of this report.

(Motion seconded by Dr. Wilder, put to vote and carried.)

Voluntary Health Agencies

The second item considered by this committee was the report of the Commission on Voluntary Health Agencies.

We commend this committee for its outstanding work during the past year and we hope that more physicians as private citizens participate in the works of these different agencies at the local level. We recommend approval of this report.

Mr. President, I move the adoption of this portion of this report.

(Motion seconded by Dr. Eades, put to vote and carried.)

AMA Guide for Industrial Immunization Programs

The third item considered was the AMA Guide for Industrial Immunization. It is the opinion of this committee that this matter should always be considered at the local level. The demands of lay groups and organizations for immunization of their families and those of a community at reduced fees should be determined by the local medical society who should advise the local medical director of such companies as to their policy in this matter. We concur with the Council's advice as printed in their report for approval.

Mr. President, I move the adoption of this portion of this report.

(Motion seconded by Dr. Rosenbloom, put to vote, and carried.)

Resolution No. 19

Introduced by: F. R. N. CARTER, M.D., SOUTH BEND

Subject: ADMINISTRATION OF SABIN ORAL VACCINE

WHEREAS, the United States Public Health Service has approved the Sabin Oral Vaccine and will license its manufacture in the near future and

WHEREAS, the vaccine will in all probability be administered at one time to large segments of our population and

WHEREAS, already different groups of people are approaching health departments and druggists inquiring where the vaccine can be purchased, and

WHEREAS, there are certain potential dangers in administering the vaccine, such as the increased virulence that may occur in unvaccinated groups who will be exposed to the attenuated virus that is excreted by people who have had the vaccine and

WHEREAS, the groups of people with the exception of doctors who are interested in administering the vaccine are not licensed to practice medicine and therefore cannot be responsible for the effects of the vaccinations and

WHEREAS, when informed of this fact, it will undoubtedly result in many different groups asking many local doctors to be responsible for the administration of the vaccine whether they are present at the actual time of administration or not and

WHEREAS, this will result in bad public relations if the doctors refuse to assume this responsibility.

NOW THEREFORE, BE IT RESOLVED, that a special committee be established by the Indiana State Medical Association whose function it will be to study the many problems which will be incurred in the administration of the vaccine and to establish a uniform set of rules for all the doctors in the state to follow when they are approached by various groups asking them to be responsible for the results incurred by administering the vaccine.

REFERENCE COMMITTEE ACTION

Dr. O. T. Scamahorn, chairman, presented the following report:

The fourth matter considered was Resolution No. 19. This committee concurs with this Resolution in principle

and we recommend that it be referred to the Commission on Public Health for future study and report.

Mr. President, I move the adoption of this portion of this report.

(Motion seconded by many, put to vote, and carried.)

Maternal Mortality Report for 1958

The next item considered was the report of the Maternal Mortality Study Committee. This is an excellent report and we wish to make special commendation to Dr. Carl Huber and his committee for this informative report. We recommend that this committee and its study be continued.

Mr. President, I move the adoption of this portion of this report.

(Motion seconded by many, put to vote, and carried.)

I wish, at this time, to thank the members of my committee for their interest and assistance in conducting the work of this committee and especially Dr. Peter Petrich and Dr. Ralph C. Eades who filled in vacancies on the committee in order that it might function as a full committee.

Mr. President, I move the adoption of this report as a whole.

(Motion seconded by Dr. Stouder, put to vote and carried.)

AMENDMENTS TO CONSTITUTION AND BYLAWS

The following matters were referred to the Reference Committee on Amendments to Constitution and Bylaws. All reports will be found on the pages indicated in the September, 1960, Vol. 53, No. 9, *Journal* of the Indiana State Medical Association. Resolutions introduced before the House and referred to this committee are printed herewith.

Commission on Constitution and Bylaws (pages 1767 and 1768) and following resolutions contained in this report;

Resolution to amend Section 12, Chapter XXV, Bylaws, concerning remission of state dues.

Resolution to amend Section 4, Chapter XXV, and Section 7, Chapter XXV, Bylaws, concerning practice, residence and membership.

Paragraph No. 6 in report of Commission on Medical Education and Licensure (page 1777) concerning establishment of a special commission on medical ethics.

Resolution No. 15—Amendment to Bylaws Establishing Commission on Aging.

REFERENCE COMMITTEE ACTION

Dr. M. C. Topping, chairman, presented the following report:

This committee was assigned consideration of the report of the Commission on Constitution and Bylaws, with resolutions from this commission to amend Section 12, Chapter XXV, concerning remission of state dues; resolution to amend Sections 4 and 7, Chapter XXV, concerning practice, membership, and residence; the report of the Commission on Medical Education and Licensure concerning the establishment of a special commission on medical ethics; and Resolution No. 15, from the Council, on amending Chapter VIII, Section 1, creating a Commission on the Aged and Aging.

The committee met in Parlor B from 9:00 to 12:00 and heard expressions from many members on each issue. It was ably advised by Dr. Mericle, Dr. Owsley, and Dr. Wood, and was assisted in several instances by Mr. Waggener, Mr. Amick, and Mr. Grindstaff.

Report of the Commission on Constitution and Bylaws

The report as published on pages 149-152 of the Handbook was reviewed. The change in the Constitution providing for election in absentia was approved at the last meeting of the House. The provision for the creation of the offices of Speaker and Vice-Speaker, and the changes in the Bylaws incident to the creation of these offices, was rejected at the last meeting of the House. These two portions of the report of the commission were therefore not considered by this committee.

a. The commission's resolution to amend Section 12, Chapter XXV of the Bylaws as printed on page 150 of the Handbook was approved.

This resolution would in effect require that the councilor shall present any case of financial hardship referred to him from a county society in his jurisdiction to the Council for their consideration for the remission of dues.

I will read this amendment, and since it was read at the last meeting of the House, your acceptance of this portion of the report will constitute this change in the Bylaws:

> "In the event the county society remits a member's dues, on account of financial hardship, the secretary of the county medical society shall recommend in writing to the councilor of his district the remission of the state association's dues of said member of the society, showing why such recommendations should be granted. The councilor in turn shall present the recommendation to the Council, which shall have the power to remit such dues."

Mr. President, I move the adoption of this portion of the report.

(Motion seconded by Dr. Kern, put to vote and carried.)

In reviewing the preceding question, it was brought to the attention of this committee that many physicians whose dues have been remitted (over 300 at this time) would feel better about their State Association status if they were carried as partial dues paying members on an inactive status rather than accepting complete remission of dues. If, as provided for in this amendment, there is genuine financial hardship, complete remission of dues is already provided for. There is also provision for remission of dues to senior members. There are, however, other physicians not now members of the Association who have retired prior to age 70 or have become non-residents of the state, or who are members of government or state agencies, or who are full-time teachers who otherwise would be eligible to membership and who now are not afforded these privileges.

With these considerations in mind, and with a desire to not only make the distribution of dues more equitable among our present members, but also to be able to embrace many new members not now eligible, this committee recommends that a Constitutional Amendment be enacted providing for the creation of a new category of "Inactive Members" on a partial dues paying basis.

We recommend consideration of this proposed change by the Commission on Constitution and Bylaws, with the appropriate amendments to be submitted at the next meeting of this House.

Mr. President, I move the adoption of this portion of the report.

(Motion seconded by many, put to vote, and carried.)

b. The commission's recommendation to amend Section 4, Chapter XXV, of Bylaws, as printed on page 150 of the Handbook was approved.

This resolution simply adds to the qualifications for membership in a county society the degree of Doctor of Medicine or Bachelor of Medicine.

I will read this amendment and since it was presented at the last meeting of the House, your adoption of this portion of the report will constitute its final passage.

"Each county society shall be judge of the qualifications of its own members, but, as such societies are the only portals of this Association and to the American Medical Association, every reputable and legally registered physician who holds a degree of Doctor of Medicine or a degree of Bachelor of Medicine, and who does not practice or claim to practice, nor lend his support to any exclusive system of medicine, shall be entitled to membership. Before a charter is issued to any county society, full and ample notice and opportunity shall be given to every such physician in the county to become a member."

Mr. President, I move the adoption of this portion of the report.

(Motion seconded by many; discussed by Drs. Hedgcock and Owsley, put to vote, and carried.)

c. The commission's recommendation to amend Section 7, Chapter XXV, of the Bylaws, as printed on page 151 of the Handbook, was approved.

This resolution simply leaves out the words "by request" and allows the secretary to send a member's transfer credentials to his new society without the formality of request.

I will read this amendment and since it was presented at the last meeting of the House, your adoption of this portion of the report will constitute its final passage:

> "Where a member in good standing in a component society moves to another county in this state, his name shall be transferred without cost, to the roster of the county society into whose jurisdiction he moves, provided the transfer is approved b ymajority vote of the membership of said society to which the transfer is proposed."

Mr. President, I move the adoption of this portion of the report.

(Motion seconded by many, put to vote, and carried.)

Paragraph 6 from the Report of the Commission on Medical Education and Licensure

The report as noted in paragraph 6 is printed on page 176 of the Handbook. It recommends the creation of a new commission to be known as the Special Commission on Medical Ethics. The need for special study, dissemination of information, and re-education of the profession in this field is clearly apparent. The chairman of this commission stated in hearings that the subject encompassed too large an area for adequate treatment in his commission which was pre-occupied with many other assigned problems. Dr. Mericle advised us however against the creation of additional commissions. It was therefore felt that this subject should be given to another commission for study, and it is the recommendation of this committee that it be assigned to the Commission on Special Activities. If this is done, another commission need not be organized and we recommend disapproval of this proposal.

Mr. President, I move the adoption of this portion of the report.

(Motion seconded by Drs. Wilder and Kern, put to vote, and carried.)

Resolution No. 15

Introduced by: THE COUNCIL

Subject: AMENDMENT TO THE BYLAWS ESTABLISHING COMMISSION ON AGING

BE IT RESOLVED, that Chapter VIII, Section 1 of the Bylaws be amended by adding thereto "The Commission on the Aged and Aging," following "The Commission on Special Activities," and preceding the last paragraph of said section, and

BE IT FURTHER RESOLVED, that the Bylaws be amended by adding thereto a new chapter to be numbered Chapter XXXII, and which reads as follows:

"Chapter XXXII. The Commission on the Aged and Aging.

"Section 1. The duties of this commission shall be to study, investigate, and make recommendations to the Association in the areas falling within the question of the aged and the aging, including medical care programs, medical care insurance, rehabilitation, and preventive medicine."

REFERENCE COMMITTEE ACTION

Dr. M. C. Topping, chairman, continued with the report of the Reference Committee on Amendments to Constitution and Bylaws, as follows:

Resolution No. 15 from the Council would create a Commission on the Aged and Aging. It has been disclosed that the problems of the aged and the aging have been studied in many of the commissions during the past two years without coordination of effort. This subject is felt by the Council to be of growing importance to us not only because of the increasing public interest in the problem, but because of its political and social significance. This is to say nothing about the personal acquaintance with it which each of us may expect with the passing years.

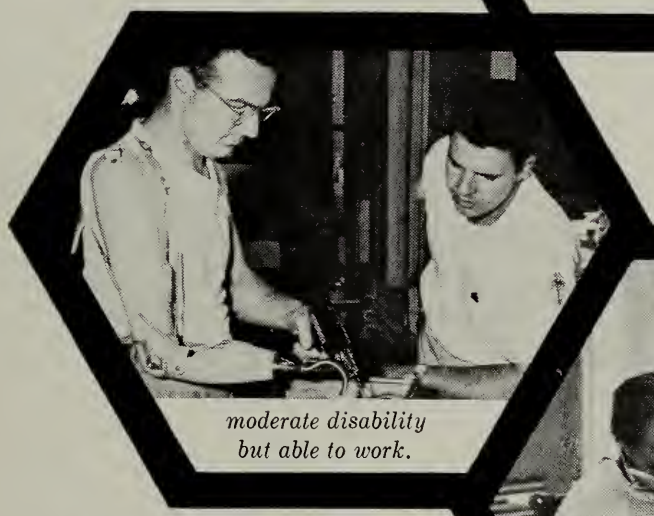
What is your goal...

in helping physically handicapped patients toward recovery?

The Rehabilitation Institute of Chicago Offers Three Possibilities:



return to normal.



moderate disability but able to work.



severely disabled but not totally incapacitated.

...through comprehensive rehabilitation for

- hemiplegia
- paraplegia
- quadriplegia
- amputations
- degenerative diseases of the nervous system
- traumatic disabilities of the hand
- arthropathies

Services Available for both in and out patients:

- Medical Care
- Nursing Care
- Laboratory Services
- Physical Therapy
- Occupational Therapy
- Speech Therapy
- Medical Social Service
- Vocational Counseling
- Psychological Service

Admission on Medical Referral Only—Referring physician has courtesy staff privileges, receives regular interim reports, complete summary at discharge, and a recommended program for continued treatment.

REHABILITATION INSTITUTE OF CHICAGO

401 E. OHIO ST., CHICAGO 11, ILL.

A UNIVERSITY AFFILIATED HOSPITAL

Direct Inquiries to:
Bernard J. Michela, M.D.
Director

It was therefore felt by this committee that the advantages to be gained by the establishment of a new commission for this special purpose would outweigh the disadvantages of its present dispersal, and we approve the adoption of this resolution.

I will read this amendment and since it was presented at the last meeting of the House, your approval of this portion of the report will constitute its final passage:

"BE IT RESOLVED, that Chapter VIII, Section 1 of the Bylaws be amended by adding thereto 'The Commission on the Aged and Aging,' following "The Commission on Special Activities" and preceding the last paragraph of said section, and

"BE IT FURTHER RESOLVED, that the Bylaws be amended by adding thereto a new chapter to be numbered Chapter XXIV, and which reads as follows:

"Chapter XXIV. The Commission on the Aged and Aging.

"Section 1. The duties of this commission shall be to study, investigate, and make recommendations to the Association in the areas falling within the question of the aged and the aging, including medical care programs, medical care insurance, rehabilitation, and preventive medicine."

BE IT FURTHER RESOLVED, that the present Chapters XXIV to XXXI be respectively renumbered by adding 1 to each of the said chapters.

Mr. President, I move the adoption of this portion of the report.

(Motion seconded by Dr. Oliphant, put to vote and carried.)

I wish to thank the other members of this committee for their earnest cooperation.

Mr. President, I move the adoption of this report as a whole.

(Motion seconded, put to vote and carried.)

INSURANCE

The following matters were referred to the Reference Committee on Insurance. All reports will be found on the pages indicated in the September, 1960, Vol. 53, No. 9, *Journal* of the Indiana State Medical Association. Resolutions introduced before the House and referred to this committee are printed herewith.

Commission on Medical Economics and Insurance report (pages 1775-1776)

Resolution No. 2—Relative Value Schedules

Resolution No. 4—Rejecting Relative Value Scale and Third Party Control of Medical Services and Fees

Resolution No. 5—Blue Shield Indemnity Schedule for Surgical Assistants

Resolution No. 6—Proposing the Transfer of X-ray and Laboratory Premiums from Blue Cross to Blue Shield to Provide Extended Office and Out-patient Benefits

Resolution No. 7—Out-patient Diagnostic X-ray and Pathology Benefits for Small-Group and Individual Blue Shield Policy Holders

Resolution No. 8—Nursing Home Benefits

Resolution No. 13—Transfer of Professional Services from Blue Cross to Blue Shield

Report of William Harry Howard, M.D., president of Blue Shield

REFERENCE COMMITTEE ACTION

Dr. James M. Leffel, chairman, presented the following report:

The Reference Committee on Insurance met at 9:00 a.m. Monday, Oct. 3, in Parlor G at the French Lick-Sheraton Hotel, recessed at 1:00 p.m. for one hour, reconvened at 2:00 p.m., and adjourned at 5:00 p.m. The committee was composed of the following doctors: Gordon B. Wilder from Anderson; David L. Adler from Columbus; R. B. Dubois from Lafayette; Stuart R. Combs from Terre Haute, and myself from Indianapolis. I should like at this time to thank the other doctors on this committee for their devoted service and for their untiring efforts to formulate a reasonable yet constructive report for the consideration of the House of Delegates.

On behalf of this Reference Committee I should also like to thank the many doctors who appeared before this committee to express their views. There was, at times, a wide diversion of opinion, but great sincerity was ever present, and we are most grateful to all of you who attended our hearing.

Your reference committee was charged by our President to consider the following matters:

I. The Report of the President of Blue Shield.

II. Resolution No. 8, introduced by the Knox County Medical Society; subject, Nursing Home Benefits.

III. Report of the Commission on Medical Economics and Insurance. This report was considered in four sections as outlined by the commission and related resolutions were studied with each section, as follows:

A. Sub-committee A: Relative Value Study. Resolution No. 2, introduced by Marion County Medical Society; subject, Relative Value Schedules. Resolution No. 4, introduced by the Madison County Medical Society; subject, Resolution Rejecting Relative Value Scale and Third Party Control of Medical Services and Fees.

B. Sub-committee B: Cooperative Care of the Surgical Patient. Resolution No. 5, introduced by the Commission on Medical Economics and Insurance; subject, Indemnity Schedule for Surgical Assistants.

C. Sub-committee C: Blue Cross-Blue Shield X-ray and Pathology Transfer. Resolution No. 13, introduced by the Commission on Medical Economics and Insurance; subject, Transfer of Professional Services from Blue Cross to Blue Shield.

D. Sub-committee D: Out-Patient Blue Shield Care. Resolution No. 6, introduced by the Commission on Medical Economics and Insurance; subject, Resolution Proposing the Transfer of X-ray and Lab Premiums from Blue Cross to Blue Shield to Provide Extended Office and Out-Patient Benefits. Resolution No. 7, introduced by Commission on Medical Economics and Insurance; subject, Out-Patient Diagnostic X-ray and Pathology Benefits for Small-Group and Individual Blue Shield Policyholders.

We should like to make the following recommendations and present the following amended resolutions to the delegates of this 1960 meeting for their consideration:

The committee wishes to commend Dr. Wm. Harry Howard, president of the Blue Shield Board for his

fine report. All of us are and should be delighted with the wonderful growth of this fine organization. We sincerely hope that this rapid expansion is never accelerated by the innuendo or wink of the eye suggesting to buyers that Blue Shield affords service type coverage. We hope further that at the earliest possible date Blue Shield will find it practical to incorporate various riders into fewer broader policies. Since the doctors and the group and individual policyholders seem to be poorly informed as to what Blue Shield offers in the way of policies and riders, it would seem to us advisable to clearly inform the above persons with a detailed description of what is available. We again wish to compliment Dr. Howard, the Board, and the entire staff of Blue Shield for their fine accomplishments.

Mr. President, I move the adoption of this portion of the report.

(Motion seconded by Dr. Wilder and others, put to vote and carried.)

Resolution No. 8

Introduced by: KNOX COUNTY MEDICAL SOCIETY

Subject: NURSING HOME BENEFITS

WHEREAS, Indiana physicians have originated health insurance in Indiana through the Blue Shield Mutual Medical Insurance and endorsed Blue Cross to provide the prepayment method of defraying medical expense incurred in hospitalized patients;

WHEREAS, in an aging population requiring extensive bed care for patients having chronic illness with both the wife and husband working and living in smaller homes with larger families and most capable practical nurses working as hospital or nursing home aides on regular shifts resulting in no one to care for these disabled patients, at home;

WHEREAS, the State of Indiana is supervising and regulating Nursing Homes by licensure just as it does hospitals;

WHEREAS, many of these patients have had their intensive treatment in a general hospital prior to entering the Nursing Home and do not now require such elaborate and expensive facilities;

WHEREAS, these patients tend to remain in hospitals resulting in greater utilization of their present hospital insurance and raising premium costs thereby;

WHEREAS, the Federal government is considering Forand type regulation for this purpose with the claim that the voluntary plans can provide for the needs of these patients;

BE IT RESOLVED, that the House of Delegates of the Indiana State Medical Association, urgently request Blue Cross-Blue Shield to favorably consider the issuance of a special rider to individual and/or group subscribers to provide for 30, 60, 90 day nursing home benefits on an indemnity or co-insurance basis not to exceed $75 per month or 75% of the usual charges which ever is the lesser.

REFERENCE COMMITTEE ACTION

Dr. James M. Leffel, chairman, presented the following report:

Resolution No. 8, on Nursing Home Benefits, printed on page 93 of your Handbook.

In regard to Resolution No. 8, your committee wishes to point out that Blue Cross now has a policy that covers convalescent patients, covered by group plans, who have been transferred from a hospital to a nursing home, for 180 days allowing up to 80% of reasonable charges. We feel that greater and more liberal coverage is needed. However, this is a precarious field of insurance and we do not wish to be expansive in our requests. Further and careful study is needed; therefore we recommend the rejection of this resolution and recommend that this matter be referred to the Commission on Medical Economics and Insurance for further study.

Mr. President, I move the adoption of this portion of the report.

(Motion seconded by many, put to vote, and carried.)

Resolution No. 2

Introduced by: MARION COUNTY MEDICAL SOCIETY

Subject: RELATIVE VALUE SCHEDULES

[*The Marion County Medical Society submits the following resolution to the House of Delegates of the Indiana State Medical Association, without prejudice and with the explanation that it is submitted solely to bring its contents to a vote. The society has taken no official position on relative value schedules.*]

WHEREAS, there is diversity and inadequacy in many insurance schedules, with improper fee relationships from one procedure to another, and

WHEREAS, these schedules were originally devised by insurance companies not having special knowledge of the work involved in various medical procedures, and

WHEREAS, the doctors of Indiana are best qualified to catalogue properly the relative values of one procedure compared to another within this state, and

WHEREAS, the insurance companies and the medical profession would benefit by the doctors establishing a relative value schedule,

THEREFORE, BE IT RESOLVED, that the Indiana State Medical Association adopt and publish a relative value schedule, without a conversion factor, for the use of its members and any other agencies in the field of health for reference and guidance in the determination of value relationships of one medical, surgical, x-ray, or laboratory procedure to another.

Resolution No. 4

Introduced by: MADISON COUNTY MEDICAL SOCIETY

Subject: RESOLUTION REJECTING RELATIVE VALUE SCALE AND THIRD PARTY CONTROL OF MEDICAL SERVICES AND FEES

WHEREAS, the determination of a physician's fees is an individual matter, to be arrived at by mutual understanding between the physician and his patient, and

WHEREAS, any attempt by any other party to influence the conduct of the individual patient-physician relationship, in the matter of arriving at a satisfactory charge for service, is unjustified and endangers personal liberty, and

WHEREAS, service contracts offered by medical care plans represent an example of third party pay or interference, and

WHEREAS, the use of a relative value scale, in conjunction with a conversion factor results in creating fixed fee schedules varying by geographic and political areas and which are announced by organized physician groups serve the interest of unions, medical care plans, insurance companies and other groups, both to promote their insistence on the acceptance of a fixed set of physicians' fees and to divide those physicians unwilling to participate from their colleagues, and

WHEREAS, a relative value scale, with its conversion factor, in the face of organized group and general public pressures against justifiable fee increases, would impose unjustifiable economic restrictions, which would prove to be a financial hardship to physicians, from which the only hope for relief would be in the direction of bargaining with representatives of labor, and insurance companies, medical care plans and others.

THEREFORE, BE IT RESOLVED, that the Madison County Medical Society condemns and rejects the relative value scale, third party control of medical services, and fees, including all government medical programs, and service plan contracts as dangerous devices capable of doing great harm to patients, physicians and the medical profession, and

BE IT FURTHER RESOLVED, that a copy of this resolution be presented to the Eighth District Medical Society Meeting at Anderson, Indiana, 8 June 1960, and to the Indiana State Medical Association, House of Delegates, at the annual meeting at French Lick, Indiana, to be held in October, 1960.

REFERENCE COMMITTEE ACTION

Dr. Leffel continued with the report of the Reference Committee on Insurance:

Report of the Commission on Medical Economics and Insurance

Report of Sub-committee A: Relative Value Study, as printed on page 171 of your Handbook.

Resolution No. 2, Relative Value Schedules, as printed on page 88 of your Handbook.

Resolution No. 4, Resolution Rejecting Relative Value Scale and Third Party Control of Medical Services and Fees, as printed on page 89 of your Handbook.

In regard to Resolutions Nos. 2 and 4, this committee last year recommended that this matter of Relative Values be studied further. The House of Delegates accepted this recommendation unanimously. From a statewide point of view little interest has been shown regarding this matter in the past year. However, there is at least one county medical society that has become interested in this problem and is at present implementing the same in its own community. We recognize further the careful study that has been and is being conducted by the AMA Committee, headed by Dr. Lester Bibler. We feel that any county society should have the privilege of studying and/or adopting this plan if they so desire. However, we do not feel that the majority of doctors in this state desire a Relative Value Schedule on a statewide basis.

We feel that the experience of one or more of our county societies will be far more helpful in aiding all of us in making a final decision than would the continued study by the Commission on Medical Economics and Insurance. Therefore, we recommend that the above stated commission postpone any further study until such time as it deems it advisable to give this matter further consideration. By this action we recommend the rejection of this "A" portion of the report of the Commission on Medical Economics and Insurance and the rejection of Resolution No. 2 and Resolution No. 4.

Mr. President, I move the adoption of this portion of the report.

(Motion seconded by Dr. Schneider, put to vote and carried.)

DR. LAMEY: I would like to recommend by a motion that Resolution No. 4 come to the floor for a separate vote at this time, either approving or disapproving a Relative Value Scale. Therefore, I ask for reconsideration of the previous action taken on this section of Dr. Leffel's report.

(Motion seconded by Dr. Eades; motion defeated on rising vote.)

Resolution No. 5

Introduced by: COMMISSION ON MEDICAL ECONOMICS AND INSURANCE, SUB-COMMITTEE B—COOPERATIVE CARE OF THE SURGICAL PATIENT

Subject: BLUE SHIELD INDEMNITY SCHEDULE FOR SURGICAL ASSISTANTS

WHEREAS, Blue Shield (Mutual Medical Insurance) was established to encourage patients to insure against medical costs by prepayment, and

WHEREAS, there is no provision for payment to surgical assistants through Blue Shield indemnities, and

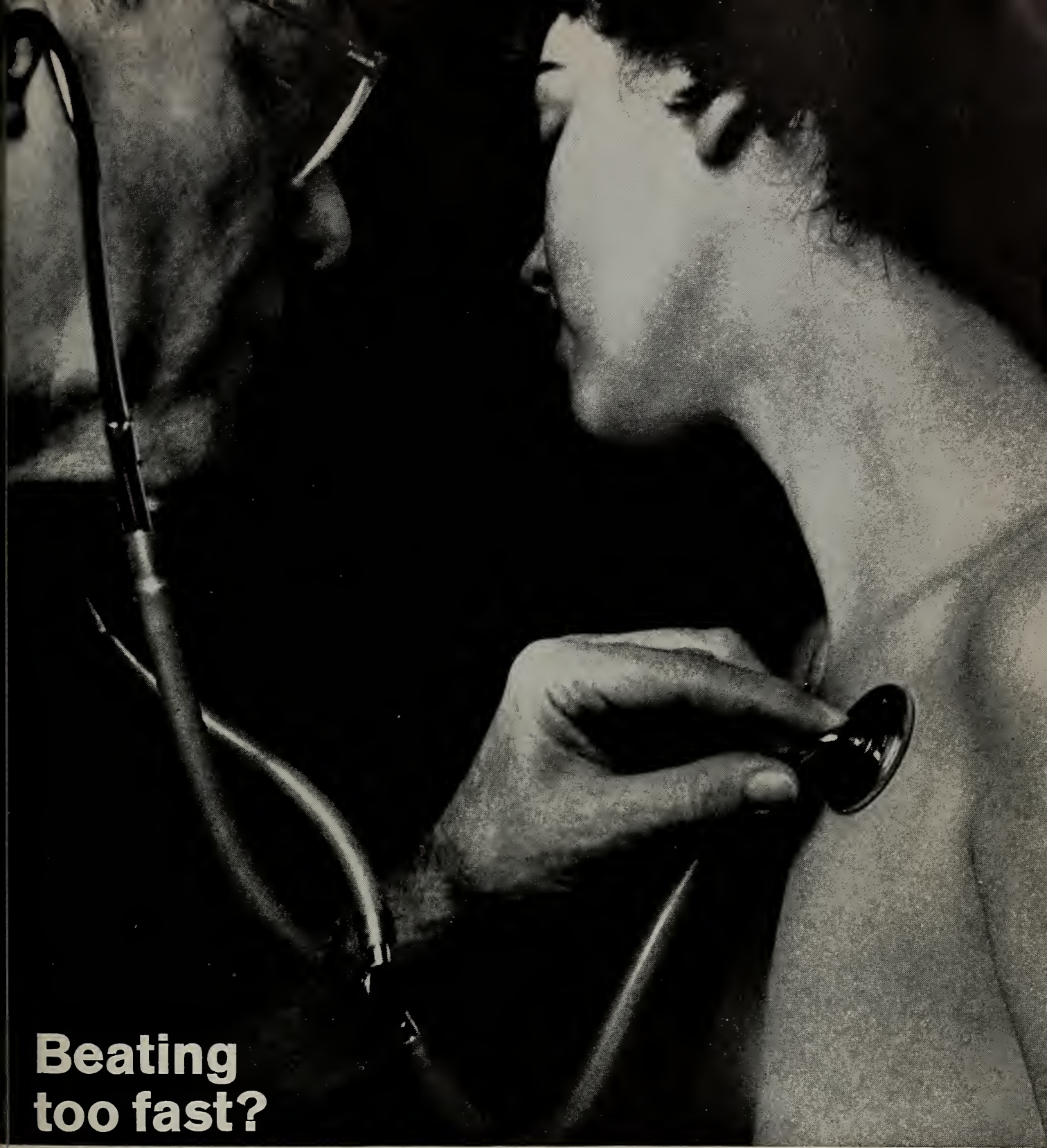
WHEREAS, it is considered unethical for a surgeon to designate any portion of the presently scheduled surgical indemnity to be paid to an assistant, and

WHEREAS, an assistant is deemed necessary in a number of major surgical procedures, and should bill the patient a reasonable fee for such services,

THEREFORE, BE IT RESOLVED, that the House of Delegates request the Blue Shield Board to establish an additional indemnity schedule for surgical assistants, requiring separate claim forms to be submitted by the assistant, and

BE IT FURTHER RESOLVED, that the indemnity schedule for surgical assistants be established at $20 for the first hour, and $10 for each succeeding hour, or portion thereof, not to exceed a total of three hours, or $40, and

BE IT FURTHER RESOLVED, that minor surgical cases, such as T and A's D and C's, and other procedures not requiring an assistant by good surgical principles (see definitions by College of Surgeons and Accreditation Commission) be *not* included in the schedule, and



Beating too fast?

Slow it down with SERPASIL®

(reserpine CIBA)

Serpasil has proved effective as a heart-slowing agent in the following conditions: mitral disease; myocardial infarction; cardiac arrhythmias; neurocirculatory asthenia; thyroid toxicosis; excitement and effort syndromes; cardiac neurosis; congestive failure. Serpasil should be used with caution in patients receiving digitalis and quinidine. It is not indicated in cases of aortic insufficiency.

SUPPLIED: Tablets, 0.1 mg., 0.25 mg. (scored) and 1 mg. (scored). Complete information available on request.

CIBA

SUMMIT • NEW JERSEY

2/2819MB

BE IT FURTHER RESOLVED, that interns and residents, or others being trained in a hospital training program, be *not* awarded the assistant's indemnity.

REFERENCE COMMITTEE ACTION

Dr. James M. Leffel, chairman, presented the following report:

Report of Sub-committee B: Cooperative Care of the Surgical Patient, as printed on page 171 of your Handbook.

Resolution No. 5, Blue Shield Indemnity Schedule for Surgical Assistants, as printed on page 91 of your Handbook.

This reference committee feels that it is essential that the assisting surgeon be paid for his services when such are needed. We further feel that an indemnity from Blue Shield should be available and that the operating surgeon should have absolutely no control over the amount of the indemnity. With government control constantly increasing the public should be educated as to the value of doctors acting as surgical assistants. Doctors assisting, we feel, should complete separate forms and the amount of the indemnity should be determined by the Blue Shield Board. If this indemnity schedule when suggested is not adequate or needs revision, such changes can be effected by proper resolutions and later action. The important thing to remember is that such a schedule is needed and is needed now. To refer this matter to various surgical groups would cause needless delay. To arrive at this indemnity figure by allowing so much per hour would, in our opinion, lower professional prestige; therefore, this reference committee recommends that the "B" portion of the Commission on Medical Economics and Insurance report be rejected and that Resolution No. 5 be adopted with the following amendments:

The sixth paragraph, starting with BE IT FURTHER RESOLVED reading:

"BE IT FURTHER RESOLVED, that the indemnity schedule for surgical assistants be established at $20 for the first hour, and $10 for each succeeding hour, or portion thereof, not to exceed a total of three hours, or $40."

be deleted and replaced with the following:

"BE IT FURTHER RESOLVED, that the indemnity schedule for surgical assistants be initially established by the Blue Shield Board with the right and privilege of the House of Delegates of this Association to make recommendations in the future if desired, and"

Mr. President, I move the adoption of this portion of the report.

(Motion seconded by many, put to vote, and carried.)

Resolution No. 13

Introduced by: COMMISSION ON MEDICAL ECONOMICS AND INSURANCE

Subject: TRANSFER OF PROFESSIONAL SERVICES FROM BLUE CROSS TO BLUE SHIELD

Supplemental Report of the Commission on Medical Economics and Insurance

WHEREAS, The Indiana Blue Cross Plan has recently provided coverage of radioactive-isotope treatment for in- and out-patients in hospitals, and;

WHEREAS, this would further encourage hospitals to practice medicine, and;

WHEREAS, this would place the hospital in direct competition with the Private Practitioner of Medicine, and;

WHEREAS, Blue Cross is designed to cover only Hospital Services and not Medical Services for its subscribers, and;

WHEREAS, this would further increase the high cost of hospitalization insurance, and;

WHEREAS, the Indiana State Medical Association is already trying to transfer all professional fees to Blue Shield;

THEREFORE, BE IT RESOLVED, that the Indiana State Medical Association express its opposition to the Blue Cross coverage of any professional service;

AND BE IT FURTHER RESOLVED, that the Indiana State Medical Association act with all its resources to effect immediately the transfer of payment for all professional services from Blue Cross to Blue Shield.

REFERENCE COMMITTEE ACTION

Dr. James M. Leffel, chairman, presented the following report:

Sub-committee C: Blue Cross-Blue Shield X-ray and Pathology Transfer, as printed on page 172 of your Handbook.

This reference committee is aware of the great danger of hospitals encroaching more and more upon the practice of medicine. We feel that serious steps must be taken at an early date to halt this trend. Every effort should be made to settle this difference in a quiet and friendly way. If such methods fail then other avenues of approach must be undertaken after thorough study. Since this is a national problem we should work with other states and with the AMA.

We therefore recommend the adoption of this portion of the report of the Commission on Medical Economics and Insurance and the adoption of Resolution No. 13, Transfer of Professional Services from Blue Cross to Blue Shield.

We further recommend that the House of Delegates authorize the Council of the Indiana State Medical Association to forward a resolution similar to Resolution No. 13 to the AMA for consideration at its interim meeting this November, 1960.

Mr. President, I move the adoption of this portion of the report.

(Motion seconded by Dr. Stover, put to vote and carried.)

Resolution No. 6

Introduced by: COMMISSION ON MEDICAL ECONOMICS AND INSURANCE, SUB-COMMITTEE D, OUT-PATIENT BLUE SHIELD CARE

Subject: RESOLUTION PROPOSING THE TRANSFER OF X-RAY AND LABORATORY PREMIUMS FROM BLUE CROSS TO BLUE SHIELD TO PROVIDE EXTENDED OFFICE AND OUT-PATIENT BENEFITS

WHEREAS, health insurance programs should enable the public to insure against large expenses resulting from illness, and

WHEREAS, in 1946, when Blue Shield was formed, Blue Cross agreed to transfer premium earnings to pay radiologist and pathologist fees to Blue Shield when the latter was financially solvent, and

WHEREAS, such transfer of funds requires a relatively small administrative cost, and

WHEREAS, this is now being done in Indiana in the payment of fees for x-ray therapy and in other Blue plans for diagnostic procedures, and

WHEREAS, it is *not* necessary to change the radiologist's or pathologist's personal contract with his hospital to provide such changes between the two insurance companies, and

WHEREAS, such a change will reduce hospital admission of ambulatory patients who could receive expensive x-ray and lab studies as office or out-patients,

THEREFORE, BE IT RESOLVED, that the House of Delegates of the Indiana State Medical Association, at its annual meeting, October, 1960, recommend to the Boards of Blue Cross and Blue Shield that the appropriate amounts of the Blue Cross premiums representing x-ray and lab benefits be transferred to Blue Shield.

Resolution No. 7

Introduced by: COMMISSION ON MEDICAL ECONOMICS AND INSURANCE, SUB-COMMITTEE D, OUT-PATIENT BLUE SHIELD CARE

Subject: OUT-PATIENT DIAGNOSTIC X-RAY AND PATHOLOGY BENEFITS FOR SMALL-GROUP AND INDIVIDUAL BLUE SHIELD POLICY HOLDERS

WHEREAS, an increasing number of hospital admissions of ambulatory patients has increased the cost of medical care, and

WHEREAS, changing social and economic factors have removed much of the patient's desire to stay out of the hospital, and

WHEREAS, the emphasis on hospital-oriented insurance programs has reduced the public understanding that quality medical care can be obtained in an office, on an ambulatory basis, by well qualified—often the same—physicians as in a hospital,

THEREFORE, BE IT RESOLVED, that the House of Delegates at its annual meeting in October, 1960, recommend to the Blue Shield Board that a policy be provided for individual and/or small groups which would include payment of office and/or hospital out-patient x-ray and laboratory fees to qualified physicians as designated by local medical societies on the basis of their training, experience and capabilities, and

BE IT FURTHER RESOLVED, that these payments not exceed 80% of the hospital in-patient fee for the same procedure in that community, with a maximum of $100 per year per contract, and with the usual restrictions used in the present riders for such benefits

REFERENCE COMMITTEE ACTION

Dr. Leffel continued with the report of the Reference Committee on Insurance:

Sub-committee D: Out-patient Blue Shield Care, as printed on page 91 of your Handbook.

Resolution No. 6, proposing the Transfer of X-ray and Lab Premiums from Blue Cross to Blue Shield to Provide Extended Office and Out-patient Benefits, as prined on page 91 of your Handbook.

Resolution No. 7, Out-patient Diagnostic X-ray and Pathology Benefits for Small-group and Individual Blue Shield Policyholders, as printed on page 92 of your Handbook.

This reference committee is in full agreement with the intent of this portion of the report of the Commission on Medical Economics and Insurance and with the intent of Resolution No. 6 and Resolution No. 7. However, the report of the above commission embodies the acceptance of both Resolution No. 6 and No. 7. We have been informed that no Blue Cross premiums are available for transfer to Blue Shield for payment of fees for diagnostic purposes. We have also been informed that Blue Shield now covers large groups for out-patient diagnostic studies. We recommend that this House of Delegates go on record as favoring extension of this coverage by Blue Shield to small groups and individuals at the earliest practical date.

Therefore this committee recommends the rejection of this portion of the report of the Commission on Medical Economics and Insurance, the rejection of Resolution No. 6 and the adoption of Resolution No. 7 with the following amendments: The deletion of the fourth paragraph headed "THEREFORE, BE IT RESOLVED" and substituting in lieu thereof the following:

"THEREFORE, BE IT RESOLVED, that the House of Delegates at its annual meeting in October, 1960, recommend to the Blue Shield Board that a policy be provided for individual and/or small groups which would include payment of office and/or hospital out-patient x-ray and laboratory fees, and"

Also, we recommend the deletion of the last paragraph of Resolution No. 7 and recommend the substitution of the following in lieu thereof:

"BE IT FURTHER RESOLVED, that these payments not exceed $100 per year per contract and with the usual restrictions used in the present riders for such benefits."

Mr. President, I move the adoption of this portion of the report.

(Motion seconded by Dr. Yunker; discussed by Drs. Corcoran, Stover, Vye, and Clark.

(Motion to take action on this portion of the report as two separate matters seconded, put to vote, and lost.

(On standing vote, Dr. Leffel's motion for adoption of this portion of the report was carried.)

Dr. Leffel continued with the report of the Reference Committee on Insurance:

I should again like to thank Doctors Wilder, Adler, Dubois and Combs for their loyal and devoted service on this reference committee.

Mr. President, I move the adoption of the entire report.

(Motion seconded by Dr. Edwards, put to vote and carried.)

MISCELLANEOUS BUSINESS

The following matters were referred to the Reference Committee on Miscellaneous Business. All reports will be found on the pages indicated in the September, 1960, Vol. 53, No. 9, *Journal* of the Indiana State Medical Association, with the exception of the report of the Building Committee, which is printed below.

Commission on Convention Arrangements (no printed report).

Commission on Governmental Medical Services (pages 1769-1772)

Commission on Inter-Professional Relations (pages 1776-1777)

Building Committee report.

Building Committee Report

Approximately one year ago, by resolution of the House of Delegates of the 1959 session and by similar resolutions of the Executive Committee and the Council, the present Building Committee was appointed and activated. It was charged with the responsibility of "securing a site and building an office building for the Indiana State Medical Association."

We will not bore you with all the problems we have had securing a site, but there have been many. At present we are working on very desirable, centrally located, readily accessible site in the 3900 block of North Meridian Street. This lot is 292 x 124 feet or about 36,108 square feet. Our option is for $60,000. This site had been cleared with the Zoning Board, but our progress is held up by the Metropolitan Plan Commission. Final action will not be forthcoming until later in October and it may be necessary for our legal advisors to file a "restraining order" against the commission. It is predicted such action will be settled in our favor.

Lennox, Mathews, Simmons and Ford have been employed as architects and conferences have been held with representations of this group and floor plans and sketches discussed. Roughly our present plans call for 7,892 square feet on the first floor and an unfinished basement of the same size.

The recommendations, resulting from the survey of the Wolf Management Engineering Company were considered in deciding our floor space needed. It is also a firm feeling of the Committee that adequate provision should be made for expansion eventually, vertically (and) or horizontally if Association activities should be increased by future developments.

Lastly and perhaps the problem of greatest concern to the committee has been just exactly how to properly finance this project and we humbly ask your distilled advice and guidance.

Financial experts have advocated the use of only $150,000 of our present assets instead of the $250,000 allocated by Council.

The committee does not recommend a dues increase, nor an assessment to meet this deficit.

It is obvious from what has just been related, that we have met with and been advised by reputable realtor, architects, financeers, attorneys and business engineers, and our decisions have been made by utilizing their expert advice in their special fields.

The devotion, diligence and sacrifice of time by the committee members, Dr. Case Hammond, Dr. Fred Brown, Dr. Jack Shields and Dr. Harry Pandolfo have been magnificent.

The building committee has cost estimates which would lead us to believe that we will need $400,000 to build a building adequate for a 10-year period. This $400,000 is broken down as follows:

$310,000 estimated cost of construction
$ 60,000 purchase of land site
$ 15,000 furnishings
$ 15,000 contingencies

The Building Committee, the Executive Committee and the Council authorize that we build a $400,000 building and that the building be paid for in the following manner:

(1) $150,000 to be taken from the General Fund

Two hundred fifty thousand dollars to be raised by (1) borrowing $125,000 and the payment of this loan without additional expense to the membership through allocations already budgeted (2) by the purchase of a repayable building certificate by the entire membership and future membership in the amount of $50.00 per certificate. This amount to be returned to the individual member upon demand, because of hardship, retirement from practice, transfer from state, or death in which case it would be paid to the estate. New members and physicians who have not been members for over three years may upon their own choosing pay the $50.00 at the rate of $25.00 per year.

RALPH V. EVERLY, M.D., *Chairman*

REFERENCE COMMITTEE ACTION

Dr. William B. Challman, chairman, presented the following report:

Convention Arrangements

Your Reference Committee commends the work of the Commission on Convention Arrangements and found that in this convention the Instructional Courses were well attended and recommends continuation of such courses. It is suggested that a long range program of these Instructional Courses (of perhaps 50 in the next 10 years) be set up, and that copies of the subjects covered, insofar as possible be on file at the headquarters office for future reference.

Mr. President, I move the adoption of this portion of the report.

(Motion seconded by Dr. Steele, put to vote and carried.)

Dr. Challman continued with the report of the Reference Committee on Miscellaneous Business:

Governmental Medical Services

Your Reference Committee commends the work of the Commission on Governmental Medical Services and heartily concurs with the view that increased Civil Defense activity be encouraged at the county level.

Your Reference Committee concurs with the Commission on Governmental Medical Services on their opposition to the manadatory use of generic terms for prescriptions for welfare recipients and wishes to commend this commission on their foresight.

Mr. President, I move the adoption of this portion of this report.

(Motion seconded by many, put to vote and carried.)

Inter-Professional Relations

Your Reference Committee read and approved the report of the Committee on Inter-Professional Relations and noted with pleasure that Dr. Kime has stated in a letter to the commission that the supply of anatomical material is increasing.

Your Reference Committee recommends continued study of the progressive care program which is aimed at lessening hospital patient load by giving adequate nursing care in the home following earlier hospital discharge as proposed by Mrs. Iva Leiferman of the Public Health Nursing Association.

Mr. President, I move the adoption of this portion of the report.

(Motion seconded by Dr. Eades, put to vote and carried.)

Building Committee

Dr. William B. Challman, chairman, presented the following report:

Your Reference Committee read the report of the Building Committee and heard several of its members elaborate upon and clarify certain points. It should be emphasized that the estimated $400,000 was not considered excessive and was believed to be "on the high side," and the actual cost may be less after bids are asked for and returned.

Your Reference Committee concurs wholeheartedly with the thought of the Building Committee in that this building should be an excellent one and a source of pride for Indiana medicine.

Your Reference Committee approves the method of financing proposed by the Building Committee with the following changes and additions: (The first two paragraphs are not changes; they are put in for clarification.)

(A) $150,000 to be taken from the General Fund

(B) $250,000 to be raised by

(1) borrowing $125,000 and the payment of this loan without additional expense to the membership through allocations already budgeted.

(This is the essence of the addition:)

(2) by the mandatory purchase of at least one repayable building certificate of $50.00 or by the donation of a tax deductible $50 contribution by all active members except interns and residents. This shall also apply to future active membership. The money for the repayable building certificate may be returned to the individual member upon demand because of hardship, retirement from practice, transfer from state, or death in which case it would be paid to the estate. New members and physicians who have not been members for over three years may upon their own choosing pay the $50.00 at the rate of $25.00 per year. The Indiana State Medical Association will send statements to the county societies at the next scheduled dues paying period for the collection of these monies. This statement should be specific as to its purpose, so that each member may indicate whether he desires to purchase one or more repayable building certificates or to make an outright tax deductible donation.

We recommend that the duly constituted committees, bodies and officers be authorized to build a $400,000 building.

Your Reference Committee wishes to commend the Building Committee for its diligent, arduous, and excellent work. It has been a difficult job well done.

Mr. President, I move the adoption of this portion of this report.

(Motion seconded by Dr. Eades.)

(Discussed by Drs. Paris, Challman, Mason and Williams. **Dr. Challman's motion that the report be amended to read "up to $400,000 building, which would include land, furnishings, etc." was adopted by consent.)**

(This section of the report discussed further by Drs. Wilder, Dalton, Shields and Stover. **Dr. Challman then made the motion that this portion of the report be accepted as amended. Motion seconded by Dr. Vye, put to vote, and carried.)**

Mr. President, I move the adoption of this report as a whole.

(Motion seconded by many, put to vote, and carried.)

ELECTION OF OFFICERS

The following officers were elected:

President-elect—Harry R. Stimson, M.D., Gary

Treasurer—Irvin W. Wilkens, M.D., Indianapolis

Assistant Treasurer—Charles F. Gillespie, M.D., Indianapolis

AMA delegates and alternates for term expiring December 31, 1962:

Delegates: Harold C. Ochsner, M.D., Indianapolis
E. S. Jones, M.D., Hammond
Francis L. Land, M.D., Fort Wayne

Alternates: James H. Gosman, M.D., Indianapolis
Robert M. Brown, M.D., Marion
George W. Willison, M.D., Evansville

ADDRESS OF PRESIDENT-ELECT

Well, this takes me by quite a shock. But it's a pleasant shock. I don't know how to thank each and every one of you. All I can say at this time is I certainly shall do my utmost to deserve the honor which you have handed me this morning. And if I can do half as good a job as the men who have preceded me, Dr. Mericle particularly and I know what Dr. Owsley will do, then I will be satisfied and I hope you will be. Thank you very much.

Place of 1962 Annual Convention

Dr. C. X. McCalla's invitation, on behalf of the Orange County Medical Society, to the Association to meet at French Lick in 1962 was accepted by consent.

Adjournment

The House of Delegates adjourned, sine die, at 12:20 p.m., Wednesday, October 5, 1960.

Commission Meetings

MEDICAL ECONOMICS AND INSURANCE

Sept. 11, 1960

The Commission on Medical Economics and Insurance convened at 9:45 a.m., Sunday, Sept. 11, 1960, in the Columbia Club, Indianapolis, Ind. The meeting was called to order by chairman, Dr. John Langohr. Present were Drs. Edward T. Edwards, Hubert T. Goodman, Albert T. Jones, Richard P. Good, John L. Arbogast, John W. Beeler, Robert N. Bills and Lowell I. Thomas. Also present were Drs. Charles R. Alvey, Harry R. Stimson and George W. Willison, members of the Liaison Committee with the Indiana Department of Public Welfare.

It was moved, seconded and carried that the reading of the minutes of the last meeting be dispensed with.

Dr. Langohr stated that the main item on the agenda was the matter of the Liaison group (Liaison with the Department of Public Welfare) meeting with the commission, and that we were here to see what we can do to help this group. Dr. Langohr asked Dr. Alvey to present the problems of the Liaison Committee wherein our commission may be concerned.

Dr. Alvey stated that his committee's meetings with Mr. Kelley of the State Welfare Department have been on a pleasant working relationship. They have had discussions regarding the possibility of the Welfare Department getting out of the administrative control of medical care for indigent patients and having it administered in some way by the doctors. In this connection his committee has investigated several plans, including BC-BS insurance for indigent patients, Medicare, the State of Washington's plan, plans from Ohio, Colorado and Iowa and certain reports on the subject furnished by the Council on Medical Services of the AMA.

The main problems discussed were fees for services, cost of drugs prescribed, the use of generic terminology in prescriptions, and the great variety of plans now in operation in the counties of Indiana.

At this point a letter addressed to Dr. Edwards, from Mr. Waggener, Executive Secretary, discussing some of these matters was read by the secretary, and made a part of the record.

Dr. Willison discussed the Vanderburgh County plan, wherein Vanderburgh County physicians render in-hospital care to welfare recipients for about 10% of normal fee. This income is used to help support the County Society and to hire an executive secretary. Dr. Willison believes a state-wide program would increase the cost of welfare in Vanderburgh County.

Dr. Alvey referred to the experience in Ohio where a program not to the liking of the doctors has been adopted by the state, including a limited formulary of drugs from which physicians must prescribe when caring for welfare recipients.

Dr. Alvey feels we need information on the breakdown of total medical care costs into medical, surgical, nursing, drugs, hospital and nursing home costs. He also feels that each county should have a committee with representation from hospitals, welfare agencies, pharmacists and doctors to meet and study welfare claims.

Dr. Edwards mentioned the distinction between the functions of trustees and of welfare agencies which must be kept in mind on the political side of these questions.

The economics involved in the use of generic terms and the probable effects on quality control of drugs was discussed.

The question of welfare departments and trustees insuring their recipients under Blue Cross-Blue

COOK COUNTY
GRADUATE SCHOOL OF MEDICINE
INTENSIVE POSTGRADUATE COURSES

STARTING DATES — WINTER-SPRING, 1961

Surgical Technic, Two Weeks, February 20
Surgery of Colon & Rectum, One Week, March 6
Gallbladder Surgery, Three Days, April 17
Surgery of Hernia, Three Days, April 20
General Pediatrics, Two Weeks, May 1
Electrocardiography & Heart Disease, One Week, April 17
Diagnostic Radiology, Two Weeks, April 3
Board of Surgery Review, Part II, Two Weeks, March 6
Gynecology, Office & Operative, One Week, February 13
Vaginal Approach to Pelvic Surgery, One Week, January 30
Obstetrics, General & Surgical, One Week, February 6
Fractures & Traumatic Surgery, Two Weeks, March 20
Practical Cystoscopy, Ten Days, by appointment
Surgery of the Hand, One Week, April 17
Advancements in Medicine, One Week, March 13
Urology, Two Weeks, April 24

TEACHING FACULTY—ATTENDING STAFF OF COOK COUNTY HOSPITAL

Address:
REGISTRAR, 707 South Wood Street, Chicago 12, Illinois

Shield was brought up by Dr. Willison and discussed.

To conclude our discussion Dr. Langohr asked Dr. Alvey to propose what this commission might do in the coming year to help the Liaison Committee with these problems.

Dr. Alvey replied that his committee is not at present able to present any certain plan to the Welfare Department, and he feels that this commission is the one to study the foregoing problems in the next few months, and make recommendations as to the type of program our state association should approve.

Dr. Langohr thanked Dr. Alvey and his committee for their comments on the questions to be considered, and for their attendance at this meeting. He assured them their request will be placed in the work schedule of this commission for the coming year.

The next item on the agenda was organization of the commission for the coming year. Dr. Bills nominated Dr. Thomas to become chairman, seconded by Dr. Beeler, and passed.

Dr. Goodman nominated Dr. Beeler as secretary, but Dr. Beeler declined because of previous commitments.

Dr. Bills nominated Dr. Edwards for secretary, seconded by Dr. Good, and passed.

Dr. Edwards moved that Dr. Langohr be elected as vice-chairman. Dr. Beeler seconded the motion, motion carried.

Dr. Langohr then asked for proposed items for commission work during the coming year. Suggested items were as follows:

(1) Medical care of welfare recipients. (BC-BS insured, Medicare, or ISMA responsibility?)
(2) Continue study of minimum standards for approval of in-hospital medical-surgical insurance coverage.
(3) Continue efforts to bring all medical professional services (including x-ray and laboratory) under Blue Shield rather than Blue Cross coverage. Study Blue Cross and hospital encroachment into practice of medicine in out-patient services.
(4) Continue study of cooperative care of the surgical patient. (See copy of letter from Edwin J. Holman, Secy. AMA to Dr. Cleon Nafe, dated July 11, 1960.)
(5) Study of state-wide plans for group insurance coverage of members of the state association.
(6) Study of pre-payment for care of the over-65 age group, eligibility open to anyone.
(7) Study problems of nursing homes with respect to standards, inspection, pre-payment.
(8) Study of "medical foundations," (San Joaquin, etc.) since some communities in this state are introducing same into practice.
(9) Items delegated to our commission after the October ISMA meeting.
(10) Working committees to be appointed by our next meeting date.

It was taken by consent to schedule our next commission meeting for Sunday, Oct. 30, 1960 at the Medical Center at noon. The commission adjourned at 1:00 p.m.

Addendum:

The letter to Dr. Nafe is being reproduced and forwarded to members of this Commission for information.

Mr. James M. Connors, President of Professional Insurance Administrators, Inc., was received by the chairman and a few remaining members of the commission who remained to discuss Mr. Connors' proposed association group plan for the state association. He was advised that for several years it has been the policy of the state association not to endorse any one insurance company's group plan. Until that policy is changed this commission has no reason to study any group plan. He is free to solicit or poll our membership in an effort to establish a demand for his plan. No action was taken and the remaining members adjourned. ◄

Association News

EXECUTIVE COMMITTEE

October 2, 1960

Roll call showed the following present: Don E. Wood, M.D., chairman; Wendell E. Covalt, M.D.; Earl W. Mericle, M.D.; Guy A. Owsley, M.D.; Maurice E. Glock, M.D.; Okla W. Sicks, M.D.

Frank B. Ramsey, M.D., editor of *The Journal;* Ralph Hamill, attorney; James A. Waggener, executive secretary.

Guests: Ralph V. Everly, M.D., chairman, and Frederic W. Brown, M.D., and R. Case Hammond, M.D., members, Building Committee.

Membership Report

Number of members as of Sept. 30, 1959 ---- 4,231

1960 members as of Sept. 30, 1960:

Full dues paying	3,603
Interns	30
Residents	173
Council remitted	42
Senior	389
Military	35
Honorary	1

Total 1960 members as of Sept. 30, 1960 ---- 4,272

Gain over last year ---- 41

Number of members Dec. 31, 1959 ---- 4,256

Number of AMA members as of Sept. 30, 1959 ---- 4,099

1960 AMA members:

Dues paying	3,462
Exempt, but active	673

Total 1960 AMA members as of Sept. 30, 1960 ---- 4,135

Gain over last year ---- 36

Number of AMA members as of Dec. 31, 1959 ---- 4,210

Number who have paid state dues but not AMA dues in 1960 ---- 123

The statement of income and budget balances as of Sept. 30, 1960, and the Treasurer's report were approved on motion of Drs. Owsley and Covalt.

The suggestion was made that future financial statements list the building fund allocations separately.

Annual Convention, Oct. 2-5, 1960, French Lick

The president's speech was approved by consent.

By consent the arrangements for the annual meeting as completed and the possible appearance of Sen. Kennedy, and the making of the AMEF awards to Dr. J. M. McIntyre and Dr. John E. Mahaffey at the annual banquet, were approved.

Legislation

The chairman of the Commission on Legislation reviewed legislative matters.

Organization Matters

A letter to Dr. William B. Challman from Dr. Cleon A. Nafe concerning assistants' fees under the Blue Shield Plan was read for the information of the committee.

A letter addressed to the executive secretary from Dr. Nafe, requesting that it be transmitted to the appropriate bodies, concerning his opinion of the proposed Constitutional amendments providing for a speaker and vice-speaker of the House of Delegates, was read.

A letter from Gausepohl Travel Service, discussing a European Tour in 1961, including medical meetings, was approved for publication in *The Journal,* on motion of Drs. Mericle and Sicks.

Letter from Mrs. Frank Gastineau, expressing her appreciation for the thoughtfulness of the Association during her year as president of the AMA Woman's Auxiliary, was read for the information of the committee.

Building Committee

Dr. Everly, chairman of the Building Committee, read the report to be presented to the Council and the House of Delegates, and this was approved by consent.

Judge Hamill reported on the progress being made with the Metropolitan Plan Commission toward clearance of the proposed site at 3935 North Meridian Street. Authority was requested for filing of a mandamus suit against the Metropolitan Plan Commission. This was approved by consent.

The committee then discussed the plans for the new building and the costs, and as a result, the committee was to recommend to the Council that the Association build the type of building proposed by the architects and approved by the Building Committee and that additional funds be appropriated to a total amount of $400,000.00 for this purpose.

New Business

Resolutions No. 15 and 16 were submitted to the committee and by consent these two resolutions are to be referred to the Council with the recommendation that the Council introduce these resolutions before the House of Delegates.

Future Meetings

Seventh Annual Conference on Mental Health, Chicago, January, 1961. The secretary was instructed to bring this up again at the November meeting of the Executive Committee.

The committee adjourned to meet again for organization for 1960-61, on adjournment of the Council meeting, following the last session of the House of Delegates.

The committee set Nov. 16, 1960, for its next regular meeting. (Later changed to Nov. 1, 1960).

EXECUTIVE COMMITTEE

October 5, 1960

Present: Don E. Wood, M.D., chairman; Wendell E. Covalt, M.D.; Guy A. Owsley, M.D.; Harry R. Stimson, M.D.; Maurice E. Glock, M.D.; Irvin W. Wilkens, M.D.; James A. Waggener, executive secretary.

By ballot, Dr. Don E. Wood was elected chairman of the Executive Committee for the year 1960-61.

The secretary asked for a clarification of the House of Delegates' action regarding the Building Fund payment of $50.00. The secretary was instructed that the dues receipts should carry an item indicating the building fund payment of $50.00.

There being no further business, the meeting adjourned to meet again on Nov. 16, 1960. (Later changed to Nov. 1, 1960).

THE COUNCIL

French Lick, Indiana
Oct. 2, 1960

The Council convened at 12 noon, Central Standard Time, Sunday, Oct. 2, 1960, in the Terrace Room, French Lick-Sheraton Hotel, French Lick, Indiana, with Maurice E. Glock, chairman, presiding. Roll call showed the following present:

Councilors:

First District—William B. Challman, Mount Vernon.

Second District—J. H. Crowder, Sullivan; E. T. Edwards, Vincennes, councilor-elect; Philip T. Holland, Bloomington, alternate.

Third District—John M. Paris, New Albany; Donald M. Kerr, Bedford, alternate.

Fourth District—Joe M. Black, Seymour.

Fifth District—V. Earle Wiseman, Greencastle, alternate (also councilor-elect); A. W. Cavins, Terre Haute, alternate councilor-elect and associate editor, *The Journal.*

Sixth District—William R. Tindall, Shelbyville, alternate.

Seventh District—Ralph V. Everly, Indianapolis.

Eighth District—Guy A. Owsley, Hartford City (also president-elect); Gordon B. Wilder, Anderson, alternate (also councilor-elect and AMA delegate).

Ninth District—Kenneth O. Neumann, Lafayette; A. E. Stouder, Kempton, alternate.

Tenth District—James P. Vye, Gary.

Eleventh District—Max R. Adams, Flora; E. S. Rifner, VanBuren, councilor-elect.

Twelfth District—Maurice E. Glock, Fort Wayne; Milton F. Popp, Fort Wayne, alternate.

Thirteenth District—Burton E. Kintner, Elkhart; Raymond E. Nelson, South Bend, alternate.

Officers:

Earl W. Mericle, Indianapolis, president.

Guy A. Owsley, Hartford City, president-elect.

Okla W. Sicks, Indianapolis, treasurer.

Journal:

Frank B. Ramsey, Indianapolis, editor.

Executive Committee:

Don E. Wood, Indianapolis, chairman (and co-chairman, Commission on Legislation).

Guests:

Robert O. Zink, Madison, chairman, Scientific Exhibits.

Philip B. Reed, Indianapolis, chairman, Grievance Committee.

Harold C. Ochsner, Indianapolis, AMA delegate.

E. S. Jones, Hammond, AMA delegate.

Francis L. Land, Fort Wayne, AMA delegate.

Wendell C. Stover, Boonville, AMA delegate.

James H. Gosman, Indianapolis, AMA alternate delegate.

Robert M. Brown, Marion, AMA alternate delegate.

George W. Willison, Evansville, AMA alternate delegate.

Walter L. Portteus, Franklin, AMA alternate delegate.

John M. Paris, New Albany, AMA alternate delegate.

Staff:

Ralph Hamill, Indianapolis, attorney.

Robert J. Amick, field secretary.

Howard Grindstaff, field secretary.

J. A. Waggener, executive secretary.

On motion of Drs. Neumann and Crowder, minutes of the meeting of July 10, 1960, were approved as printed in the September, 1960, *Journal.*

Reports of Officers

Dr. Mericle, president, Dr. Owsley, president-elect, and Dr. Ramsey, editor of *The Journal,* had no special reports.

Dr. Sicks, treasurer, reported as follows:

INVESTMENTS IN BONDS:

	General Fund (Face Value)	General Fund (Mkt. Value)	Medical Defense Fund
Sept. 30, 1959	$291,000.00		$26,000.00
Sept. 30, 1960	281,000.00	$271,642.31	26,000.00

CASH BALANCE, GENERAL FUND:

Sept. 30, 1960	$ 52,521.04
Sept. 30, 1959	25,975.66
Cash increase	$ 26,545.38
Investment decrease	$ 10,000.00
Net gain	$ 16,545.38
General Fund outstanding obligation	14,500.00
Gain in cash assets	$ 2,045.38

Dr. Sicks explained that monies received from matured investments during the year had been placed in the General Fund checking account in order to be prepared to buy land for the State Association office building.

(On motion of Drs. Popp and Black, the Council accepted the treasurer's report.)

District Meetings

The councilors reported district meeting scheduled as follows for 1961:

First District—Not set.
Second District—Not set.
Third District—Jasper, May 11, 1961.
Fourth District—Seymour, May 3 or 17, 1961.
Fifth District—Terre Haute, 1961.
Sixth District—Rushville, May 11, 1961.
Seventh District—Indianapolis, 1961.
Eighth District—Muncie, June 7, 1961.
Ninth District—Crawfordsville, May 18, 1961.
Tenth District—Whiting, May 10, 1961.
Eleventh District—Huntington, May 17, 1961.
Twelfth District—Columbia City, May 17, 1961.
Thirteenth District—LaPorte, Sept. 27, 1961.

Unfinished Business

1. *Convention Arrangements and Scientific Exhibits.* In the absence of Dr. Ray H. Burnikel, chairman, and Dr. Jack G. Weinbaum, vice-chairman of Convention Arrangements, the executive secretary made several announcements regarding convention arrangements.

Dr. Robert O. Zink, chairman of Scientific Exhibits, reported that 30 scientific exhibits had been obtained and asked that the members of the Council and officers, and general membership "pay some attention to these exhibits that have been prepared by many individuals all over the United States. . . . They deserve your support."

2. *Student Loan Fund.* In the absence of Dr. Harry Ross, chairman, Dr. Sicks reported that the fund balance at this time was $2,065.00. Since establishment of the fund in October, 1955, to date, 56 loans have been granted to 42 students; 12 students have received two loans each, one student has been granted three loans, and 29 students have received one loan each.

Allocation of additional funds to the Student Loan Fund was discussed by Drs. Sicks, Paris, Wood, Land, Kerr and Challman.

(On motion of Dr. Paris the Council voted by consent to send greetings and best wishes to Dr. Ross, who is ill.)

3. *Building Committee.* Dr. Everly, chairman, presented a report from the Building Committee. (See page 2306, December *Journal,* for full report.)

Following discussion by Drs. Paris, Mericle, Brown, Hammond, Edwards, Wood, Challman, Kintner, Owsley, Vye, Shields, Cavins and Everly, **on motion of Drs. Everly and Mericle, the report was approved for presentation to the House of Delegates.**

4. *Grievance Committee.* Dr. Philip Reed, chairman, reported briefly, as follows: The Grievance Committee, aside from routine business, had this question about any possible use that this state might have, and more specifically the medical profession, and still more pertinently, the Indiana State Medical Association members might have, for a medical disciplinary type of law such as was passed and is operative in the State of Washington. . . . I listened to about 40 doctors, and this matter is in their consensus highly debatable. I'm inclined to think at the moment that much of the debate rests upon misunderstanding or misconception as to exactly how medical disciplinary committees and medical disciplinary legislation, either enacted or in process, has operated or is designed to operate in these states that are yet to try it.

We feel that rather than making a report to the House of Delegates at this meeting, which carries a recommendation, it would be much wiser to move very slowly and to take advantage, among other things, of the work that the AMA medical disciplinary committee is doing in collecting information from every state that has had particular experience. It is likely that four to six months will be required to get in the necessary reports before we can determine that a definite pattern exists.

5. *Osteopathic matters.* Dr. Challman, member of the Council Fact-Finding Committee, said: It's my belief that this has to be solved on the national level with the American Medical Association. I sincerely hope our delegates to the AMA will be able to get this done at the meeting in Washington this winter. (Discussed also by Drs. Kerr and Neumann.)

6. *Election of two members to Editorial Board.* **On motion of Drs. Paris and Challman, Dr. George M. Johnson, Richmond, and Dr. Irvin W. Wilkens, Indianapolis, were re-elected members of the Editorial Board, each for a three-year term ending Dec. 31, 1963.**

7. *Election of two members of Trust Committee of Indiana Medical Education Foundation.* **On motion of Drs. Everly and Mericle, Drs. Don E. Wood and Roy Geider were elected to succeed themselves for the three-year term ending Oct. 31, 1963. Membership of this Trust Committee therefore is as follows:**

	Term expires
James W. Denny, Indianapolis	Oct. 31, 1961
Roy V. Myers, Indianapolis	Oct. 31, 1961
Maurice V. Kahler, Indianapolis	Oct. 31, 1962
Lawson J. Clark, Indianapolis	Oct. 31, 1962
Don E. Wood, Indianapolis	Oct. 31, 1963
Roy Geider, Indianapolis	Oct. 31, 1963

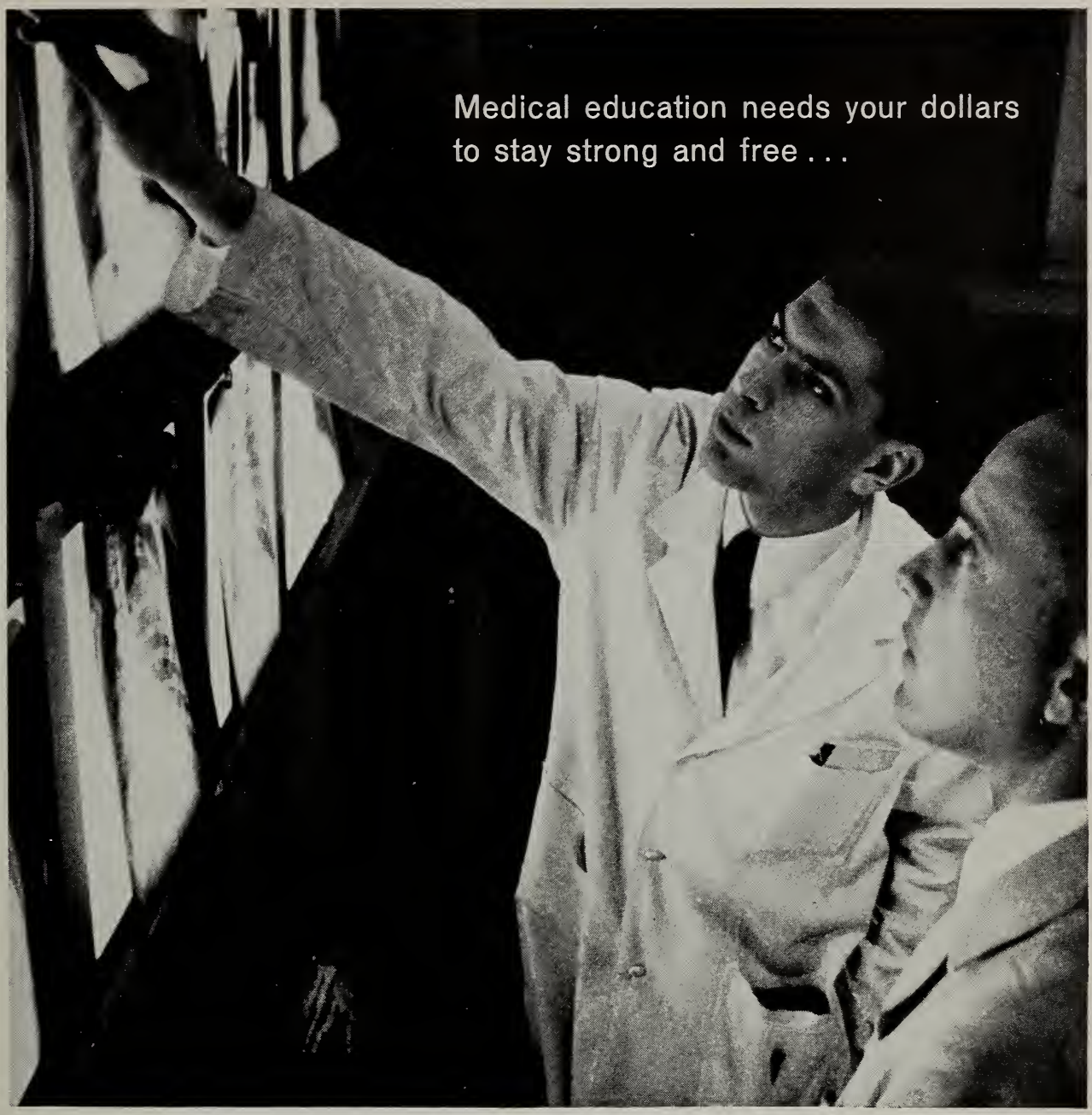
8. *Nominations for membership on Blue Shield Board of Directors.* **On motion of Drs. Paris and Vye, the Council confirmed the following district nominations for membership on the Board of Directors of Blue Shield for the three-year term expiring March, 1963:**

Representing:
District 13—Robert H. Denham, South Bend.
District 10—Harry R. Stimson, Gary.
District 4—Joe M. Black, Seymour
District 7—Glen V. Ryan, Indianapolis.

Members-at-large. **On motion of Drs. Paris and Black, Dr. John W. Beeler, Indianapolis, was nominated to succeed himself for a three-year term ending March, 1963.**

Dr. Everly nominated Dr. Thomas W. Johnson, Indianapolis, to succeed Dr. Marlow W. Manion for a three-year term ending March, 1963.

Other nominations of members-at-large may be made at the January meeting of the Council.



Give to the school of your choice through AMEF

To train the doctors of tomorrow, the nation's medical schools must have your help today. It is a physician's unique privilege and responsibility to replenish his own ranks with men educated to the highest possible standards. *Invest in the future health of the nation and your profession. Send your check today!*

American Medical Education Foundation

AMEF

535 North Dearborn Street
Chicago 10, Illinois

9. *Report on AMEF.* Dr. Francis L. Land, chairman of the Commission on Medical Education and Licensure, reported that $36,095.00 has been collected by the Indiana State Medical Association in 1960 for the American Medical Education Foundation. In addition, the Woman's Auxiliary to the state association is promoting several AMEF fund-raising projects.

Dr. Owsley commented on the fact that a nationwide map exhibited at the AMA meeting in Miami, December, showed Indiana sixth of the exhibiting states with bequests to the American Medical Education Foundation.

10. *Legislative Matters* were discussed by Dr. Wood, co-chairman of the Commission on Legislation, as follows:

1. The Forand bill was defeated in the last Congress. Every member should be alert to the reintroduction of this type of legislation in some form.

a. The Kennedy amendment in this regard would establish a new Social Security fund, to be subscribed to by every new employee who would pay into this new fund. This new fund would run for a given period of years, according to law about seven as I recall, after which time it would then take over the Social Security fund as we know it today. Obviously, you can see what that means . . . that everybody from then on, whoever got a job to work, would be under Social Security and medicine would be socialized entirely. I only put that out for your information.

b. Why would Mr. Rockefeller like to have our program under Social Security? It's real interesting. He represents the money interests, he doesn't want to have to pay the taxes to pay the bills to take care of this particular thing at the time of 65. He wants to put it all on the burden of the guy who is being insured and let him pay 17% of his taxes. I only want to bring that out to you so that all of you will know what the facts are.

2. The Jenkins-Keogh Bill was defeated.

THE CHAIRMAN: The whole legislative program has been wrapped up in a letter that you received from HOPE. Nothing is so important to the organization as the fulfillment of the obligations that Dr. Olson has written in this letter. Please don't argue, contribute, and contribute heavily.

Membership Matters

Remission of state dues. **On motion of Drs. Owsley and Vye, remission of the state dues of a member of the Delaware-Blackford County Medical Society, a hardship case because of illness, was approved.**

On motion of Drs. Vye and Challman, the remission of the state dues of a member of the Lake County Medical Society, who has retired from active practice, was approved.

New Business

1. *Matters referred to Council by Executive Committee.* Dr. Wood, chairman, presented the following matters:

a. *Resolution No. 15,* amendment to the Bylaws establishing a Commission on Aging, was discussed by Drs. Wood, Mericle and Jones. **(On motion of Drs. Mericle and Paris the resolution was approved for submission to the House of Delegates.)**

b. *Resolution No. 16* concerning non-partisan selection of judges **was approved for presentation to the House of Delegates on motion of Drs. Owsley and Kintner.**

c. *Better Business Bureau membership for 1961.* **(On motion of Drs. Black and Paris, the Council authorized the payment of $150.00 membership fee in the Better Business Bureau for 1961.)**

d. *Speaker and vice-speaker of House of Delegates.* Letter received from Dr. Cleon A. Nafe, expressing doubt as to the need at this time of adding such officers and objecting to the suggestion that the speaker and vice-speaker be members of the Executive Committee, was read to the Council. In part the letter read: "The speaker and vice-speaker are not members of the Executive Committee of the AMA. I do not know of any organization in which they serve as members of the Executive Committee. It seems to me that the Executive Committee is large enough as it is and functions much better than it would adding these two individuals. I hope the Executive Committee of the State Association of which I was chairman for 10 years remains with the same personnel and that the vice-speaker and speaker are not added to the Executive Committee. Otherwise the Executive Committee will be approximately the size of the Council."

Following discussion by Drs. Paris, Wilder, Mericle and Owsley, of the proposed amendments to the Constitution and Bylaws which would create the offices of speaker and vice-speaker, **the Council went on record as opposed to the passage of these amendments, on motion of Drs. Paris and Vye.**

2. *Election of JOURNAL Editors.*

a. *Editor.* **On motion of Dr. Black, seconded by many, Dr. Frank B. Ramsey, present Editor of THE JOURNAL, was re-elected for 1961.**

b. *Associate Editors.* **The following four present associate editors of THE JOURNAL were re-elected for 1961 on motion of Drs. Paris and Challman:**

A. W. Cavins, Terre Haute.
Lall G. Montgomery, Muncie.
David A. Bickel, South Bend.
Stephen L. Johnson, Evansville.

3. *Letter from Dr. M. A. Austin,* past president of the Indiana State Medical Association, was deferred until the next meeting of the Council.

4. *Resolutions to be introduced in the House of Delegates* were read by title and discussed.

It was called to the attention of the councilors that two resolutions on Board of Impartial Medical Witnesses had been submitted, one of which came from the Council. The chairman of the Council stated that he understood from the members of his local society that this plan does not work too well in other communities and he would appear before the reference committee and talk against adoption of such a plan. He also stated that he had been told that the physicians in Gary were not sold on the idea.

Midwinter Meeting

On motion of Drs. Vye and Challman, the Council set Jan. 15, 1961, for the midwinter meeting of the Council.

There being no further business, the Council adjourned to meet again on Wednesday, Oct. 5, 1960, in the West Dining Room, French Lick-Sheraton Hotel, immediately following adjournment of the House of Delegates.

THE COUNCIL

Oct. 5, 1960

The Council met for its second meeting immediately following adjournment of the House of Delegates, Wednesday afternoon, Oct. 5, 1960, in the West Dining Room, French Lick-Sheraton Hotel, French Lick, Indiana.

Twelve councilors, the president, president-elect, the treasurer and the executive secretary were present.

The chairman discussed the action of the House of Delegates in adopting Resolution No. 13 on Transfer of Professional Services from Blue Cross to Blue Shield. By consent the secretary was ordered to transmit this to the American Medical Association in accordance with the action of the House.

Elections for 1960-61

1. *Executive Committee.* On motion of Drs. Black and Everly, Dr. Don E. Wood, Indianapolis, was re-elected a member of the Executive Committee for 1960-61. On motion of Drs. Wilder and Paris, Dr. Wendell E. Covalt, Muncie, was re-elected a member of the Executive Committee for 1960-61.

2. *Chairman of Council.* By ballot, Dr. Maurice E. Glock, Fort Wayne was re-elected chairman of the Council for 1960-61.

Appreciation

On motion of Dr. Black, taken by consent, letters of appreciation are to be sent to the Orange County Medical Society and to the French Lick-Sheraton Hotel for their cooperation in making arrangements for the 1960 annual convention.

Upon motion of Drs. Kintner and Wilder, the Council instructed the Executive Committee to recognize Dr. Okla W. Sicks, former treasurer of the Association, in some appropriate manner.

There being no further business, the meeting was adjourned. ◄

PHYSICIANS' DIRECTORY

SURGERY AND GYNECOLOGY

WILLIAM B. SIGMUND, M.D.
DISEASES AND SURGERY OF THE GENITO-URINARY TRACT
2355 Central Avenue — Columbus

FLeetwood 9-2279 — MElrose 9-3466
FRED R. DALLAS, M.D.
Practice limited to
UROLOGY & GENITO-URINARY SURGERY
Community Medical Bldg.
5317 East 16th Street, Suite 6C
Indianapolis 18

Hours by Appointment — Telephone WAlnut 5-4255
C. BASIL FAUSSET, M.D.
NEUROLOGICAL SURGERY
2901 N. Meridian St. — Indianapolis 8

Hours by Appointment — Phone, WA. 6-4564
WILLIAM N. WISHARD, JR., M.D.
HOMER G. HAMER, M.D.
MYRON H. NOURSE, M.D.
JOHN H. O. MERTZ, M.D.
GENITO-URINARY DISEASES
1711 N. Capitol Ave. — Indianapolis 7

Office: WAlnut 6-0321 — Residence: CLifford 1-2413
ROBERT M. RABER, M.D.
PLASTIC and RECONSTRUCTIVE SURGERY
Physicians Building — 1633 N. Capitol Ave.
Indianapolis 2

Hours: 2 to 3 Monday, Tuesday and Thursday
GOETHE LINK, M.D.
PRACTICE LIMITED TO
THYROID DIAGNOSIS AND SURGERY
608 Indiana Pythian Bldg. — Indianapolis 4

HAROLD M. TRUSLER, M.D.
THOMAS B. BAUER, M.D.
JOHN M. TONDRA, M.D.
Plastic and Reconstructive Surgery
408 Hume Mansur Bldg. — Indianapolis 4
Phone, MElrose 7-1495

Hours by Appointment — Phones: Office, WAlnut 5-4214
Medical Society Exchange, MElrose 9-3466
DENNIS S. MEGENHARDT, M.D.
JOHN P. BAXTER, M.D.
GENERAL AND ABDOMINAL SURGERY
1633 North Capitol Avenue — Indianapolis 2

Check the Commercial Announcements at the end of this section for equipment for sale at reasonable prices.

Hours: 2-4 Monday, Tuesday, Thursday and Friday
L. H. KORNAFEL, M.D.
PRACTICE LIMITED TO
THYROID DIAGNOSIS AND SURGERY
608 K. of P. Bldg. — MElrose 7-3635
219 N. Pennsylvania St. — Indianapolis 4

Hours: 10 A.M. to 1 P.M. — MElrose 2-2509
JAMES F. BALCH, M.D.
CHARLES J. VAN TASSEL, JR., M.D.
Practice Limited to DISEASES and SURGERY
of the GENITO-URINARY TRACT
709 Hume Mansur Bldg. — Indianapolis 4

By Appointment — Telephone: MElrose 5-8848
ROBERT D. FRY, M.D.
GYNECOLOGY
ABDOMINAL SURGERY
517 Hume Mansur Bldg. — Indianapolis 4

A limited number of professional card spaces are available to Indiana doctors. Only $24.00 per year keeps your name before the medical profession for 12 months. Contact THE JOURNAL, 1019 Hume Mansur Building, Indianapolis 4.

Phone: Office, MElrose 5-2306
Medical Society Exchange, MElrose 9-3466
EMMETT B. LAMB, M.D.
RUSSELL W. LAMB, M.D.
GENERAL SURGERY
205 Hume Mansur Bldg. — Indianapolis 4

Telephone: WAlnut 3-1538
KARL R. RUDDELL, M.D.
RAY THARPE, M.D.
KEITH R. RUDDELL, M.D.
SURGERY
3202 N. Meridian St. — Indianapolis 8

Office: WAlnut 5-2284 — Residence: ATwater 3-8380
H. C. MOSS, M.D.
SURGERY
401 East 34th Street — Indianapolis 5

SCIENTIFIC ARTICLES

Adrenal Insufficiency Due to Histoplasmosis—A Case Report (Pierce) 57
Abnormal Electrocardiogram and a Normal Heart (Fisch) .1497
Adrenal Cortex and Reproductive Failure, The (Stander) ..1873
Anemia, Sickle Cell: Case Report and Review (Morse Jr.) 1857
Anti-Emetics and Tranquilizers in Surgical Patients (Giorgio) 441
Anus, Treatment of Imperforate (DeBoer).....1116
Bloated Bartender, The Case of the (Lieberman).....1884
Breast Lesions, Relationship of Benign and Malignant (Shellhouse) 63
Atrial Fibrillation, Atrial Tachycardia with Block, and Ventricular Tachycardia, Due to Digitalis Intoxication (Fisch) 1889
Cancer—The Research Approach (Little).....1469
Cancer, Thyroid, In Childhood and Adolescence (Gibson).. 676
Caps, Gowns and Masks—Who Should Wear Them and of What Material Should They be Manufactured (Noe).. 445
Carcinoma of Pancreatico-Duodenal Region (von der Lieth) 454
Carcinoma of the Uterine Cervix, Radiologic Management of (Dunham) 453
Cardiacs, Employment of (Fisch) 255
Cardiology at General Hospital (Kohlstaedt)..... 253
Cement Boot, The Case of the (Lieberman).....1137
Cholangiography, Immediate (Caylor).....2014
Challenge of Triacetyloleandomycin in Pediatric Infections (Newsome) 1131
Changing Personality, The Case of the (Lieberman).....1623
Chest Injuries (Buckner) 1484
Cleaning the Hands of the Surgical Team, Re-evaluation of the Methods of (Estes) 445
Cobalt-60 Therapy in Mammary Cancer (Katterjohn)....1606
Comatose Truck Driver, The Case of the (Lieberman).... 460
Congestive Heart Failure, Non-cardiac (Miller)..... 290
Coroners, A Program for Indiana (Myren).....2191
Degeneration, Hepato-Lenticular, A Report of Two Cases (Musser) 68
Depression of Arrhythmias by Potassium, Transient Nature of (Fisch) 1331
Digitalis, Effect of, On the Master Exercise Test (Steinmetz) 259
Digitalis Intoxication, Atrial Fibrillation, Atrial Tachycardia with Block and Ventricular Tachycardia, due to (Fisch) 1889
Diverticula, Multiple Jejunal: Report of Three Cases (Noveroske-Miller) 2009
Duck Embryo (DE) Rabies Vaccine Against Street Virus in Rabbits and Guinea Pigs, Tests of (Powell-Culbertson-Peck) 1307
Duration of Convalescence Following Surgery (Moss).... 1134
Dyspnea (Fasola) 466
Early Active Motion in Joint Pain and Stiffness (Mumford) 1303
Electrocardiographic Diagnosis and Clinical Implications of Ventricular Premature Systoles (Chevalier-Fisch).. 263
Employment of Cardiacs (Fisch)..... 255
Fluid Balance in Obstruction of the Large Intestine (Snively Jr.) 427
Four-Sided Triangle, The Case of the (Lieberman)..... 2202
Fractures, Overlooked and Misdiagnosed (Zeier)..... 447
Gelfoam in the Treatment of Stasis Ulcers (Nierman).... 1317
General Hospital, Cardiology at (Kohlstaedt) 252
Genito-Urinary Malignancies in Children (Yurdin)..... 671
Gonorrhea and Syphilis—A New Problem? (Hess-Roth-Kaminsky-McLaren Jr.) 1487
Gout (Oyer) 1863
Griseofulvin—An Advance in the Treatment of Tinea Capitis (Chivington-Gray-Wolf-Dalton) 1120
Gunshot Wounds (Lyle) 2185
Heart Clinic, Robert M. Moore (Pictorial View)..... 254
Heart, Second Sound (Fisch)..... 697
Hepato-Lenticular Degeneration, A Report of Two Cases (Musser) 68
Hereditary Hyperparathyroidism (Jackson-Talbert-Caylor). 1313
Histoplasmosis, Adrenal Insufficiency due to: A Case Report (Pierce) 57
Homicide, Suicide, Accident or Natural Death, "Masquerades" (Cleveland) 2181
Hydrocephalic Newborns, Three, Each of a Successive Pregnancy of a White Female (Mehne) 1472
Hyperfunctioning Adrenal Lesions (Priestley)..... 1109
Hyperparathyroidism, Hereditary (Jackson-Talbert-Caylor) 1313
Hypothyroid Constipation, The Case of (Lieberman)..... 1324
Immediate Cholangiography (Caylor) 2014
Intestinal Obstruction, Treatment of Acute (Lichtenstein) 1465
Jejunal Diverticula, Multiple, A Report of Three Cases (Noveroske-Miller) 2009
Joint Pain and Stiffness, Early Active Motion in (Mumford) 1303
Juvenile Jetsam, The Case of the (Lieberman)..... 1493
Large Intestine, Fluid Balance in Obstruction of (Snively Jr.) 427
Lipoma of the Heart, Report of Two Cases (Pierce-Bakemeier) 294
Luetic Couple, Case of the (Lieberman)..... 692
Malignancies, A Case of Seven Primary, and a Report of 30 Cases of Multiple Malignancies (Graham)..... 683
Malignant Bone Tumors of Childhood (Garceau)..... 645
Malignant Gynecologic Tumors in Infants, Children and Adolescents, Diagnosis of (Gardiner)..... 655
Mammary Cancer, Cobalt-60 Therapy in (Katterjohn).... 1606
Master Exercise Test, Effect of Digitalis on the (Steinmetz) 259
Meckel's Diverticulum Presenting as a Pelvic Tumor (Baxter-Megenhardt-Thornburg) 1867
Mental Health and the Transplanted School Child (Swenson) 2028
Metastatic Tumors of the Pericardium (Genovese-Fouts Sr.) 267
Mucosal Perforation in the Course of Pyloric Myotomy, Management of (Scott) 457
Multiple Jejunal Diverticula: Report of Three Cases (Noveroske-Miller) 2009
Myocardial Infarction (Fisch) 2036
Myocardial Infarction, 'Silent' (Shullenberger)..... 285
Neoplastic Disorders of the Reticuloendothelial System in Infants and Children (Rohn-Bond-Hodes) 649
'Non-cardiac' Congestive Heart Failure (Miller)..... 290
Obstruction, Treatment of Acute Intestinal (Lichtenstein) 1465
Ocular Tumors in Children (Harger)..... 662
Older Versus Newer Preanesthetic Drugs (Layman-Stoelting) 2023
Ovarian Cysts, Problems of (Woodruff) 1124
Pancreatico-Duodenal Region, Carcinoma of (von der Lieth) 454
Patent Ductus Arteriosus with Pulmonary Hypertension without Reversed Flow, Diagnosis of (Laramore)..... 280
Pericardial Effusion, Diagnosis of Chronic (Steinmetz)... 1146
Pericardium, Metastatic Tumors of the (Genovese-Fouts). 267
Pheochromocytoma and Neurofibrosarcoma in a Patient with Neurofibromatosis (Palmer) 2197
Preanesthetic Drugs, Older Versus Newer (Layman-Stoelting) 2023
Preanesthetic Evaluation of the Surgical Patient (Taylor) 435
Quinidine Purpura, A Case Report (Storey)..... 89
Rabies Vaccine, Tests of Duck Embryo (DE) Against Street Virus in Rabbits and Guinea Pigs (Powell-Culbertson-Peck) 1307
Radiation for Carcinoma of the Breast, Postoperative (Beeler) 1614
Radioisotopes, Diagnostic Uses of (Loh)..... 2209
Radiologic Management of Carcinoma of the Uterine Cervix (Dunham) 453
Re-evaluation of the Methods of Cleaning the Hands of the Surgical Team (Estes) 445
Reiter's Syndrome (Hickman-Childress)..... 1599
Relationship of Benign and Malignant Breast Lesions (Shellhouse) 63
Reproductive Failure, The Adrenal Cortex and (Stander). 1873
Reticuloendothelial System, Neoplastic Disorders of, in Infants and Children (Rohn-Bond-Hodes) 649
Robert M. Moore Heart Clinic (Pictorial View)..... 254

Salicylates and the Stomach (Hurley-Ivy-McArt) 84
Scalp, Trichophyton Tonsurans Infection of the, In Central Indiana (Gray-Dalton-Starcs) 75
Second Heart Sound (Fisch) 697
Sensitivity to Elemental Sulfur (Gaul) 81
Sex and Chromosomes (Hammond) 1870
Shirodkar Procedure and the Habitual Aborter, The (Lein-Stander-Hunter) 2017
Sickle Cell Anemia: Case Report and Review (Morse Jr.) 1857
'Silent' Myocardial Infarction (Shullenberger) 285
Snakebites, Treatment of Poisonous: Present Status of Incision and Excision (Parrish) 1879
Stasis Ulcers, Gelfoam in the Treatment of (Nierman).. 1317
Stomach, Salicylates and the (Hurley-Ivy-McArt) 84
Sulfur, Elemental, Sensitivity to (Gaul)..... 81
Surgical Patient, Preanesthetic Evaluation of the (Taylor) 435
Surgical Team, Re-evaluation of the Methods of Cleaning the Hands of the (Estes) 445
Thyroid Cancer in Childhood and Adolescence (Gibson).. 676
Thyroid Malignancy (Link) 680
Tinea Capitis, Griseofulvin—An Advance in the Treatment of (Chivington-Gray-Wolf-Dalton) 1120
Tranquilizer, Which? (Hewitt) 1475
Tranquilizers and Anti-emetics in Surgical Patients (Giorgio) 441
Transfusions, Do's and Don'ts in 464
Treatment of Imperforate Anus (DeBoer) 1116
Treatment of Poisonous Snakebites: Present Status of Incision and Excision (Parrish) 1879
Triacetyloleandomycin, The Challenge of, in Pediatric Infections (Newsome) 1131
Trichophyton Tonsurans Infection of the Scalp in Central Indiana (Gray-Dalton-Starcs) 75
Tuberculin Test, The (Custer) 1618
Tumors, Diagnosis of Malignant Gynecologic, in Infants, Children and Adolescents (Gardiner) 655
Tumors, Malignant Bone, of Childhood (Garceau)..... 645
Tumors, Ocular, In Children (Harger) 662
Uterine Cervix, Carcinoma of, Radiologic Management of (Dunham) 453
Vaccinia Immune Globulin used for Vaccinia of Eyelids (Harger-Arata) 1323
Ventricular Aneurysm with Characteristic EKG Changes, Report of a Case (Rice-Fisch-Hays) 297
Ventricular Premature Systoles, Electrocardiographic Diagnosis and Clinical Implications of (Chevalier-Fisch), 263
Ventricular Tachycardia, Diagnosis of (Fisch)..... 1629
Wolff-Parkinson-White Syndrome Simulating Ventricular Tachycardia (Fisch) 2211
Which Tranquilizer? (Hewitt) 1475

EDITORIALS

Accidental Poisonings are Preventable 302
Aged Have Choice of 288 Health Insurers 2217
AMEF Dollars and Donors Rise 702
AMEF Shows Steady but Vigorous Growth..... 303
Americans More "Health Conscious"..... 1155
Annual Convention, 111th 1336
As L.A. Goes, So Goes The Nation..... 474
Cancer of the Colon: Detection or Prevention, (from Texas) 703
Complex—Controversial—Costly 1635
Cooperation Will Add Authority 472
Dangers of Mail Order Dispensing..... 1502
Democracy is Not a Spectator Sport (Rogers)..... 1900
Diabetes Week 1896
Don't Relax Yet 2040
Drug Prices 303
Editorial Notes 1897, 2045, 2218
Enforcement Program Saves Lives 2216
Fat Metabolism and Cholestrol 301
Few Oldsters Need Help 2216
Fifty Years of Conserving Human Life (American Red Cross) 305
Forand Legislation, Who Needs? 473
Foreign Medics Must Meet Standards 1636
From AMA: The Needy and the Near-needy Physician.. 859
Growth, Sales and Profits in Drug Industry..... 859
Health Information Foundation 94
Health Versus Wealth 1503
Homely but Helpful 1338
Increase in Hospital Admittance and Prepayments..... 1337
Interprofessional Strength 2044
Kaiser Plan in Honolulu, (from Hawaii)..... 704
Medical Education 92
Medicolegal Digest 1338
Most Aged Don't Want Federal Help..... 1896
Nation Fights No-Vote-Itis (Staudacher) 1898
Newer Progestins, The 1503
New State Medical Journal 474
No Such Thing as an Unloaded Gun 93
111th Annual Convention 1336
Population on the Rise 1503
Practical Politics and Doctors 858
Practical Politics—Better Government 702
Progressive Care Experiment 1155
Rabies Trend (Salisbury) 1899
Readiness Is a Desire for Perfection..... 2217
Retirement—Activity or Apathy? 1154
Seat Belts can Control Death, Injury..... 2043
Socialized Medicine Fails to Keep Promises..... 2043
To Encourage Giving (from the Northwest)..... 475
Voluntary Plans Grow in Coverage, Benefits..... 1634
Watch Out, (from Virginia) 1156
What Defeated MD Social Security? 2042
Why Blame Blue Cross?, (from N. Y.)..... 304
Youngsters are Safest 1637

SPECIAL FEATURES

Albert Stump Memorial Lecture, Medicine and the Law: a Socially Necessary Alliance (Murphy)..... 2066
AMA Annual Meeting, 109th: Forum by 2,000 medical men 861
AMA Clinical Meeting 2057
AMA House of Delegates Acts Favorably on Three Indiana Resolutions at Texas Meeting 100
AMA, Miami Meeting, Hoosiers Participate in, House of Delegates Actions Listed 1533
AMA President Meets Hoosier Leaders 485
AMA Scientific Symposium 855
Analysis, Review and Evaluation of Clinical Practice in the Hospital 1918
Are We Caring for the Old Folks? (Lamb)..... 709
Auxiliary Meeting Spotlights Accomplishments, Aims (Black) 1388
Blue Shield Benefits, Memo re Outpatient (Edwards).... 524
Child Psychiatry in Indiana (Simmons) 1348
Drug Prices . . . Here and Abroad (Smith Kline & French Laboratories) 1505
Duties of the Medical Expert in Court (Donadio)..... 851
Eisenhower Administration's Plan for Aged, from AMA.. 1105
Election Scene, On the 1960: Physicians Gear for Political Action as New Hoosier Group Forms..... 1923
Health and Medical Platform Summaries..... 1925
State Legislation Roundup 1927
Family Practice Program, I. U. School of Medicine Explains New 42
Forand Bill, The (Crimm) 714
Forand Bill and the Record of AMA, Re: The (correspondence) 1194, 1195, 1204
Hawaii—Rich in Lore of Medical Herbs (Wilson)..... 1206
Hoosier Winterland, a pictorial feature 98
Hospital Bill, Forces Affecting the Community's (Brown) 132
Hoosiers Participate in AMA Miami Meeting, House of Delegates Actions Listed 1533
How Something for Nothing Legislation Hurts Those who are Supposed to Benefit 1558
ISMA Annual Convention, 111th, Instructional Course Application Blanks 1510
I. U. School of Medicine Explains New Family Practice Program 42
Influenza Immunization (Burney) 2220
I was in Prison and You Came to Me..... 240
Inaugural Address of Mrs. Ina Rigley 1226

Indiana's Psychiatric Care, Treatment and Rehabilitation 110
It's That Time Again (Orr) 503
Law, Medicine and the, a Socially Necessary Alliance, Albert Stump Memorial Lecture (Murphy) 2066
Law-Science Academy of America (Smith) 1512
Lightening Does Strike (Marshall, Jr.) 1164
Medicine-at-Law, Decisions and Opinions from "The Citation", AMA 2108
'M. I.' (Medical Intelligence) (Offutt) 477
M.D. Degrees in 1958-59, 6,860 Students Receive 46
Old Folks at Home, The (Lamb) 518
One of the Finest (Askey) 2056
Owsley, Guy A., M.D. 1934
Panel Medicine, Steel Workers—Sooner or Later (Edwards) 532
Pharmaceutical Industry, Contributions of the, to Medical Science (McKeen) 328
Pharmaceutical Manufacturers, On Behalf of (Carney) ... 1526
Political Medicine (Editorial from Indianapolis News) ... 489
Political Medicine or Personal Medicine (Orr) 490
Proposal Submitted by the Treasury in Lieu of HR 10, 86th Congress 1158
Psychiatric Care, Indiana's, Treatment and Rehabilitation 110
Quarantine Procedures, Group Clearance Eliminated in... 1216
Report to the Nation (Smith) 1166
Schizophrenia in Children (Brown) 1906
Science Fair, 1960, Youngsters have future well in hand.. 1382
School Phobia: Psychiatric First Aid (Brown) 320
Steel Workers Panel Medicine—Sooner or Later (Edwards) 532
What is a Congressional Investigation? The Drug Industry's Trial—by Publicity (Wiley) 1362
Wings Over the World (Furbay) 1648

REGULAR FEATURES

Abstracts, Book Reviews 229, 744, 1298, 1530, 1844, 2118
AMEF 347, 601, 792, 1070, 1243
Add 1 (by Corki) 172, 361, 570, 762, 1059, 1236
Blue Cross-Blue Shield Series.....34, 236, 484, 732, 832, 1220, 1384, 1532, 1680, 1852, 2125, 2232
Deaths 176, 368, 573, 766, 1065, 1238, 1397, 1548, 1949, 2132, 2254
Fourth Estate 16, 230, 412, 630, 824, 1098, 1276, 1440, 1588, 1814, 1984, 2166
Herbs in Medical History (Wilson)....316, 482, 712, 1206, 1380
Indiana State Board of Health Report.....50, 242, 576, 734, 1051, 1235, 1378, 1547, 1694, 1943, 2126, 2243
Lighter Vein 375, 1069
Medical Essay Contest 97, 376, 459, 654, 1483, 1622, 1893, 2135, 2196
Medical Panorama (Cavins) 308, 1050
News Notes 158, 351, 552, 699, 750, 753, 1052-54, 1056-58, 1231-32, 1234, 1390-92, 1540, 1542, 1546, 1684, 1936, 1941, 2128-30, 2240
Our Cover 98, 278-79, 737, 1048, 1360, 2238
President's Page (Mericle) 95, 306, 479, 705, 863, 1161, 1340, 1507, 1638, 1902
President's Page (Owsley) 2048, 2222
To the Editor 424, 1292, 1460, 1854, 2127
Wanted: Physicians, Locations 40, 546, 834, 1224, 1299, 1462, 1948, 2234
Washington, Month in 12, 226, 402, 624, 816, 1092, 1264, 1434, 1580, 1808, 1976, 2160
Woman's Auxiliary Report to ISMA (Black).....96, 307, 481, 706
Woman's Auxiliary Reports to ISMA (Rigley).....1046, 1162, 1344, 1508, 1644, 1904, 2052, 2226

CONVENTION ISSUE

Amendments to the Constitution and Bylaws..... 1748
Announcement 1725
Convention Arrangements Committees..... 1744
Entertainment 1743
Fifty Year Club 1731
House of Delegates 1727
House of Delegates, Official Call to the..... 1726
Instructional Courses 1742
Journal, The 1734
Officers of I.S.M.A. 1732
Program, 111th Annual Convention 1738
Reference Committees 1731
Reports of Commissions 1767
Reports of Committees 1761
Reports of Officers 1751
Resolutions 1780
Scientific Exhibits 1783
Section Officers 1735
Technical Exhibits 1785
Women's Program 1746

ASSOCIATION BUSINESS

Council, ISMA, Meetings 586, 1407, 1700, 2311, 2315
District and County Society News....176, 369, 573, 770, 1065, 1238, 1398, 1548, 1950, 2133, 2255
Executive Committee, ISMA, Meetings.....178, 372, 582, 787, 1068, 1242, 1696, 1951, 2134, 2310
House of Delegates, ISMA, Minutes of 1960 Session.... 2279
Commission Meetings 581, 779, 1402, 1550, 2308

YEARBOOK SECTION

Approved Hospitals in Indiana..... 994
Approved Mental Hospitals 1004
Constitution and Bylaws of the ISMA..... 1024
Deaths of Indiana Physicians in 1959..... 1020
Disease Prevention by Immunization and Chemoprophylaxis 1040
Indiana Accredited Practical Nursing Schools..... 992
Indiana Accredited Schools of Nursing..... 990
I. U. School of Medicine, Heads of Departments..... 689
Licensed Nursing Homes in Indiana..... 1006
Membership Roster
Alphabetically 869
By Counties 901
Woman's Auxiliary 937
Poison Control Centers in Indiana..... 1038
Presidents of ISMA Since Its Organization..... 1023
Professional Medical and Allied Organizations..... 976
State Elected Officials 964
State Health Organizations 965
Voluntary Organizations 986

AUTHORS

Arata, Lucian, M.D., (Vaccinia Immune Globulin Used for Vaccinia of the Eyelids)..... 1323
Askey, E. Vincent, M.D., (One of the Finest)..... 2056
Bakemeier, Robert, M.D., (Lipoma of the Heart—Report of Two Cases) 294
Baxter, John P., M.D., (Meckel's Diverticulum Presenting as a Pelvic Tumor) 1867
Beeler, John W., M.D., (Postoperative Radiation for Carcinoma of the Breast) 1614
Black, Mrs. Mary A., (Woman's Auxiliary Reports to ISMA) 96, 307, 481, 706
Black, Mrs. Mary A., (Auxiliary Meeting Spotlights Accomplishments, Aims) 1388
Bond, William H., M.D., (Neoplastic Disorders of the Reticuloendothelial System in Infants and Children)... 649
Brown, Gordon T., M.D., (Psychiatric First Aid)..... 320
Brown, Ray E., M.D., (Forces Affecting the Community's Hospital Bill) 132
Buckner, George D., M.D., (Chest Injuries)..... 1484
Burney, Leroy E., M.D., (Influenza Immunization)..... 2220
Carney, Thomas P., M.D., (On Behalf of Pharmaceutical Manufacturers) 1526
Caylor, Harold D., M.D., (Hereditary Hyperparathyroidism) 1313
Caylor, Harold D., M.D., (Immediate Cholangiography).. 2014
Chevalier, Robert B., M.D., (Electrocardiographic Diagnosis and Clinical Implications of Ventricular Premature Systoles) 263
Childress, Richard H., M.D., (Reiter's Syndrome)..... 1599
Chivington, Paul V., Jr., M.D., (Griseofulvin—An Advance in the Treatment of Tinea Capitis)..... 1120

Cleveland, Frank P., M.D., ("Masquerades:" Homicide, Suicide, Accident or Natural Death) 2181
Crimm, Paul D., M.D., (The Forand Bill) 714
Culbertson, C. G., M.D., (Tests of Duck Embryo (DE) Rabies Vaccine Against Street Virus in Rabbits and Guinea Pigs) 1307
Custer, Edward W., M.D., (The Tuberculin Test) 1618
Dalton, John Eric, M.D., (Griseofulvin—An Advance in the Treatment of Tinea Capitis) 1120
Dalton, John Eric, M.D., (Trichophyton Tonsurans Infection of the Scalp in Central Indiana) 75
DeBoer, Arthur, M.D., (Treatment of Imperforate Anus) 1116
Donadio, James V., LL.B., (Duties of the Medical Expert in Court) 851
Dunham, H. H., M.D., (Radiologic Management of Carcinoma of the Uterine Cervix) 453
Edwards, E. T., M.D., (Memo re: Outpatient Blue Shield Benefits) 524
Edwards, E. T., M.D., (Steel Workers Panel Medicine—Sooner or Later) 532
Estes, Ambrose C., M.D., (Re-evaluation of the Methods of Cleaning the Hands of the Surgical Team) 445
Fasola, Alfred F., M.D., (Dyspnea) 466
Fisch, Charles, M.D., (Abnormal Electrocardiogram and a Normal Heart) 1497
Fisch, Charles, M.D., (Atrial Fibrillation, Atrial Tachycardia with Block, and Ventricular Tachycardia, due to Digitalis Intoxication) 1889
Fisch, Charles, M.D., (Diagnosis of Ventricular Tachycardia) 1629
Fisch, Charles, M.D., (Electrocardiographic Diagnosis and Clinical Implications of Ventricular Premature Systoles) 263
Fisch, Charles, M.D., (Employment of Cardiacs) 255
Fisch, Charles, M.D., (Myocardial Infarction) 2036
Fisch, Charles, M.D., (Second Heart Sound) 697
Fisch, Charles, M.D., (Transient Nature of Depression of Arrythmias by Potassium) 1331
Fisch, Charles, M.D., (Ventricular Aneurysm with Characteristic EKG Changes, Report of a Case) 297
Fisch, Charles, M.D., (Wolff-Parkinson-White Syndrome Simulating Ventricular Tachycardia) 2211
Fouts, Dallas B., Sr., M.D., (Metastatic Tumors of the Pericardium) 267
Furbay, John H., Ph.D., (Wings over the World) 1648
Garceau, George J., M.D., (Malignant Bone Tumors of Childhood) 645
Gardiner, Sprague H., M.D., (Diagnosis of Malignant Gynecologic Tumors in Infants, Children and Adolescents) 655
Gaul, L. Edward, M.D., (Sensitivity to Elemental Sulfur) 81
Genovese, Pasquale D., M.D., (Metastatic Tumors of the Pericardium) 267
Gibson, Robert K., M.D., (Thyroid Cancer in Childhood and Adolescence) 676
Giorgio, Douglas J., M.D., Anti-emetics and Tranquilizers in Surgical Patients) 441
Graham, Edward W., M.D., (A Case of Seven Primary Malignancies and Report of 30 Cases of Multiple Malignancies) 683
Gray, Howard R., M.D., (Griseofulvin—Advance in the Treatment of Tinea Capitis) 1120
Gray, Howard R., M.D., (Trichophyton Tonsurans Infection of the Scalp in Central Indiana) 75
Hammond, Keith, M.D., (Sex and Chromosomes) 1870
Harger, Robert William, M.D., (Ocular Tumors in Children) 662
Harger, Robert William, M.D., (Vaccinia Immune Globulin Used for Vaccinia of the Eyelids) 1323
Hays, Everett L., M.D., (Ventricular Aneurysm with Characteristic EKG Changes, Report of a Case) 297
Hess, Elmer, M.D., (Gonorrhea and Syphilis—A New Problem?) 1487
Hewitt, Mark I., M.D., (Which Tranquilizer?) 1475
Hickman, Jack W., M.D., (Reiter's Syndrome) 1599
Hodes, E., M.D., (Neoplastic Disorders of the Reticuloendothelial System in Infants and Children) 649
Huber, Carl P., M.D., (Diagnosis of Malignant Gynecologic Tumors in Infants, Children and Adolescents) .. 655
Hunter, Charles A., M.D., (The Shirodkar Procedure and the Habitual Aborter) 2017
Hurley, J. W., M.D., (Salicylates and the Stomach) 84
Ivy, J. D., M.D., (Salicylates and the Stomach) 84
Jackson, Charles E, M.D., (Hereditary Hyperparathyroidism) 1313
Kaminsky, Anthony, M.D., (Gonorrhea and Syphilis—A New Problem?) 1487
Katterjohn, James C., M.D., (Cobalt-60 Therapy in Mammary Cancer) 1606
Kohlstaedt, Kenneth G., M.D., (Cardiology at General Hospital) 253
Lamb, Emmett B., M.D., (Are We Caring For the Old Folks?) 709
Lamb, Emmett B., M.D., (The Old Folks at Home) 518
Laramore, Ward, M.D., (Patent Ductus Arteriosus with Pulmonary Hypertension without Reverse Flow, Diagnosis of) 280
Layman, Douglas, M.D., (Older Versus Newer Preanesthetic Drugs) 2023
Lein, John N., M.D., (The Shirodkar Procedure and the Habitual Aborter) 2017
Lichtenstein, Manuel E., M.D., (Treatment of Acute Intestinal Obstruction) 1465
Lieberman, Arnold, M.D., (Bloated Bartender, The Case of the) 1884
Lieberman, Arnold, M.D., (Cement Boot, The Case of the) 1137
Lieberman, Arnold, M.D., (Changing Personality, The Case of the) 1623
Lieberman, Arnold, M.D., (Comatose Truckdriver, The Case of the) 460
Lieberman, Arnold, M.D., (Four-Sided Triangle, The Case of the) 2202
Lieberman, Arnold, M.D., (Hypothyroid Constipation, The Case of) 1324
Lieberman, Arnold, M.D., (Juvenile Jetsam, The Case of the) 1493
Lieberman, Arnold, M.D., Luetic Couple, The Case of the) 692
Link, Goethe, M.D., (Thyroid Malignancy) 680
Little, Clarence C., (Cancer—The Research Approach) .. 1469
Loh, Wei-Ping, M.D., (Diagnostic Uses of Radioisotopes) 2209
Lyle, Herbert P., M.D., (Gunshot Wounds) 2185
McArt, B. A., M.D., (Salicylates and the Stomach) 84
McKeen, John E., (Contributions of the Pharmaceutical Industry to Medical Science) 328
McLaren, Harold, Jr., M.D., (Gonorrhea and Syphilis—A New Problem?) 1487
Marshall, A. L., Jr., M.D., (Lightening Does Strike) 1164
Mehne, Richard G., M.D., (Three Hydrocephalic Newborns—Each of a Successive Pregnancy of a White Female) 1472
Megenhardt, Dennis S., M.D., (Meckel's Diverticulum Presenting as a Pelvic Tumor) 1867
Miller, Dean A., M.D., (Non-cardiac Congestive Heart Failure) 290
Miller, Roscoe E., M.D., (Multiple Jejunal Diverticula: Report of Three Cases) 2009
Morse, Arthur S., Jr., M.D., (Sickle Cell Anemia: Case Report and Review) 1857
Moss, N. Henry, M.D., (Duration of Convalescence Following Surgery) 1134
Mumford, E. B., M.D., (Early Active Motion in Joint Pain and Stiffness) 1303
Murphy, Robert B., M.D., (Medicine and the Law: A Socially Necessary Alliance) 2066
Musser, A. Wendell, M.D., (Hepato-Lenticular Degeneration) 68
Myren, Richard A., (A Program for Indiana Coroners) .. 2191
Newsome, C. K., M.D., (The Challenge of Triacetyloleandomycin in Pediatric Infections) 1131
Nierman, M. Murray, M.D., (Gelfoam in the Treatment of Stasis Ulcers) 1317
Noe, William R., M.D., (Caps, Gowns and Masks—Who Should Wear them and of what Material Should they be Manufactured) 445
Noveroske, Richard J., M.D., (Multiple Jejunal Diverticula: Report of Three Cases) 2009

Offutt, A. C., M.D., ('M.I.'—Medical Intelligence) 477
Orr, Louis M., M.D, (Political Medicine or Personal Medicine) 490
Oyer, John H, M.D., (Gout) 1863
Palmer, Harley P., M.D., (Pheochromocytoma and Neurofibrosarcoma in a Patient with Neurofibromatosis) 2197
Parrish, Henry M., M.D., (Treatment of Poisonous Snakebites: Present Status of Incision and Excision) 1879
Peck, F. B., Jr., M.D., (Tests of Duck Embryo (DE) Rabies Vaccine Against Street Virus in Rabbits and Guinea Pigs) 1307
Pierce, Emmett C., M.D., (Adrenal Insufficiency Due to Histoplasmosis, A Case Report) 57
Pierce, Emmett C., M.D., (Lipoma of the Heart—Report of Two Cases) 294
Powell, H. M., M.D., Tests of Duck Embryo (DE) Rabies Vaccine Against Street Virus in Rabbits and Guinea Pigs) 1307
Priestley, James T., M.D., (Hyperfunctioning Adrenal Lesions) 1109
Rice, Howard M., M.D., (Ventricular Aneurysm with Characteristic EKG Changes, Report of a Case) 297
Rogers, John F., M.D., (Democracy is not a Spectator Sport) 1900
Rohn, Robert J., M.D., (Neoplastic Disorders of the Reticuloendothelial System in Infants and Children) 649
Roth, Russell B., M.D., (Gonorrhea and Syphilis—A New Problem?) 1487
Salisbury, J. D., D.V.M., (Rabies Trend) 1899
Scott, Frank, M.D., (Management of Mucosal Perforation in the Course of Pyloric Myotomy) 457
Shellhouse, M., M.D., (Relationship of Benign and Malignant Breast Lesions) 63
Shullenberger, Wendell A., M.D., 'Silent' Myocardial Infarction) 285
Simmons, James E., M.D., (Child Psychiatry in Indiana) 1348
Smith, Austin, M.D., (Report to the Nation) 1166
Smith, Edward B., M.D., (A Case of Seven Primary Malignancies and a Report of 30 Cases of Multiple Malignancies) 683
Smith, Hubert Winston, LL.B., M.D., (Law-Science Academy of America) 1512
Smith, Kline & French Laboratories, (Drug Prices . . . Here and Abroad) 1505
Snively, W. D., Jr., M.D., (Fluid Balance in Obstruction of the Large Intestine) 427
Stander, Richard W., M.D., (The Adrenal Cortex and Reproductive Failure) 1873
Stander, Richard W., M.D., (The Shirodkar Procedure and the Habitual Aborter) 2017
Starcs, Helene, M.S., (Trichophyton Tonsurans Infection of the Scalp in Central Indiana) 75
Staudacher, Russell F., (Nation Fights No-Vote-Itis) 1898
Steinmetz, Edward F., M.D., (Diagnosis of Chronic Pericardial Effusion) 1146
Steinmetz, Edward F., M.D., (Effect of Digitalis on the Master Exercise Test) 259
Stoelting, V. K., M.D., (Older Versus Newer Preanesthetic Drugs) 2023
Storey, D. Edmund, M.D., (Quinidine Purpura) 89
Swenson, Esther J., Ph.D., (Mental Health and the Transplanted School Child) 2028
Talbert, Pierre C., M.D., (Hereditary Hyperparathyroidism) 1313
Taylor, Cyril, M.D., (Preanesthetic Evaluation of the Surgical Patient) 435
Thornburg, Kenneth, M.D., (Meckel's Diverticulum Presenting as a Pelvic Tumor) 1867
von der Leith, William C., M.D., (Carcinoma of the Pancreatico-Duodenal Region) 454
Wiley, Alexander, (What is a Congressional Investigation? The Drug Industry's Trial—by Publicity) 1362
Wilson, Miki, (Herbs in Medical History) ..316, 482, 712, 1380
Wilson, Miki, (Hawaii—Rich in Lore of Medical Herbs). 1206
Wolf, Robert L., M.D., (Griseofulvin—An Advance in the Treatment of Tinea Capitis) 1120
Woodruff, J. Donald, M.D., (Problems of Ovarian Cysts) 1124
Yurdin, Donald H., M.D., (Genito-Urinary Malignancies in Children) 671
Zeier, Francis G., M.D., (Overlooked and Misdiagnosed Fractures) 447

DEATHS

Allison, H. Rutherford, M.D., LaPorte County 766
Arford, Roxford D., M.D., Anderson 176
Ball, Robert S., M.D., Lebanon 1065
Barnett, Charles Eldridge, M.D., Fort Wayne (formerly). 573
Bassett, Clancy, M.D., Thorntown 1065
Bear, Lowery H., M.D., Vevay 176
Bender, Cecil K., M.D., Goshen 1238
Borders, Theodore R., M.D., Fort Wayne 1949
Brenner, Andrew M., M.D., Winchester 1949
Briscoe, Clarence E., M.D., New Albany 176
Brown, Asa W., M.D., Bluffton 368
Buttz, Rose J., M.D., Indianapolis 1065
Calvin, Jessie C., M.D., Fort Wayne 176
Combs, Charles N., M.D., Terre Haute 766
Craven, Howard T., M.D., Indianapolis 1397
Culmer, Walter N., M.D., Bloomington 2132
Dalton, John E., M.D., Indianapolis 1949
Dancer, Charles R., M.D., Fort Wayne 1949
Dudding, Joseph E., M.D., Hope 1397
Dugan, William M., M.D., Indianapolis 1397
Elliott, Lloyd A., M.D., Elkhart 1949
Englebert, William F., Jr., M.D., Tuscaloosa, Ala 1238
Fine, Nathaniel J, M.D., Indianapolis 1949
Glosson, Jack R., M.D., Clay City 2132
Hathaway, Clayton B., M.D., Butler 368
Hiestand, Harley, M.D., Pennville 368
Hinchman, Clarence P., M.D., Geneva 1238
Hull, Arthur W., M.D., Elkhart 2132
Ivey, Donnell R., M.D., Royal Center 573
Jones, Hiram H., M.D., Salamonia 573
Knepple, LaMar, M.D., Kokomo 1949
Laird, Leslie A., M.D., Richmond 766
Larkin, Bernard J., M.D., Indianapolis 2132
Leff, Abe H., M.D., Indianapolis 2132
Luckey, Harold A., M.D., Wolf Lake 573
Markel, Ivan J., M.D., Elkhart 573
McCaskey, Carl H., M.D., Indianapolis 2254
Michaels, J. F., M.D., Edinburg 1949
Miller, J. Don., M.D., Indianapolis 766
Miller, Minor, M.D., Evansville 176
Morrison, Lindsey, M.D., Hammond 573
Murphy, Harold Oliver, M.D., Warsaw and Claypool 1397
Nisenbaum, Harold, M.D., Evansville 1950
Ottinger, Ross C., M.D., Indianapolis 1397
Piazza, Leonard F., M.D., Michigan City 368
Pierce, Harold J., M.D., Terre Haute 2254
Rawles, Lyman T., M.D., Fort Wayne 1950
Rothring, Howard E., M.D., Seymour 1238
Sandorf, Marvin, M.D., Indianapolis 1548
Savery, Charles Edward, M.D., South Bend (formerly) .. 768
Schaefer, C. Richard, M.D., Indianapolis 1238
Schulze, Hans A., M.D., Pendleton (formerly) 1950
Simpson, Morrell, M.D., Bedford (formerly) 768
Stewart, Milton B., M.D., Logansport 368
Swihart, Leonard F., M.D., Elkhart 1548
Take, John F., M.D., French Lick 1397
Vail, George A., M.D., Lawrenceburg 1548
VanArsdall, Clarence R., M.D., Terre Haute 2132
Walker, Frank C., M.D., Indianapolis 368
Walker, William G., M.D., East Chicago 768
Whallon, Arthur J., M.D., Richmond 1548
Williams, Aubrey H., M.D., Fort Wayne 1950
Williams, Theodore L., M.D., Bloomington 768
Wisener, Guthrie H., M.D., Richmond 1397
Wood, Elmer E., M.D., Columbus 2132
Wyland, B. J., M.D., Mishawaka 1065
Yencer, Martin W., M.D., Richmond 768

To Remove This Index
Pull Back Cover to Right
and Unfasten Staples.

61-1125

Indiana state medical association.
Journal.
v.53, 1960.

DATE	ISSUED TO
MAR 9 '62	L. Steinberg

61-1125

Indiana state medical association. Journal.
v.53, 1960.

RETURN THIS BOOK ON OR BEFORE LAST DATE STAMPED

MAR 9 '62

APR 17 '65

OCT 22 '6[illegible]